SHE mapping report

Lessons learnt from policies and practices of SHE member countries

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Schools for Health in Europe

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Place: Schools for Health in Europe Network Foundation (SHE), Haderslev, Denmark

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Abstract

The Schools for Health in Europe Network Foundation mapping (SHE mapping) survey is a cross-national study to map the level of implementation of health promotion in schools of the SHE member countries and how this implementation is carried out. SHE mapping collected international data on: the integration of the national Health Promoting School (HPS) policy into other national policies; how national policies frame school practices in the whole school approach of HPS; how national policies contribute to a healthy physical environment in the school setting; the contributions of national policies to a school's social environment, favourable to health promotion; the guidelines, tools and resources for a school to become a HPS; the national process of monitoring / evaluation of HPS; health topics included in the national HPS policy; health promoting school label; sources of funding for national HPS; main expectations of the SHE national coordinators for their national HPS scheme; number of HPS in SHE member countries; HPS facilities; how inclusion of health promotion is done in the school curriculum; health topics worked regularly in HPS; learning methods / strategies in HPS; practices and suggestions for the SHE School Manual and its two accompanying tools; facilitating factors and barriers faced by HPS in the SHE member countries. Data were collected using the Survey Monkey. All SHE national and regional coordinators from the 37 SHE member countries were invited to complete a questionnaire, upon completion of a statement of informed consent. Data were received from 75.7% of countries, but after removal of the incomplete questionnaires and two SHE regional coordinators who responded in duplicate for their country, because it was not possible to gather information from regions as there were only three regional coordinators who answered, 64.9% of countries were analysed.

Keywords

School for Health in Europe Network Foundation
Health promoting schools
Whole school approach
SHE national coordinator
SHE regional coordinator
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Healthy school physical environment
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Table of Contents

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Acronyms

SHE	Schools for Health in Europe Network Foundation
HPS	Health Promoting Schools
SHE NC	Schools for Health in Europe Network Foundation National Coordinator
HP	Health Promotion

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Chapter 1. Introduction

Background

Since the 1st European Conference on Health Promoting Schools (HPS), held in Thessaloniki-Halkidiki, Greece in 1997, the European Network of Health Promoting Schools, currently The Schools for Health in Europe Network Foundation (SHE), has advocated the implementation of the health promoting school concept throughout Europe, encouraging government action for its full implementation (see, for example, Conference Resolution for the 1st European Conference on HPS (WHO, 1997); the Egmond Agenda: Education & Health in Partnership (WHO, 2002); the Vilnius resolution: Better Schools through Health (WHO, 2009); the Odense Statement: Our ABC for Equity, Education and Health (SHE, 2013)).

In the Odense Statement, all participants re-affirmed that the principles, values, aims and objectives of this European network remain strong and reinforced the commitment to broaden and strengthen relevant research to enable the development and implementation of health promoting schools between 2014 and 2020 (SHE, 2013).

Therefore, the principles, values, aims and objectives associated with the SHE concept of health promoting schools, the critical health education approach within the paradigm of health promoting schools (e.g. McNamara & Simovska, 2015), the National Health Education Standards (NHES) of the Centre for Disease Control and Prevention (National Health Education Standards, n.d.), the SHE Factsheets (SHE, 2013 a, 2013b, 2014, 2018), research on implementation of health promotion programmes or projects in schools (e.g. Bessems et al., 2012; Darlington et al., 2018; Mladenovik et al., 2010; O'Toole, 2017; Rosário et al., 2016; Vilaça, 2017), the health and education objectives of the 2030 Agenda for Sustainable Development (United Nations, 2015) among others were used as the theoretical framework for the elaboration of the SHE mapping survey.

The SHE Core Values (Figure 1) established in the Vilnius Resolution (WHO, 2009) and reaffirmed again in *The Moscow Statement: Health, Wellbeing and Education in Times of Uncertainty assumed* by all participants in the last European Conference on HPS (Dadaczynski, Jensen, Viig, Sormunen, von Seelen, Kuchma, & Vilaça, 2019), were the main guidelines for the questioning about public policies and policies adopted by the health promoting schools which are the objectives of the mapping in this report.

Equity. Equal access for all to education and health.

Sustainability. Health, education and development are linked. Activities and programmes are implemented in a systematic way over a prolonged period.

Inclusion. Diversity is celebrated. Schools are communities of learning, where all feel trusted and respected.

Empowerment. All members of the school community are actively involved.

Democracy. Health promoting schools are based on democratic values.

Figure 1. *SHE Core values*

One of the main aims of the Schools for Health in Europe Network Foundation is to create and maintain active collaboration between health and education ministries along with national and regional networks

of health promoting schools to encourage them to carry out a whole-school approach, assuming that all aspects of the school community can impact upon pupils' health and wellbeing, and that health and learning are linked and are mutually depend. SHE recommends the focus on six components in order to achieve a whole-school approach (Figure 2).

1. **Healthy school policies** are clearly defined documents or in accepted practice that are designed to promote health and well-being. These policies may regulate which foods can be served at the school or describe how to prevent or address school bullying. The policies are part of the school plan.

2. **School physical environment** includes the buildings, grounds and school surroundings. For example, creating a healthy physical environment may include making the school grounds more appealing for recreation and physical activity.

3. **School social environment** relates to the quality of the relationships among and between school community members, e.g., between students and students and school staff. The social environment is influenced by the relationships with parents and the broader community.

4. **Individual health skills and action competencies** can be promoted through the curriculum such as through school health education and through activities that develop knowledge and skills which enable students to build competencies and take action related to health, well-being and educational attainment.

5. **Community links** are links between the school and the students' families and the school and key groups/individuals in the surrounding community. Consulting and collaborating with community stakeholders will support health promoting school efforts and support the school community in their health promoting actions.

6. **Health services** are the local and regional school health services or school-linked services that are responsible for students' health care and health promotion by providing direct student services. This includes students with special needs. Health service workers can work with teachers on specific issues, e.g., hygiene and sexual education. (*Create healthy and supporting environments*, n.d.)

Figure 2. *Components of the whole-school approach*

To make this mapping relevant to policy and practice, while engaging with national or regional SHE coordinators in identifying key issues that could deepen the international reflection on the power of the SHE Network Foundation to operationalize collaborative work among both researchers and stakeholders working on HPS based on a whole school approach, this survey uses the whole school approach guidelines to question SHE coordinators about the practices of their country's health promoting schools.

Against this background, the SHE mapping aims to map the level of implementation of health promotion in schools of the SHE member countries, and how this implementation is carried out. Therefore, the following research questions are the fundamental core of this mapping:

1. What are the national policies for the implementation of health promotion in schools (6 to 18 years-old children/students) and, if appropriate for the country, in kindergarten/day care/ pre-schools (3-5 years-old)?
2. How do national policies establish that schools organize themselves to operationalize national or regional policies for the implementation of health promotion in schools?

3. Are there national or regional guidelines, institutional tools, resources or professional support systems in order to become a health promoting school and if so, what are they?
4. How is each component of the health promoting schools approach materialized in schools, and how many schools in each country follow this approach?
5. Is there a national process for monitoring / evaluating the implementation of health promotion in schools and if so, how is this process working?
6. Is there a school / national concern with continuing professional development (CPD) of health and education professionals to support the implementation of health promotion projects/ programs in schools and if so, how is this process working?
7. What is the place of the school practices related to health promotion in the school curriculum, and what are these practices?
8. What are the potential barriers and facilitating factors for the implementation of health promoting schools, and how do they impact the process?
9. Is there a national qualification for schools which carry out excellent health promotion and if so, what is the process for assigning this qualification?

The SHE mapping intends to provide the analytical framework to: (i) (re) think the SHE internal policies towards SHE Member countries; (ii) propose some guidelines for the (re) organization of support structures in the SHE Network Foundation to differentially support countries with different degrees of implementation of health promotion in schools, to promote international equity in health promotion in schools; iii) disseminate successful practices; iv) deepen the international reflection on the influence of the SHE Network Foundation to operationalize collaborative work among both researchers and stakeholders working on HPS.

In this chapter, the construction of the data collection instrument, how participants were selected, and how data collection and data treatment were carried out, will be presented. In the following section, characteristics of the SHE coordinators will be described. Finally, the content of this report will be briefly outlined.

The questionnaire

The research questions and the topics for SHE mapping were first discussed in the working group consisting of twelve members of the SHE research group, from eight different countries (Denmark, France, Hungary, Italy, Portugal, Republic of North Macedonia, Spain, The Netherlands) who voluntarily decided to participate in this SHE mapping task. The task force integrated six members who produced the outputs, and the reading group included more five more members who gave feedback to the task force on their deliveries. A working plan guided both the progress of the task and data collection procedures.

The conceptual framework for the design of the online survey was based on the SHE Network Foundation pillars and values and research on health promoting schools as referred to above. The questionnaire is structured into three main sections: (a) background information, (b) questions regarding national policies for the implementation of health promotion in schools, and (c) questions concerning how the implementation of health promotion is carried out (Appendix 2). The background information includes gender, age, academic background and the number of years in the position of the respondent.

Background information includes the identification of the SHE coordinator's country identification, her/his position in SHE (SHE national coordinator, SHE regional coordinator or Key informant selected by the national/ regional coordinator), who appointed him/her as SHE coordinator, how long he/she has been in the position in SHE referred to, and what is her/his gender, age, scientific area of the highest level of formal education completed, and his/her main tasks as SHE coordinator.

Questions regarding national policies for the implementation of health promotion in schools, the second part of the questionnaire, includes, when appropriate, the same indicators of the SHE rapid assessment tool. After questioning about how national HPS is included in national policies (questions 11 and 12), the questionnaire invites participants to use a scale (required by national policies, recommended by national policies, not mentioned in national policies, not sure) to describe how national policies establish that schools organize themselves to operationalize a healthy school policy (question 13), a healthy physical school environment (question 14), and a school's social environment favourable to health promotion (question 15). The question on a healthy school policy includes items of the following type: "Health promotion is part of the schools' educational goals"; "Schools have a written policy on students', and teachers' / non-teaching staff' s health and wellbeing", "health education is part of the curriculum". Regarding the school's physical environment, items are, for example: "School facilities such as the playground, classrooms, toilets, canteen and corridors are student-friendly, safe clean and promote hygiene, enough hand soap and paper towels in the toilets) for all students", "Students' physical education in schools follows national standards / recommendations / guidelines", "The route to school is safe and designed to encourage students to engage in physical activity (e.g. cycling or walking)". Finally, regarding how national policies contribute to a school social environment favourable to health promotion, the items are of the following type: "The space in the canteen, playground, classrooms and corridors is organized to promote student socialization and wellbeing", "Health education and health promoting activities are included in after-school programmes"; "A support system (services and accommodations) is in place at schools for students with special learning, developmental and physical needs".

The second part of the questionnaire also asks participants if there are national or regional guidelines (question 16) and institutional tools or / and resources (question 17) for a school to become a health promoting school, or actions to encourage schools to use the SHE school manual, SHE Rapid Assessment Tool and the School Action Planner (Question 18). To finish this second part, participants are invited to indicate if there is a national process to monitor /evaluate health promoting schools (question 19), continuing professional development (CPD) for professionals involved in school health promotion (question 20), what health topics are included in the national HPS policy (question 21), if there are health promoting school labels (Questions 22) and how the health promoting school scheme is funded (Question 23).

The third part of the questionnaire, after identifying the size of the national network and the school profile (e.g. deprived area or not) (questions 25, 26, 27 and 28) asks participants to characterize the facilities of national health-promoting schools (question 29), how health promotion is included in the school curriculum (question 30), what health issues schools work with (question 31), and what learning methods they use most (question 32). After, respondents are invited to give suggestions for improving the SHE School Manual (question 33), the SHE Rapid Assessment Tool (question 34) and the SHE School Action Planner (question 35). To conclude the questionnaire, four open-ended questions are used to ask SHE

coordinators to reflect on the facilitating factors and barriers that schools in their country encounter, to become and continue being recognized as health promoting schools.

The questionnaire was constructed in the English. After the validation of the questionnaire by the working group on mapping, a pilot study of the instrument was carried out in order to ascertain whether the wording of items was clear to all respondents and to determine whether the questions had the same meaning for all participants.

Participants and data collection

All SHE national and regional coordinators were invited to participate in this research. They were informed that if they did not have conditions to complete the online survey, they could invite a relevant key informant selected by them to do this task. There are 37 SHE Member countries (Figure 3).

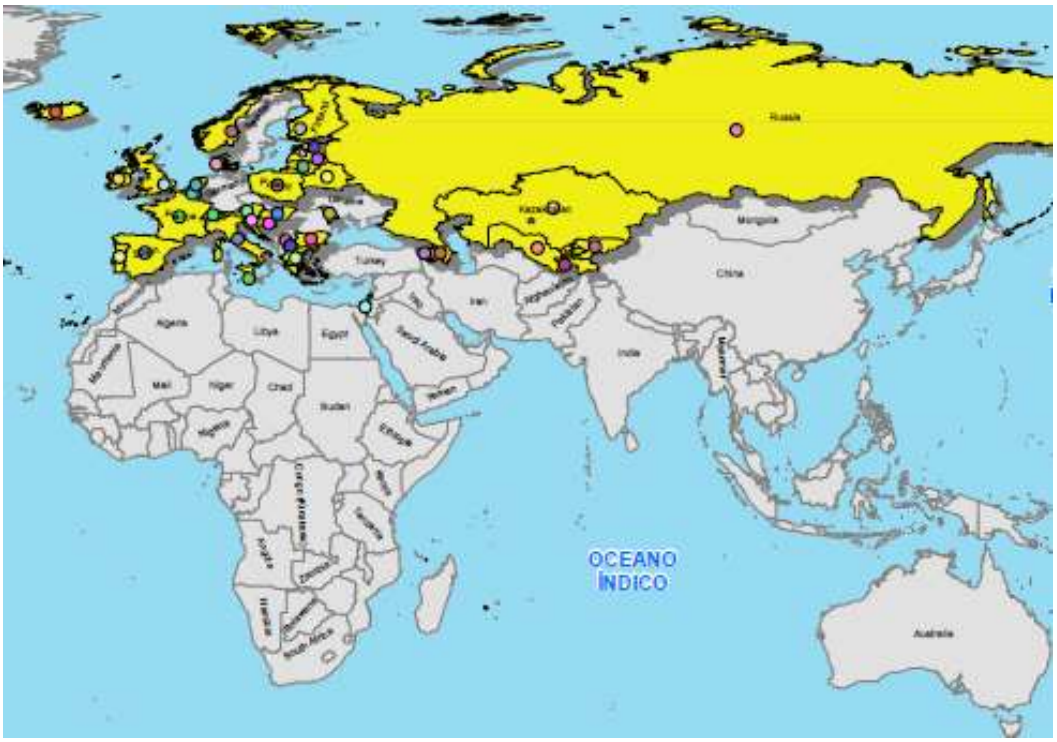

Figure 3. *SHE member countries*

Some of these countries have national and regional coordinators (See appendix 1). The participants were contacted by an email that provided information about the aims of the study, the ethics, the method and the amount of time that the questionnaire would be expected to take to complete. Subsequently, the link to access the online questionnaire was written in the email, emphasizing the right to withdraw from the

study without prejudice. Participants' written consent was incorporated on the first page of the online survey.

Ethical considerations

The invitation to respondents to participate in this study was accompanied by an Informed Consent that included the following information: purpose of the research; procedures involved in the research; possible risks and discomforts to the subject; benefits of the research to society and to the school community; length of time the subject is expected to participate; person to contact for answers to questions in the event of a research-related injury or emergency; statement indicating that participation is voluntary and that refusal to participate will not result in any type of action; statement regarding the subjects' right to withdraw from the study at any time without any consequences.

Data analysis

The answers to the open questions were analysed following the content analysis and a mix (inductive and deductive) categorization system was created by three members of the task force on mapping, including the description of the categories and the coding of data in function of this description. This process was submitted to an independent examination of another three members of the task force on mapping. When there was no consensus this data was ignored. The quantitative data was submitted to a descriptive statistical analysis.

Characteristics of respondents

Of the 37 SHE Member countries, 28 countries answered the online questionnaire (75.7%): Austria, Belarus, Belgium, Bulgaria, Croatia, Denmark, Estonia, Finland, France, Greece, Hungary, Iceland, Ireland, Italy, Kazakhstan, Latvia, Lithuania, Moldova, North Macedonia, Netherlands, Norway, Poland, Portugal, Russian Federation, Slovenia, Switzerland, Uzbekistan, Wales (UK).

In Poland, the national and the regional coordinators replied and in Italy the two regional coordinators responded, having completed a total of 30 questionnaires. The questionnaires from four countries were incomplete and because of this, were removed from the analysis. Therefore, in total, data were collected from 24 countries (64.9%).

Most SHE coordinators are women (84.6%) and half are 51 years old or older (Table 1).

Table 1. *Personal characteristics of SHE coordinators*

	(n=26)	
Characteristic	f	%
Sex at birth		
Female	22	84.6
Male	4	15.4
Age		
< 40 years old	5	19.2
41-50 years old	8	30.8
51-60 years old	6	23.1
>61 years old	7	26.9
Scientific area of the highest level of formal education completed		
Social and human sciences	16	61.5
Life and health sciences (e.g. Medicine, Biology, Pharmacy)	10	38.5

The scientific area of the highest level of formal education completed by most SHE coordinators is Social and human sciences (61.5%), which includes a diverse range of courses (e.g. Education, Sociology, Psychology, Administration, Management, Social Sciences).
Almost all respondents have the role of SHE national coordinators (92.3%) and have been appointed to this role by an official institution (Table 2).

Table 2. *Characteristics of SHE coordinators*

		(n=26)
Characteristic	f	%
Position in SHE		
SHE National coordinator	23	88.5
SHE Regional coordinator	3	11.5
Appointed as a coordinator by an official institution		
No	4	15.4
Yes	22	84.6
Official institution which appointed the SHE national/ regional coordinator		
Ministry of Education	4	15.4
Ministry of Health	7	26.9
Ministry of Health and Ministry of Education	5	19.2
Other	6	23.1
He/ She was not appointed by an Official institution (Poland, Russian Federation, Uzbekistan and Wales (UK))	4	15.4

It is noted that most of the SHE national coordinators (n=17; 77.3%) were appointed by the Ministry of Health (Belarus, Greece, Ireland, Kazakhstan, Moldova, Slovenia) or the Ministry of Health in conjunction with the Ministry of Education (Belgium, Hungary, Iceland, Lithuania, Norway) or other official (Estonia - National Institute for Health Development; Latvia -The Centre for Disease Prevention and Control of Latvia) and non-official health related organizations (Finland - NGO SOSTE, a Finnish Federation of Social Affairs and Health which is an umbrella organisation for over 230 member organisations; Russia- National Institute/Centre of Public Health; Uzbekistan - National Institute/Centre of Public Health; Wales (UK) - National Institute/Centre of Public Health).

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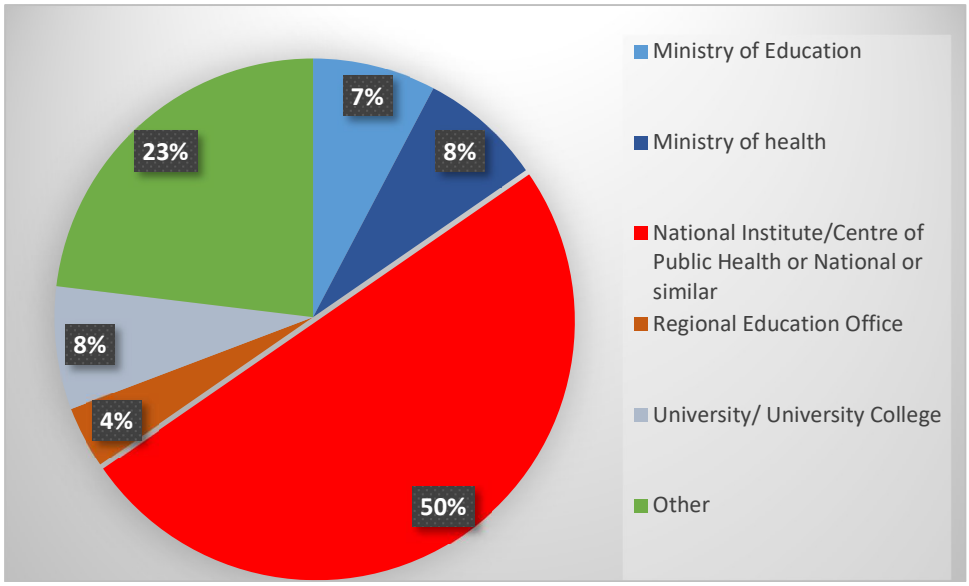
A minority of SHE national coordinators (n=5; 19.2%) were appointed by the Ministry of Education (Denmark, France, Poland, Portugal).

There were three regional coordinators who participated in this survey. In Italy both coordinators were nominated by the Department of Health. In Poland the coordinator did not mention who indicated him.

As noted above, most of the SHE national coordinators were appointed by the Ministry of Health, or by the Ministry of Health with the Ministry of Education, or other Health related organizations. It is also noted that most of the SHE national or regional Coordinators perform their role as SHE coordinators in Health related organizations (73.1%), more specifically, at the National Institute / Centres of Public Health or similar (50.0%, 13 countries; Belgium, Croatia, Estonia, Greece, Iceland, Kazakhstan, Latvia, North Macedonia, Moldova, Russian Federation, Slovenia, Uzbekistan, Wales (UK)), Ministry of Health (7.7%, Ireland, Lithuania) or other health-related institutions (15.4%, Belarus- State Educational Establishment «Belarusian Medical Academy of Postgraduate Education», Finland, Hungary, Italy- Regional coordinators) (Figure 4).



(n=26)

Figure 4. *Organization where SHE national/ regional coordinators works*

Only a small part of SHE national/ regional coordinators work in education-related organizations (23.0%), more specifically, in the Ministry of Education (7.7%, France, Portugal), University / University College (7.7%, Denmark, Norway), Regional Education Office (3.8%, Poland – regional SHE Coordinator), and National In-service Teachers Training Centre (3.8%, Poland-national Coordinator).

Although almost half of SHE national / regional coordinators have less than five years of experience in their position, while the other half have many years of experience (Figure 5).

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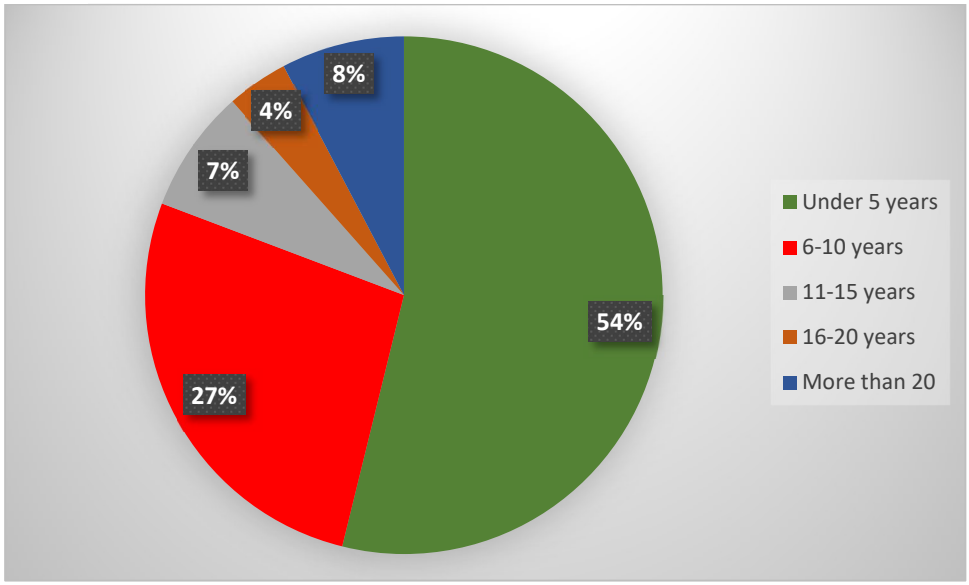
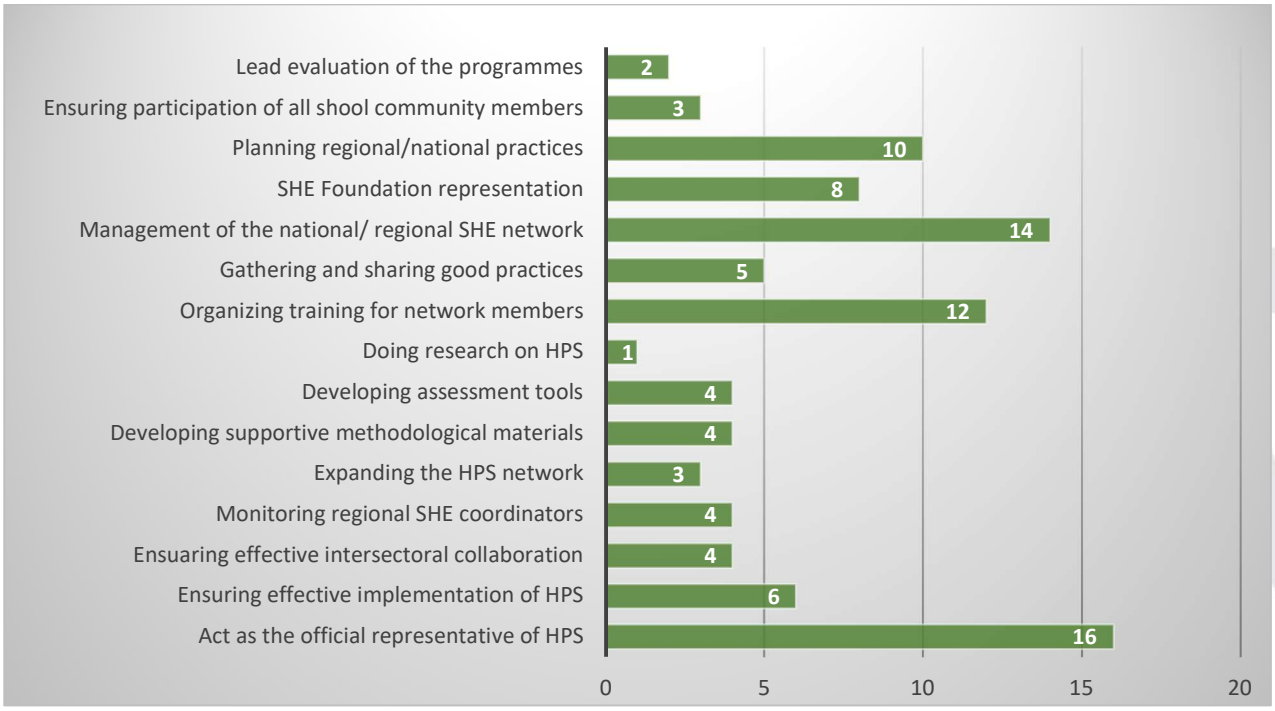


(n=26)

Figure 5. *How long SHE national/ regional coordinators perform their work*

Main tasks performed by SHE national / regional coordinators in their countries are listed in the figure 6.



(n=26)

Figure 6. *Main tasks performed by SHE national / regional coordinators their countries*

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Most SHE national / regional coordinators reported performing various tasks. However, those most mentioned were: acting as the official representative of HPS (62.5%); management of the national/ regional SHE network (58.3%); organizing training for network members (50.0%), and planning regional/national practices (41.7%).

The following are some of the answers given by respondents that emphasize the multitude of tasks that most reported:

> Supporting, counselling and training of the local health promoting coordinators (trainings, supervisions) Developing supportive methodological materials and assessment tools for educational institutions Research Providing training for educational institutions staff on various health and welfare topics. Organizing Summer Workshops for network members (1 for kindergartens and 1 for schools). Gathering and sharing good practices among network members. (Estonia, SHE National Coordinator)"
>
> Establishing relationships with Regional Education Offices, management of regional SHE network, planning, integration of SHE with regional policies, training, relations with other regions, SHE Foundation representation. Activity planning, regional policies, relations with other institutions (Italy, SHE Regional Coordinator)
>
> Acting as the official representative of Health Promoting Schools of the Kazakhstan; ensuring effective implementation of Health Promoting Schools; ensuring effective collaboration at the intersectoral level to promote health in schools; monitoring of the regional coordinators in the country; expanding a network of health promoting schools (Kazakhstan, SHE National Coordinator)
>
> Coordinating health services and health promotion training for schools, liaising with the Department of Education on strategic direction of health promotion in schools. (Ireland, SHE National Coordinator)
>
> Helping the work of the Ministry of Human Capacities which also contains the State Department of Health and the State Department of Education, working with the aim of improving educational institutions in their daily health promoting tasks prescribed in holistic health promotion for all educational institutions (since 2012), working at the European level with SHE. (Hungary, SHE National Coordinator)
>
> Development of criteria for health promoting schools, training for education and health professionals, development of criteria for the effectiveness of health promotion schools (Belarus, SHE National Coordinator)
>
> Coordinate the Finnish network of healthy schools (national education for schools, communication with schools, dissemination of information, support for schools). Dissemination of information and experience produced by SHE and the Finnish Healthy Schools Network to various expert groups, communication channels and make use of knowledge in advocacy (decision-makers, experts). Strengthening school-organization cooperation. Increasing the number of schools in the Finnish Healthy Schools network (Filand, SHE National Coordinator)
>
> I am in charge of supporting the deployment of the Health Promoting School approach in the schools and secondary schools that are committed to it. Educational and pedagogical resources and tools are made available on the website for education professionals. In collaboration with the Continuing Education Department, I am developing the program for the national training seminar on the Health Promoting Schools. Finally, I am in charge of leading the network of academic referees appointed by the rectors of the academy. (France, SHE National Coordinator)

Network development, organising and running workshops and seminars for schools and preschool coordinators, dissemination of the concept of HPS in Poland, giving support to regional coordinators, conducting training, supporting school activities in the field of health promotion, supporting the exchange of good examples among schools, dissemination of materials and good practices. (Poland, SHE National Coordinator)

The main tasks include the coordination of member schools of HPS in Latvia, developing and carrying out the working plan and organizing activities in conjunction with member schools – informative lectures, training activities, experience exchange events for coordinators of participating schools. The National coordinator provides support for school coordinators by sending informative materials, work sheets that can be used in work projects with students in order to promote health prevention and to raise understanding about various health issues. The National coordinator organizes an annual seminar for coordinators of HPS in Latvia and also coordinates the work of the Council of National Healthy schools in Latvia. (Latvia, SHE National Coordinator)

Leading the delivery of education setting programmes at an all-Wales level, including the Welsh Network of Healthy Schools Schemes, ensuring that programmes and activities are based on sound public health principles and evidence, leading the implementation, monitoring and evaluation of the programmes, working across organisations and sectors, ensuring that the Educational Settings Programmes are co-produced with the public, pupils/students and key partners. (Wales, SHE National Coordinator)

Leading a group of 9 regional coordinators, designing an annual program for schools (according to national and WHO/Unicef/SHE guidelines) - together with the regional coordinators, programme focused on the selected topics of health, assistance in the implementation of 3 regional meetings for each region (27 meetings in total), cooperating with MH health professionals and other sectors relating to current problems of children and adolescents, organizing trainings for teachers and health professionals, supporting schools to implement HE/HP programs and projects, translating materials and developing own HP materials with professionals. (Slovenia, SHE National Coordinator)

Participating in the work of the Ministry for Health and Education, to improve school health promotion and health promotion in other educational institutions. Taking part in the work to improve HPS at the international level. (Hungary, SHE National Coordinator)

Organization of the report

This report is organized into four chapters. In the first chapter, Introduction, following a set of background information on how SHE mapping emerged and the clarification of the research questions, there is a description about how the questionnaire was prepared and validated, how the selection of participants and data collection were done, and what are the characteristics of the participants in the study.
The second chapter, Growing up unequal: contextual and political factors in health promoting schools, begins by examining how national HPS policy is integrated into other national policies, how national policies frame HPS practices, and how they contribute to a healthy physical environment and a healthy social environment. Subsequently, the mapping of the existing guidelines, tools and resources in the SHE member countries to the HPS, the national process of monitoring and evaluation HPS, the health topics included in the national HPS policy, the HPS labelling processes and the sources of funding for EPS are discussed. This chapter concludes with the presentation of the expectations of the SHE national coordinators for their country.

In the third chapter, Practices, barriers and facilitating factors in health promoting schools, the number and percentage of HPS in each country and the facilities in EPS are presented. Subsequently, the mapping on how the inclusion of health promotion in the curriculum is done, the health topics worked regularly in HPS and the learning strategies used are presented. Finally, the practices and suggestions for the improvement of the SHE School Manual and the facilitating factors and barriers for the implementation of the HPS are analysed.
In the fourth chapter, Summary and implications, a summary of the results and their implications for the future are presented.

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Chapter 2. Growing up unequal: contextual and political factors in health promoting schools

Integration of the national HPS policy into other national policies

Fourteen (58.3%) of the SHE member countries that participated in this study have a formal Health Promoting Schools policy. National HPS policy is included in the national education and public health policies in 17 (70.8%) of the SHE member countries involved in this survey. Figure 7 illustrates in which national policies the national HPS policy is included in for the 24 responding countries.

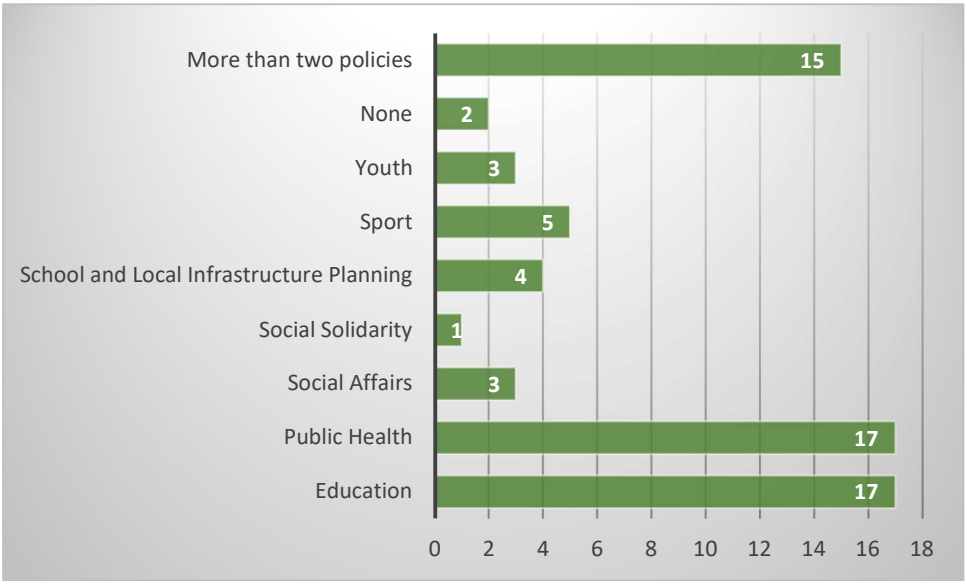

Figure 7. *Integration of national HPS policy into other national policies*

Fifteen of the countries (62.5%) have incorporated the HPS policy into three or more other national policies.

How national policies frame school practices

In almost 80% of SHE member countries, national policies require (50.0%) or recommend (33.3%) that health promotion be part of the schools' educational goals, that health education be part of the curriculum (66.7% of countries require this and 12.5% recommend it) and that health and wellbeing, and preventing and dealing with health related problems be part of the school policy (45.8% of countries require this and 33.3% recommend it) (Figure 8).

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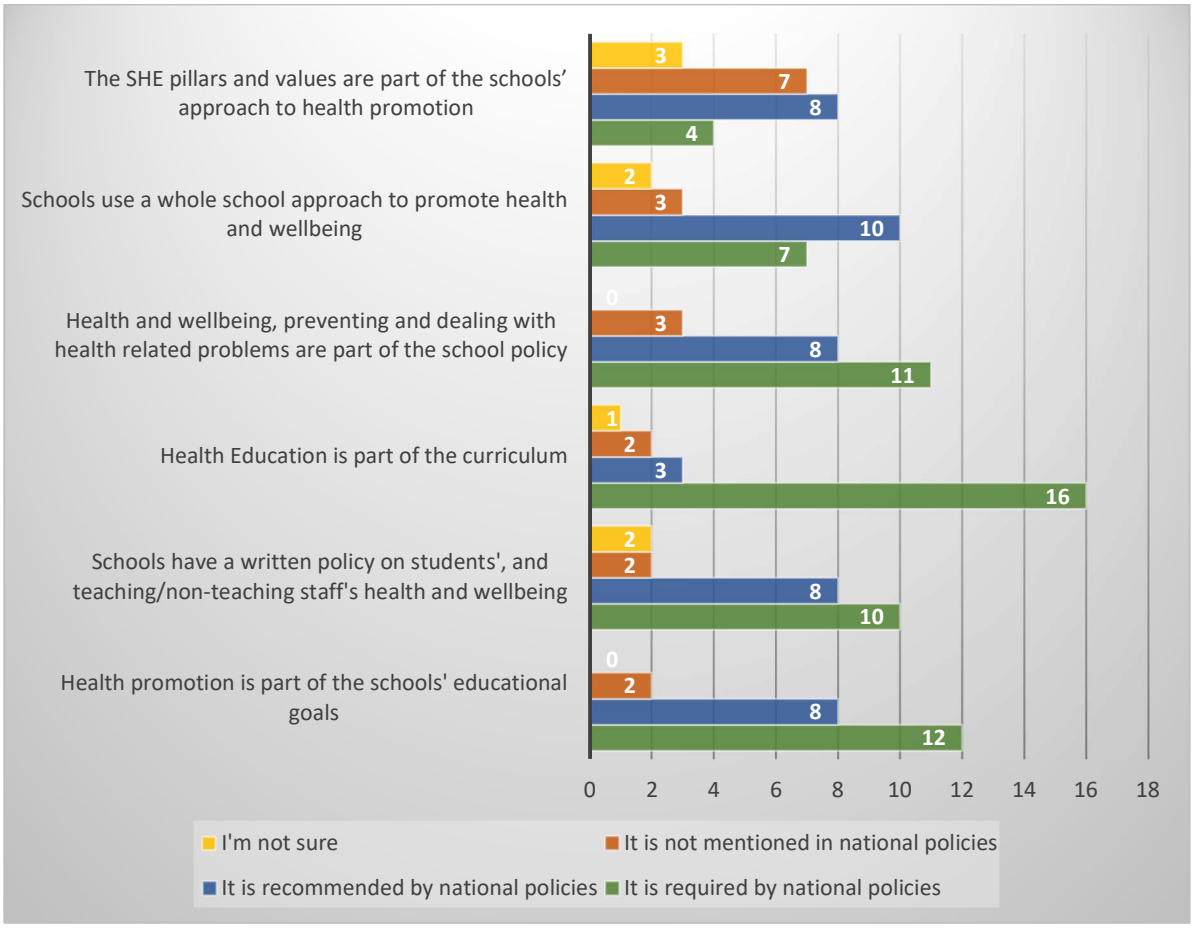

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Figure 8. *How national policies frame school practices*

It is also noted that in almost 70% of SHE member countries, national policies require or recommend that schools have a written policy on students', and teaching / non-teaching staff's health and wellbeing (41.7% of countries require this and 33.3% recommend it) and that schools use a whole school approach to promote health and wellbeing (29.2% of countries require this and 41.7% recommend it).

The SHE pillars and values as part of the schools' approach to health promotion are only required (16.7%) or recommended (33.3%) in about half of these SHE member countries.

Figure 9 shows how Belgium is a good example of the congruence between national policies and SHE values and principles.

> Every 10 years, the minister of health sets up different "Health Objectives". The general objective is that by 2025 Flemish people will live healthier. The specific objective for education is that by 2025 80% of the schools maintain a preventive health policy that meets minimal quality criteria. The minimal quality criteria are based on our healthy school framework and we monitor this objective by our health policy survey. There is a new decree concerning pupil guidance that clarifies the roles of all players and which requires that the health policy in schools is a part of the policy on pupil guidance. From September 1st, there are new attainment targets in the 1st stage of secondary schools. The aim is to gradually implement new attainment targets in all years

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of secondary education. The new learning outcomes are based on 16 European key competences. Three of these have a direct link with health policy. The difference with the past is that learning outcomes concerning health are now to be achieved, instead of only pursued. Attainment targets are also no longer linked to one subject. Instead, they are competence-oriented, allowing schools to decide how the whole school team can collaborate to achieve them.

We also have a new reference framework for the quality of education. During a school inspection, the education inspectorate examines the school's quality of education as well as the quality of its policy on pupil guidance, including the health policy of the school. The difference with the past is that it takes the whole school approach into account. So, attention is paid not only to what happens in the classroom, but also the inspectorates looks at the whole school approach, for example what is written in the school-regulations about healthy snacks and drinks. There is also more attention paid to the processes by which schools come to decisions, for example the way they provide for participation of pupils in the policy of the school. Another example is attention to the way the schools decides to make special efforts in a specific domain: Is it based on an analysis? The main goal is the achievement of wellbeing of both students and school staff members.

(Belgium, SHE National Coordinator)

Figure 9. *The voice of the Belgian SHE National Coordinator on how national policies frame school practices*

Other important data were collected on the importance attached in SHE member countries' national policies to health promoting schools. For example, in Greece there is a National policy on healthy food provided by school canteens, a provision of a school psychologist for schools in need, health education is provisional as a project for primary schools and some topics such as healthy eating and traffic safety are integrated in taught lessons, and there is a compulsory week for implementing health education projects in secondary education. In Iceland health and wellbeing are one of six pillars of the National Curriculum of Education for children age 2-19 years of age. Finally, in Poland there is a National Mental Health Policy and a National Health Policy.

The contribution of National policies to a healthy physical environment in the school setting

The school's physical environment is regulated by national policies to be healthy in approximately 80% of the surveyed schools. It is noted that in almost all countries legislation requires or recommends that school facilities such as the playground, classrooms, toilets, canteen and corridors be student-friendly, safe, clean and promote hygiene (enough hand soap and paper towels in the toilets) for all pupils (62.5% of countries require this and 16.7% recommend it), be age-appropriate (58.3% of countries require and 20.8% recommend), and appropriate with regard to pupils with special needs (54.2% of countries require and 29.2% recommend) (Figure 10).

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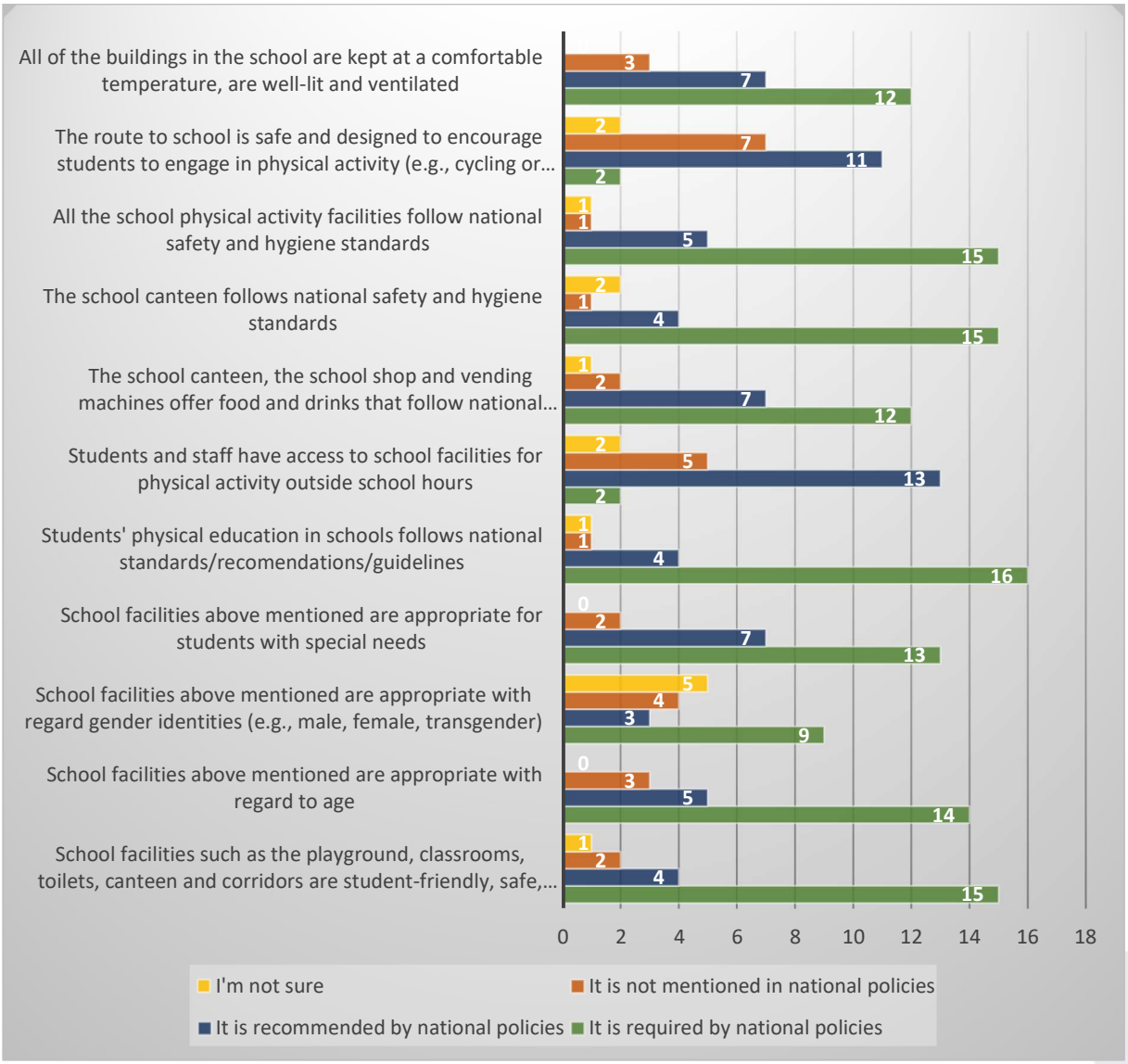

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Figure 10. *The contribution of National policies to a healthy school physical environment*

In almost 80% of countries, all school physical activity facilities follow national safety and hygiene standards (62.5% of countries require this and 20.8% recommend it) and students' physical education in schools follows national standards / recommendations / guidelines (66.7% of countries require this and 16.7% recommend it).

The same kind of legislation applies to school canteens. The school shop and vending machines offer food and drinks that follow national food standards (50.0% of countries require this and 29.2% recommend it) and exist national safety and hygiene standards (62.5% of countries require this and 16.7% recommend it).

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National legislation in 79.2% of countries also requires or recommends that all buildings in the school be kept at a comfortable temperature, are well-lit and ventilated.

There are, however, some aspects that are only required or recommended by the national policies of almost 50% of countries and which are therefore, still a challenge for the work of SHE in the future. The legislation of these countries does not yet take into account that school facilities must be appropriate with regard to gender identities (e.g., male, female, transgender) and that routes to school should be safe and designed to encourage students to engage in physical activity (e.g. cycling or walking).

Figure 11 gives voice to the Norwegian and French SHE National Coordinators who talk about their national legislation.

> All children have the right to enjoy a safe and good school environment that promotes health, wellbeing and learning. The Norwegian government has defined the following three sector goals for primary and secondary education: pupils shall have a good, inclusive learning environment. The pupils shall master basic skills and have sound subject knowledge; More pupils and apprentices will completion of upper secondary education and training. Quality in education can be defined as the degree of fulfilment of these sector goals as well as the curriculum and the Education Act. A quality system consists of a common knowledge base, tools, procedures and goals for key actors on different levels in the Education system. National and local plans and goals are the basis for a systematic process to enhance quality development. The overarching goal is better wellbeing and learning outcomes for children, students and apprentices. (Norway, SHE National Coordinator)
>
> The legal education code sets the regulatory framework for the use of premises, health, hygiene and safety standards. Article 30 of Act No. 2004-806 of 9 August 2004 on public health policy, stipulates that vending machines for beverages and food products accessible to students are prohibited in schools. The law for balanced trade relations in the agricultural sector and healthy and sustainable food, promulgated on 1 November 2018, provides for the strengthening in the fight against food waste and introducing more certified organic products or products with a label of origin and quality, in all collective catering, including school canteen. Finally, the legal education code specifies that the public service of education is designed and organized according to the needs of pupils and students and that it ensures the inclusion of all children in the school system, without any form of distinction. (France, SHE National Coordinator)

Figure 11. *The voice of the Norwegian and French National Coordinators on how national policies contribute to a healthy school physical environment*

The SHE Italian Regional Coordinator noted that specific guidelines and actions are going to be included in the next National Prevention Plan 2020-2025. Several countries have referred to national legislation that they consider most important in promoting a healthy physical environment at school. In the Russian Federation, the law that addresses the aforementioned aspects is the Federal Law "On the Basics of Protecting the Health of Citizens in the Russian Federation" dated November 21, 2011 N 323-ФЗ. Other countries explain that there are several laws that can be consulted online, as is the case with Slovenia (https: // www. gov.si/drzavni-organi/ministrstva/ministrstvo-za-izobrazevanje-znanost-in-sport/zakonodaja/#e25821), Iceland (Compulsory School Act: https://www.government.is/media/menntamalaraduneyti-media/media/law-and-regulations/Compulsory-School-Act-No.-91-2008.pdf), and Portugal (https://data.dre.pt/eli/dec-lei/55/2018 / 07/06 / p / dre / en / html).

The SHE national coordinator of Greece explains that in her country, there is a law regarding the provision of healthy food in school canteen and sanitary standards, but it is often not implemented. Also, municipalities and parents' associations decide whether there are physical activities provided to students outside school hours (i.e. football lessons in the weekends or afternoons), but according to law, schools are not obliged to be open outside school hours. This shows how important it is that in the future, SHE creates conditions for SHE national coordinators to encourage their country's health-promoting schools to implement existing national legislation.

National policies regarding school social environment

The aspect required by most countries in their national policies that contributes to a health promoting environment in the school setting is the legislation related to pupils with special learning, developmental and physical needs. In 62.5% of countries a support system (services and accommodations) in schools for these students is required, and in 54.2% of countries, it is required that schools have a system for identifying and referring students with special needs to outside professionals if the student's needs are beyond the scope of the school's expertise (Figure 12).

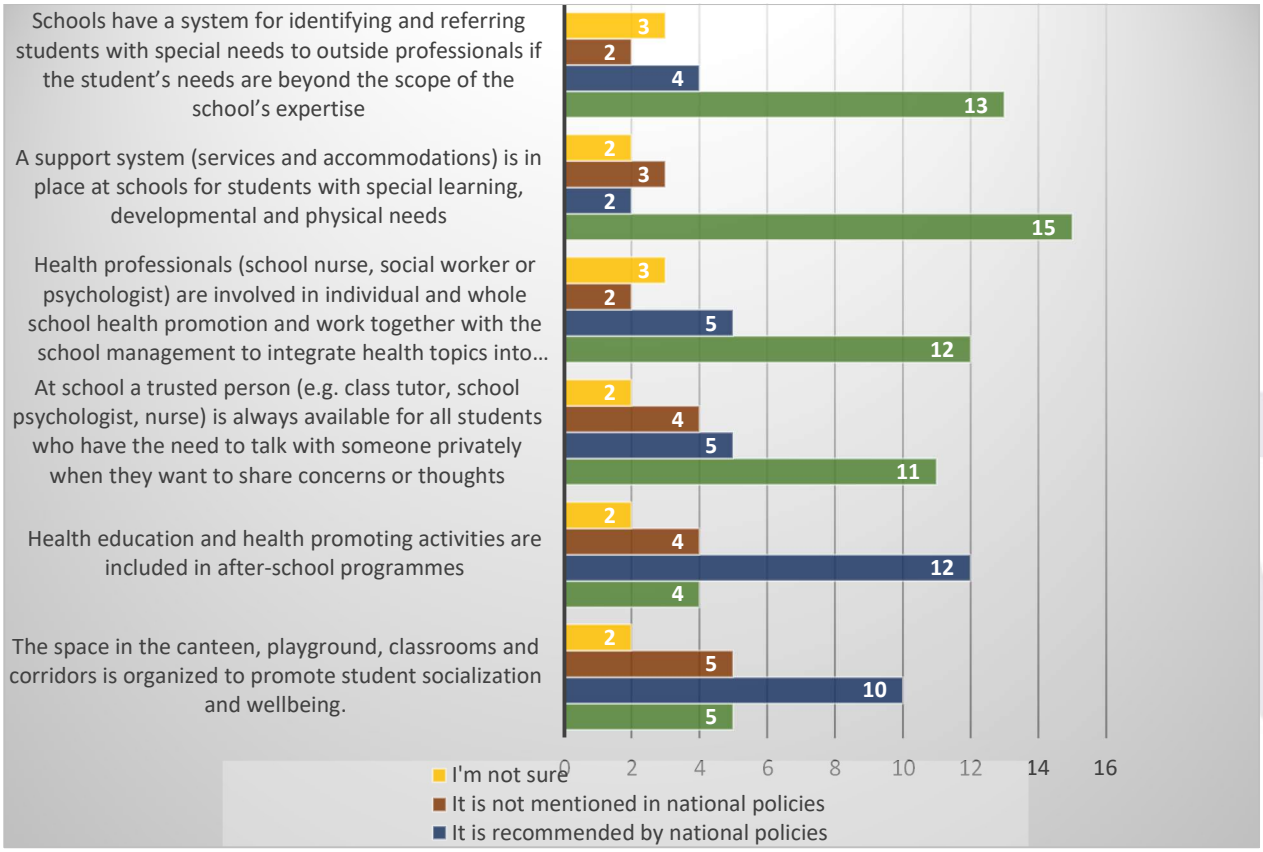

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Figure 12. *National policies regarding school social environment*

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It is also noted that the national policies of 50.0% of countries require that health professionals (school nurse, social worker or psychologist) be involved in individual and whole school health promotion, and work together with the school management to integrate health topics into the school curriculum and policy and, 45.8% of countries require that a trusted person (e.g. class tutor, school psychologist, nurse) is always available for all students who have the need to talk to someone privately when they want to share their concerns or thoughts at school.

It is interesting to note that 50.0% of the countries recommend that health education and health promoting activities be included in after-school programs and 41.7% that the space in the canteen, playground, classrooms and corridors be organized to promote student interaction and wellbeing.

In light of these results, it is important to further strengthen the role of the SHE Network Foundation and SHE national / regional coordinators in enhancing an inclusive, participatory and democratic social school environment in all countries, and more specifically in SHE member countries.

Guidelines, tools and resources for a school to become a health promoting school

In 72.7% of the SHE member countries involved in this survey, there are national or regional guidelines for a school to become a health promoting school and 81.8% of the countries have national or regional institutional tools or/and resources to become a health promoting school. The following is a brief overview of the information provided by the SHE national coordinators.

Belgium (Flanders). The "healthy school framework" helps Flemish schools to improve their preventive health policy. It is based on the principles of SHE. It is a choice of the government that all of the partners who are involved in the implementation of a healthy policy in schools use this framework. Schools however aren't obliged to use the framework. School governing boards have a wide autonomy in Flanders, including the autonomy about the methods they use. The healthy school framework is however used in the different kind of measures and the main pillars are seen as a starting point for all the partners surrounding and supporting schools. The "healthy school framework" consists of three tools: the health matrix, a 7 step roadmap and a spider web. The combination is crucial to realize effective health changes with the pupils. The health matrix encourages schools to implement a mix of different strategies: education, environmental interventions, agreements and rules, care and guidance and to work on different levels: pupils, the class, the school and the environment outside the school. The 7 step roadmap, based on the Plan Do Check Act circle and implement pilot studies, guides a school through the different steps they must take to implement a coherent preventive health policy. The spider web is a tool that helps schools to recognize the success factors of a coherent policy. This framework can be used by primary and secondary schools, mainstream and special needs education. The framework can be used for all of the health themes. To put the healthy school framework into practice hands on tools are provided by the thematic expertise centres. Examples are education guidelines, teaching materials, guidelines on how to organize the school in a healthy way, theme-specific checklists, sample letters for parents etc.

Belarus. The guidelines in Belarus show the presence of a policy to preserve the health of school children and teachers, creating a supportive school environment, nutrition, physical activity; a healthy lifestyle

training, and interagency collaboration. There is the "Organization of a resource centre for health preservation in institutions of general secondary education" (// Instructions for use registration number 018-1215 of 03/21/2016)

Estonia. The school/kindergarten has a health promoting school work group The school/kindergarten has carried out health and welfare assessments: "Assessment tools: Assessment tool for health promoting school work groups"; Assessment tool for internal evaluation, the SHE rapid assessment tool; Assessment for the current state of nutrition and physical activity; Assessment tool for the psychosocial environment; Assessment tool for the safety and security. The health promoting work group has developed a Health Action Plan for comprehensive support of the health and wellbeing of children and staff. Different kinds of written materials are published online (https://www.terviseinfo.ee/et/tervise-edendamine/koolis/olulised-abimaterjalid; https://www.terviseinfo.ee/et/tervise-edendamine/lasteaias/juhendmaterjalid)

Finland. Health promoting school contents are largely included in national curriculums at different school levels and are currently working to expand their network.

France. The Health Promoting Scho A vademecum, distributed to all schools, explains the Health Promoting School approach to all educational teams. An academic referent team is in charge of supporting the entry of schools into this process. A Health Promoting School is a three-step process and schools can apply for a label for each of these steps. The Eduscol website portal dedicated to school health promotion provides educational and pedagogical tools and resources to implement health promotion actions.

Greece. The guidelines developed according to SHE / ENHPS have been used since 1993. However, in 2004 the country stopped using these guidelines. There are SHE tools provided by the Institute of Child Health, but currently they are not implemented at a national or regional levels. However, they are trying to fix this.

Hungary. As in Hungary holistic health promotion is a prescription for all educational institutions, we put the main emphasis not on how to become a health promoting school, but on the practical health promoting tasks teachers have to do with all children or pupils. Our guideline serves this. According to the special situation in Hungary, we give help not just for becoming a health promoting school but for doing their HP work better. We give help through several projects and more recently, through a national questionnaire, which will be sent to all schools in the coming days.

Iceland. There are guidelines, checklists and indicators published by Directorate of Health Iceland (DOHI) and the national curriculum for schools. These materials are available in an interactive website published by DOHI.

Ireland. There is a Wellbeing Policy Statement and Framework for Practice, revised October 2019, which can be accessed on a website (Www.education.ie/en/schools-colleges/information/wellbeingineducation/wellbeing-in-education.html)

Italy. Italian general guidelines define the SHE pillars, the whole school approach and intersectoral collaboration. At a regional level several documents and tools have been published.

Latvia. The guidelines include informative material entitled "Health promoting school". This material was prepared and published by The Centre for Disease and Prevention of Latvia. In this material schools can access basic information about the “Health promoting school” program, participation criteria, steps on how to engage in the program, good practice examples, etc. In the website of The Centre of Disease Prevention and Control, accessible structured information on how to become a health promoting school is available.

Lithuania. There is a description of the Procedure for Schools designated as HPS and approved by the Ministry of Health and Education. They have methodological guidance on how to design HPS programs in schools and then how to measure all health promoting activities.

Moldova. The pilot schools have adopted the SHE online school manual.

Poland. There are HPS Standards, Indicators and Tools.

Portugal. There are Guidelines for Health Promotion and Education, elaborated by the Ministries of Education and Health. The Portuguese Health Promotion and Education guidelines play a key role in the development of healthy, sustainable and happy citizens and societies, which is why they contribute to the goals and objectives set by the World Health Organization for Health and Wellbeing in Europe - Health 2020, and the EU2020 Strategy on Sustainable Growth and Inclusive Education and, the United Nations 2030 Agenda for Sustainable Development. Following the IX World Conference on Health Promotion (2016), the guidelines reinforce the importance of promoting health and improving health literacy in a global context promoting sustainable development. The Health Education Framework (HEF) is organized by levels of education and education cycles - pre-primary, primary, secondary and secondary education. Conceived as a coherent whole, this Framework is based on a structure common to the various levels and cycles of education and teaching, offering for each of them a proposal for a specific approach of the HEF. Five global themes are identified: Mental Health and Violence Prevention, Food Education, Physical Activity, Addictive Behaviours and Dependencies, Affections and Sexuality Education. The municipalities, using their expanded responsibilities for education, provide the schools with human and material resources to allow them to obtain a better response to the needs of a Health Promoting School.

Russian Federation. There is a Guide with national guidelines entitled "Schools health promotion in Russia: the principles and organization of work. Monitoring and efficiency".

Slovenia. The guidelines are on the website of the Slovene Network of HPS (https://www.nijz.si/sl/slovenska-mreza-zdravih-sol) that is translated into English. There is a call for tender every several years to all Slovene schools.

The SHE online school manual and its two accompanying tools, the SHE Rapid Assessment Tool and the School Action Planner, are available in the Schools for Health in Europe Network Foundation (SHE) website (https://www.schoolsforhealth.org/resources/materials-and-tools/health-promoting-school-manuals/english).

When asked if the national coordinators performed any national or regional actions to encourage schools to use these materials, half of them replied that they did not (Figure 13).

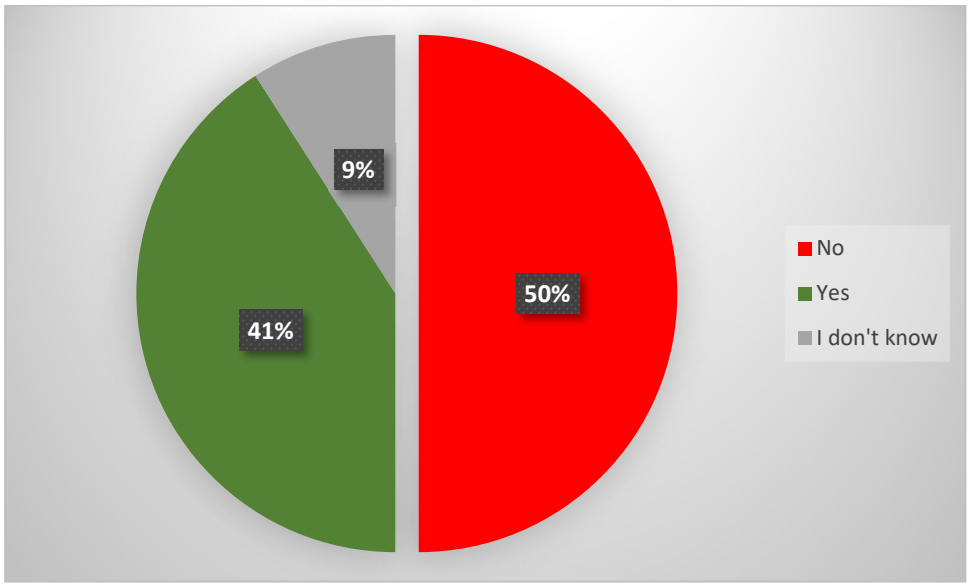

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Figure 13. *Existence of national / regional actions to encourage schools to use the SHE online school manual and tools*

Schools in Flanders, Ireland and Iceland do not use this SHE material because they use their own material: the healthy school framework to develop their health policy, that were based on the SHE principles (Flanders); the guidelines for wellbeing developed by the Department of Education (Ireland), and guidelines, checklists and indicators built on the SHE material). However, SHE material is mentioned as further reading material for health promoting schools.

Various countries translated these materials, uploaded them into their website (Estonia, Greek, Italy, Poland, Portugal, Slovenia) and trained teachers (Estonia, Greece, Portugal) or regional coordinators (Slovenia) in their use. In Moldova, currently these resources are used by 20 pilot schools in the country. In Lithuania schools are recommended to use these material and in Finland schools are informed about the use of these tools.

National process to monitor / evaluate health promoting schools

Fourteen (58.3%) of the SHE member countries that participated in this survey have a national process to monitor/ evaluate health promoting schools. These processes are developed with different modalities and frequency.

In Kazakhstan, the National Centre for Public Health collect reports from regional coordinators every six months.

Belarus, Iceland, Latvia, Poland, Slovenia and Wales (UK) evaluate health promoting schools annually, although with different objectives and assessment tools, according to SHE national coordinators (Figure 14).

The assessment of Health Schools is carried out once a year in April. (Belarus)

With the interactive website we have checklists, indicators and automatic reports once a year. (Iceland)

In each year, all member schools have to complete and submit the surveys (questionnaire form) in order to have their work in health promotion evaluated during that current year. The national coordinator, together with a team, evaluates submitted surveys. If a school has fulfilled all the relevant criteria, it receives the confirmation to continue to be a member in the programme. It is also important to participate in activities and events which are organised for HPS schools – annual seminars, experience exchange for school coordinators. (Latvia)

An annual report of regional coordinators who monitor/evaluate implementation of the programme in their regions is completed. (Poland)

Schools submit the planning and evaluation of their tasks in an online questionnaire at the end of the school year and a regional and national report is then produced. Three times a year there are regional meetings with schools, examples of good practices, lectures and reporting on school work. (Slovenia)

Each year, the main paediatricians of the regions submit a report on the dynamics of any incidences in schools, and the sanitary status of schools. (Wales (UK))

Figure 14. *Different types of annual evaluation of health promoting schools*

The Belgian national coordinator gave a detailed explanation of the evaluation carried out every four years in her country regarding health promoting schools:

> Off course, the health objectives need to be monitored and evaluated throughout the years. The government therefore looks at our Health Policy Survey, which we complete every four years. A unique feature of this survey is the measurement at the organisational level. We never measure the behaviour of the individuals (students), but what the schools does to encourage a healthier lifestyle. We survey all primary and secondary schools in Flanders. We hope to influence policy makers with the results. The survey is filled with questions based on the content of our framework: Healthy School. We ask questions about: organisational management: Is there any budget available for health initiatives? Building expertise: e.g. Is there collaboration with experts?; Participation: e.g. Is there participation by pupils?; Working evidence based: e.g. do you evaluate the health initiatives or policies at school? We also ask questions about: Education: e.g. Is alcohol addressed as a health issue in the school lessons?; Environmental interventions: e.g. Are there vending machines available in the school, with or without soft drinks?; Regulation and agreements: e.g. Are there any agreements made for the maintenance of the ventilation system in school?; Care and coaching: e.g. does the school play a role in providing smoking cessation counselling?

The SHE national coordinator of Hungary explained that they just are putting on Survey Monkey the HHP questionnaire constructed according to the HHP Recommendation sent out to all schools in 2016, and according to several ongoing assistance processes.

A group of SHE national coordinators described the process of monitoring / evaluation based only on what is evaluated and who evaluates, as can be read in the following excerpts:

> It is focused on the impact of HPS, it is managed by local health units and managed by the regional government. (Italy, SHE regional coordinator)

> The Directorate-General for School Education (Dgesco) supports the monitoring of the deployment. At the academic level, the referent teams are the interlocutors of the educational teams. Video conferences are organised between Dgesco and the academic teams to monitor the implementation of the measure (France, SHE national coordinator)

It is part of the Department of Education school self-evaluation process (Ireland, SHE national coordinator)

Continuing professional development of health and education professionals to support HPS

Continuing professional development of teachers (58.3%), psychologists (50.0%), childhood educators (45.8%) and school principals (45.8%) is considered by most countries as a priority for the development of health promoting schools (Figure 15).

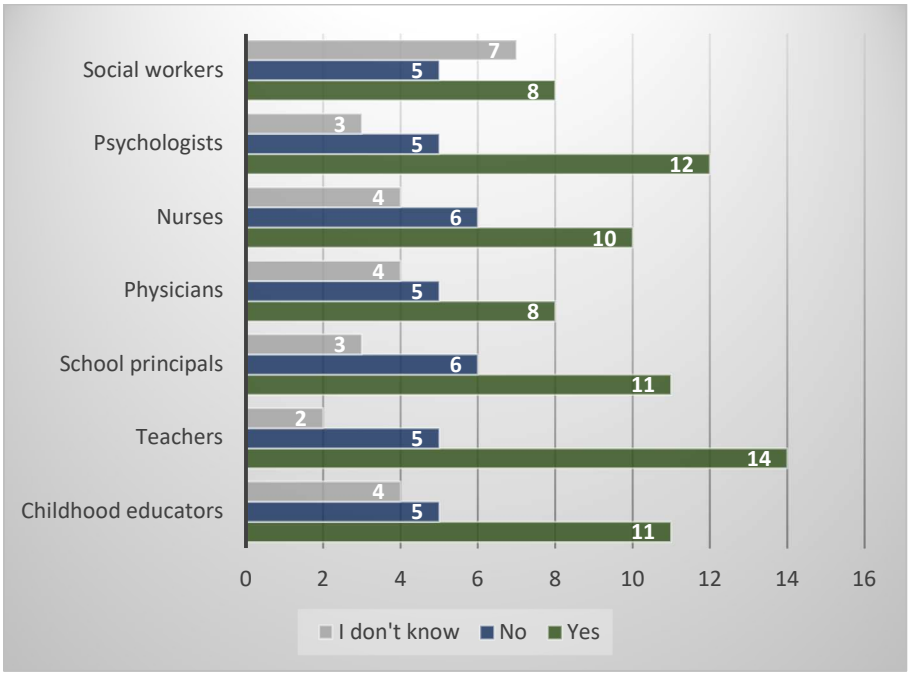

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Figure 15. *National concern with continuing professional development of health and education professionals*

Physicians (33.3%) and nurses (41.7%) are considered by fewer countries to require continuing professional development to support the implementation of HPS.

In the future, it is important for SHE to understand more deeply, why most countries consider that education professionals' and psychologists' CPD is more prioritized than those of health professionals.

Health topics included in the national HPS policy

As seen above, in almost 70% of SHE member countries, national policies require or recommend that schools use a whole school approach to promote health and wellbeing. However, in most countries (87.5%) more than 9 specific health topics are included in the national HPS policy. Figure 16 illustrates the health topics included in the national HPS policy. Almost all of the 24 countries include Physical activity/ sports (95.8%), healthy eating (95.8%), mental health (95.8%), smoking (87.5%), alcohol (87.5%), hygiene

(83.3%), Illegal psychoactive substances (Illicit drugs) (72.9%), safety (72.9%), and environment (72.9%) in their national HPS policy.

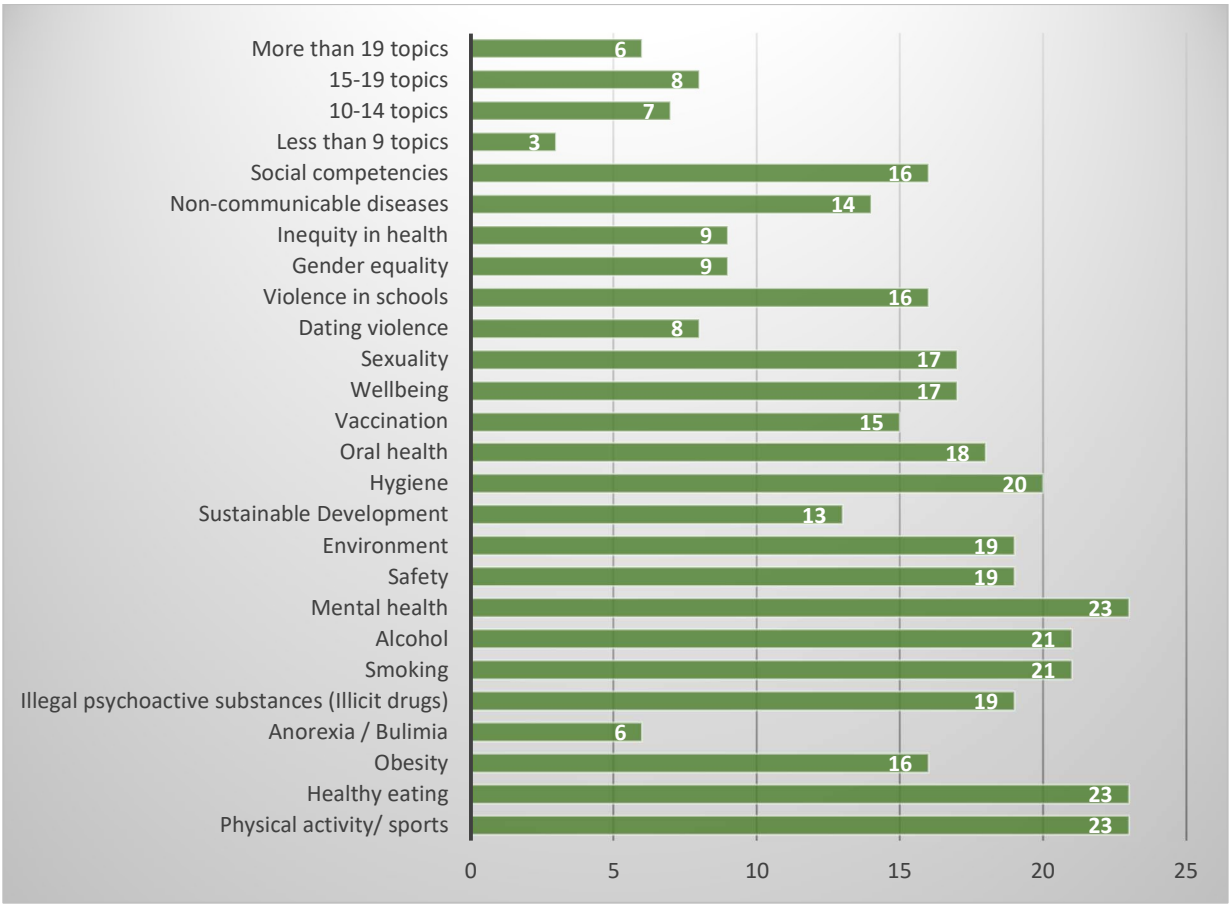

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Figure 16. *Health topics included in the national HPS policy*

Belgium added to these topics, sedentary behaviour and Greece, the volunteerism and migration. The Croatian national coordinator, as well as the 70% of SHE member countries above-mentioned who indicated that their country's national policies require or recommend a whole school approach, stressed in this question that all topics were dealt with under this approach.

The Icelandic national coordinator explained that she had difficulty answering this question because in her perception, some of the topics were more related to actions and goals but others to outcomes and goals:

> Health promoting school and community work are very comprehensive in Iceland and are involved in many aspects. Some of these topics are put in words in the policies but not others even though they are related to the outcomes of the actions. Other topics we know about, show that a very good job is being done nationally in Iceland but are not particularly included in the policies (PH and education). My conclusion is

therefore, even though all of these topics are not put in words in the policies about public health and education they are related to other things obliging schools to be involved in/ or in cooperation with others like the health service etc. to work on and fulfil. (Iceland, National Coordinator)

The Hungarian National Coordinator sent the health literacy topics presented in the national policies of her country (Figure 17), to show the similarities and differences with the topics of the question formulated in this survey.

- Common responsibility for the health of the individual and of the whole society
- The child's awareness of his/her rights and duties
- Preserving good health
- Personal hygiene
- Sound psycho-sexual growth
- Sound environment
- Media awareness, link between health and media consumption
- How arts do promote mental and spiritual health, sound personal development and academic efficiency
- Consumers' rights
- Timing as a health factor, sleeping, bio-rhythm, proper time planning
- Co-existence with the handicapped, help to be offered where needed
- The impact of food and nutrition on our health and illnesses
- Healthy eating, local produce, local consumption
- Nutritional disorders of psychic origin
- How to feed ill people
- How physical exercise affects health and illnesses
- How much of physical exercise is needed to be and stay healthy
- The effect of physical exercise on growing and development
- How sports activities do improve mental, spiritual health, personal development and academic efficiency
- Primary prevention of violence and addictions (smoking drinking, drugs, games, internet and TV addiction, etc.)
- Problem solving, coping with stress and conflicts, assertiveness, skills of communication
- Self-esteem emotions, respectful communication and its impact on the partner's self-esteem
- Female roles, male roles
- Society, manners and ethics, morality
- Family, relations, activities, communication
- Prevention of communicable illnesses
- Prevention of non-communicable chronic illnesses
- Spine protection
- Prevention of accidents, first aid
- Pregnancy, mother's experiences transmitted to the foetus as growth affecting stimuli
- How to relate to the child at home, at school so as to promote healthy development
- How to use the medical services
- How to use the services of school medicine
- Home nursing.

Figure 17. *Hungarian national health literacy topics*

Health promoting school label

Of the 24 countries, ten (41.7%) report that there is a health promoting schools label in their country. However, countries develop different processes to health promoting schools in order to attain this label (Figure 18).

Each school can register on a website to become a member of the Russian Network of Health Promoting Schools (http://school-forhealth.ru/registration). For this to happen, it fills in a step by step questionnaire, and submits it. Further data on the school is sent to the secretariat of the national support centre of the Russian Network of HPS and is considered by experts. If approved, the school is awarded the status of one of the school health promoting stages of development. (Russian Federation, SHE National Coordinator)

Schools prepare a five-year program, and the Health and Education Commission decides whether the school meets the requirements to grant the HPS label. (Lithuania, SHE National Coordinator)

Labelling is not mandatory. The request is made to the academic team in charge. There are three levels of accreditation depending on the level and degree of commitment of the school to this approach: Level 1 – Entrance to the Health Promoting School approach; Level 2 – Deepening of the Health Promoting School approach; Level 3 – Deployment of the HPS approach. (France, SHE national coordinator)

The General Directorate of Education has created a quality award to distinguish schools that promote health and wellbeing in their community, enabling them to apply for financing for their projects. The Schools must: 1st – to develop projects of Health and wellbeing; 2nd have a strong partnership with the local health services, the municipality, as well as with NGOs; 3rd count on the engagement of parents, teachers, all school staff and above all the REAL participation of the pupils. (Portugal, SHE national coordinator)

Each year schools can obtain official confirmation (in paper form, like a certificate) if they have fulfilled all relevant criteria: have actively participated in activities all year long; attended annual seminars; have submitted an evaluation form in which schools are providing a survey of the main activities carried out in their schools related to health promotion. We have developed a health promoting schools label – logo, that is used in various visual and publicity materials. (Latvia, SHE national coordinator)

Applying for a call, attending regular regional training meetings, performing HP tasks and tracking HPS compliance, planning and evaluating tasks in an online questionnaire…active co-working. (Slovenia, SHE national coordinator).

All schools can apply and when they do this, they are required to submit an application with statistical information about the number of students, staff etc. and the name of the coordinator for the school. The application is a declaration of intent to work on health promotion topics and has to be signed by the headmaster. This is a long-term working process starting with preparation and filling out checklists and getting a baseline. In the follow up process working on the topics, schools get support from DOHI and use the interactive website for their work. When schools apply, they can call themselves HPS and get posters, flags etc. to identify that. There is no final appraisal, the focus is on the process according to the checklists and cooperation with the community or the municipality. (Iceland, SHE national coordinator)

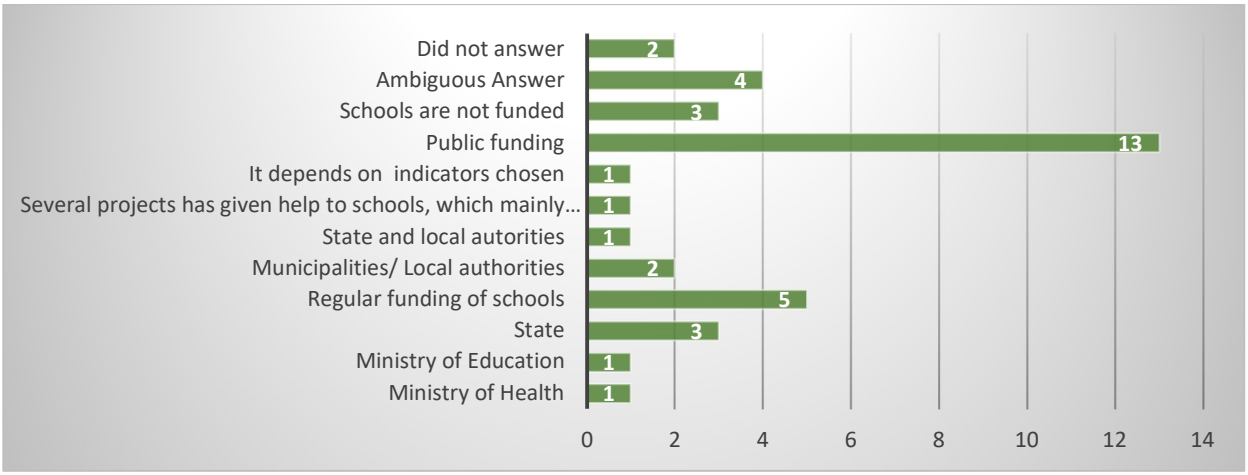
Figure 18. *Different processes to attain a health promoting school label*

According to the Hungarian National Coordinator, there is no labelling required in Hungary as holistic health promotion (HHP) is prescribed for all schools since 2012 (that means, all schools have to put HHP

into practical). Kazakhstan also does not have a label for health promoting schools, however, according to the national coordinator they are planning to provide a competition among HPS and regional coordinators to create a national label.

Sources of funding for national HPS

Six SHE national coordinators did not respond or gave ambiguous answers when asked how health promoting schools in their country are funded. Of the 18 SHE national coordinators who answered this question, 13 countries (54.2%) receive public funds from different sources: Sate (20.8%, that is Ministry of Health, Ministry of Education or generally the State); regular funding of schools (20.8%); municipalities / local authorities (8.3%), and the State and local authorities (4.2%) (Figure 19).



(n=24)

Figure 19. *Sources of funding for national HPS*

Public financing is explained in detail by some of SHE national coordinators as follows:

> Responsibility for financing education and the building of schools is shared between the state and local education providers. Local education providers receive a government share of the cost of setting up and running the schools. (Finland, SHE national coordinator)
>
> State budget for the curricula and personnel training. Budgets of local authorities for alimentation and facilities. From other sources (grants, donations, etc.) for other health promotion activities. (Moldova, SHE national coordinator)
>
> By the schools and the municipality. There is no special participation fee for HPS. All the support, tools and material schools receive from DOHI are free of charge. (Iceland, SHE national coordinator)
>
> On the central level, HPS is funded by the Ministry of National Education. (Poland, SHE national coordinator)
>
> Incorporated in regular school activities, the specific resources are allocated by the national budget of the Croatian Institute of Public Health for coordination of activities. (Croatia, SHE National Coordinator)

In Kazakhstan, the resources for funding depend on the indicators chosen by HPS. According to the SHE national coordinator, if indicators are from a physical environment, then school principals request financial funding from local authorities.

Some of the National Coordinators (62.5%), report that funding for HPS is limited or insufficient. However, 16.7% consider that it is sufficient because it depends on the projects to which schools apply for or on the indicators chosen for their HPS. It is interesting to note that 20.8% of the national coordinators did not answer this question.

Main expectations of the SHE National Coordinators for their national HPS scheme

Table 3 presents the SHE National Coordinator's main expectations for their country's future national HPS scheme.

Table 3. *Main expectations of SHE national coordinators*

(n=24)

Expectations	f	%
Increasing the number / recognition of HPS	9	37.5
Increasing the number of HPS using the whole school approach	4	16.7
Increasing funding for health promotion	5	20.8
Networking and collaboration among stakeholders, parents, and regional and school coordinators	5	20.8
Increasing the inclusion of health and well-being in the national curriculum	2	8.8
Improving the motivation of teachers in doing their daily health promoting tasks	2	8.3
Strengthening health team coordination	1	4.2
Developing an online tool to help schools to evolve from single actions to a coherent thematic health policy	1	4.2
Good health for all students and staff	1	4.2
Developing students' lifelong skills about healthy lifestyles	1	4.2

One of the main expectations of the SHE National Coordinators is increasing the number and the recognition of health promoting schools in their country (37.5%), and the number of HPS using the whole school approach (16.7%). Another important expectation is increasing funding for health promotion (20.8%), more specifically increasing national/ municipal level funding for coordination, research, training, and counselling (four SHE NC), and teaching HPS how to find funding opportunities (one SHE national coordinator).

Networking and collaboration are the main expectation for 20.8% of the SHE national coordinators, which means networking among stakeholders (two SHE national coordinators), more active involvement of parents in HPS (one SHE national coordinator), and shared good practices and greater collaboration between regional and school coordinators (one SHE national coordinator).

Increasing the inclusion of health and wellbeing in the national curriculum (8.3%) and improving the motivation of teachers in doing their daily health promoting tasks (8.3%) are also expectations of the SHE national coordinators. There are also significant expectations for the future highlighted by each one of the SHE national coordinators, that could contribute to the implementation of the SHE principles: strengthening team coordination; developing a step by step online tool to help schools to evolve from

single actions to a coherent thematic health policy; good health for all students and staff, and developing student lifelong student skills about healthy lifestyles.

The voice of some SHE national coordinators who were more detailed in presenting their main expectations for his/her national HPS scheme are presented in Figure 20.

> Together with the department of health, the logo's (our local partners) and a lot of thematic organizations, we are developing an online tool 'My healthy school'. The tool helps schools, step by step to evolve from single actions to a coherent thematic health policy. The pilot project started in October. We also give a presentation about this tool in another session. The evaluation of the tool will help us know whether additional support is needed for schools. We are going to make an evaluation of the decree on pupil guidance, in which we pay attention to the fact that we arranged that schools have a final responsibility for pupil guidance including health policies without any additional resources for all the different parties who can support them. We also have new ministers of Education and Health. We have to wait for the choices they will make. Being the Department of Education and Training, we gave them some advice on possible measures that can be taken, for instance that it's necessary to invest in resilience of children and youngsters at schools. Our work to help schools work on a healthy and sustainable diet and on physical exercise and breaking down sedentary behaviour is not yet complete. There is still a lot of work to be done regarding the prevention of unacceptable behaviour, but the decision lies with the minister. He may or may not make it possible to provide additional support measures from the department of Education. In times when the Flemish Government is having to cut back a lot, we are obliged to keep looking for channels to continue our work for healthy schools. (Belgium, SHE national coordinator)
>
> A more holistic approach at HP nationally (for all schools), integrating health content into the curriculum, the HP concept and the principles of HPS work in all schools is necessary. All sectors should be aware of the importance of health and HP - better collaboration in common tasks. (Slovenia, SHE national coordinator)
>
> All schools will become HPS with the support of their municipalities. All participating schools (HPS) are showing processes according to their ability to move on. Schools are using indicators more in their process to achieve more success. (Iceland, SHE national coordinator)

Figure 20. *Main expectations of some SHE National Coordinators*

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Schools for Health in Europe

Chapter 3. Practices, barriers and facilitating factors in health promoting schools

Number of health promoting schools in SHE member countries

According to this survey, the total number of health promoting schools in the SHE member countries in the school year 2019-2020 is at least 36 632 schools including 7 200 pre-schools, 6 530 primary schools, 18 577 secondary schools, 525 vocational schools and 3800 of all levels of education together because two SHE National Coordinator don't discriminate by level of education (Table 4). This number can be seen as an underestimation number because five of SHE National Coordinators did not answer and this survey only involved 24 of all SHE National Coordinators (N=37), which means that this data corresponds to 37.8% of the total SHE member countries.

Table 4. *Number of health promoting schools in SHE member countries by level of education*

(n=24)

Level of education	f
Pre-schools	7 200
Primary schools	6 530
Secondary schools	18 577
Vocational schools	525
All levels in the country	3 800
Total	36 632
No answer	5 SHE National Coordinators

Of the 16 countries which indicated the percentage of preschool institutions that are health promoting schools, six countries have less than 25%, two countries between 26-50%, one country between 51-75% and in two countries all pre-schools are health promoting schools (Table 5).

Table 5. *Percentage of HPS by level of education*

(n=24)

Percentage of HPS in the country	Level of education							
	Pre-schools		Primary schools		Secondary schools		Vocational schools	
	f	%	f	%	f	%	f	%
I don't know	5	20.8	4	16.7	2	8.3	5	20.8
< 25%	6	25.0	5	20.8	7	29.2	8	33.3
26-50%	2	8.3	2	8.3	4	16.7	---	---
51-75%	1	4.2	3	12.5	2	8.3	---	---
76-99%	---	---	1	4.2	1	4.2	1	4.2
All schools	2	8.3	3	12.5	4	15.7	3	12.5
No answer	8	33.3	6	25.0	4	16.7	7	29.2

It is possible to observe that globally, the number of health promoting schools has increased throughout schooling. Table 6 details the percentage of HPS in each country by level of education.

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Table 6. *Percentage of HPS by country and level of education*

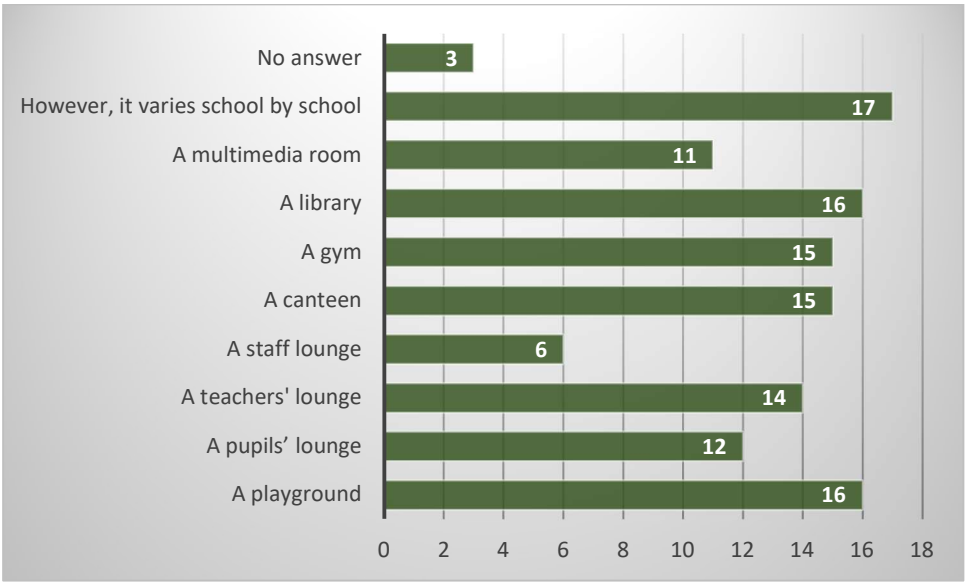
(n=24)

Country	Level of education			
	Pre-schools	Primary schools	Secondary schools	Vocational schools
Belarus	26-50%	26-50%	26-50%	26-50%
Belgium	I don't Know	51-75%	51-75%	I don't Know
Croatia	<25%	<25%	<25%	<25%
Estonia	51-75%	26-50%	26-50%	
Hungary	All schools	All schools	All schools	All schools
Iceland	26-50%	51-75%	All schools	All schools
Ireland	I don't Know	All schools	All schools	
Italy-Lombardy Region		51-75%	26-50%	<25%
Kazakhstan	<25%	26-50%	51-75%	<25%
Latvia	<25%	26-50%	<25%	<25%
Lithuania	26-50%		26-50%	<25%
Moldova	I don't Know	I don't Know	<25%	I don' t Know
North Macedonia		76-99%	76-99%	76-99%
Poland	<25%	<25%	<25%	<25%
Portugal	All schools	All schools	All schools	All schools
Russian Federation			26-50%	
Uzbekistan	<25%	<25%	<25%	<25%
Wales (UK)	<25%	<25%	<25%	<25%

According to the SHE National Coordinators, in 15 countries, over 76% of health promoting schools are public schools. The majority (75.0%) of them do not know what percentage of HPS are in socially deprived areas.

Health Promoting Schools facilities

Despite the national policies of 80% of the countries, as we have seen previously, requires or recommends that school facilities such as the playground and canteen be student-friendly, safe and clean and, all school physical activity facilities follow national safety and hygiene standards, only 66.7% of HPS indicated that they have a playground and 62.5% a gym and a canteen (Figure 21).



(n=24)

Figure 21. *HPS physical environment*

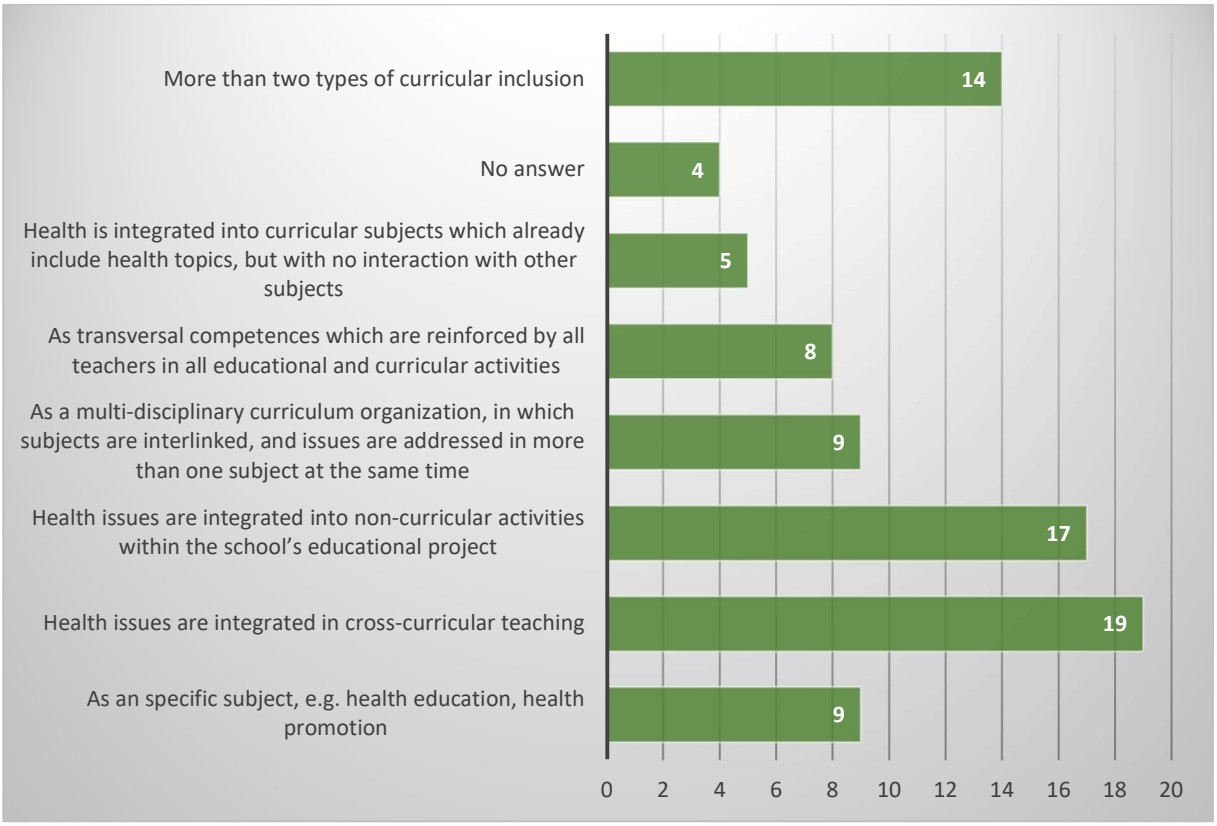
It is also interesting to note that the potential spaces to promote the socialization and wellbeing of the school community, such as a pupils 'lounge (50.0%) and teachers' lounge (58.3%) exist in only about half of the HPS, and a staff lounge (25.0%) exists in fewer health promoting schools. This differentiation may show a different concern with the wellbeing of the various participants in the school community.

Inclusion of health promotion in the school curriculum

In this survey, 58.3% of the SHE member countries have more than two types of curricular inclusion of health promotion (Figure 22).

In over 70% of countries, health issues are integrated in cross-curricular teaching (79.2%) and non-curricular activities within the school's educational project (70.8%). In 37.5% of the countries questioned, a multi-disciplinary curriculum organization exists, in which subjects are interlinked, and issues are addressed in more than one subject at the same time, and in 33.3% of the countries, health promotion is developed as transversal competences which are reinforced by all teachers in all educational and curricular activities. However, also 37.5% of SHE member countries where the curriculum integration of health promotion is carried out, existing through a specific subject, e.g. health education, health promotion.

In a much smaller number of countries, health is integrated in curricular subjects which already include health topics, but with no interaction with other subjects.



(n=24)

Figure 22. *Inclusion of health promotion in the school curriculum*

The subjects mentioned by respondents that already include health topics are Biology (Hungary, North Macedonia, Poland), Life Competencies (Hungary), Technical Competencies (Hungary) and Physical Education (Hungary, Poland), Social Education (Poland), Geography (Poland), Languages (Poland), Safety education (Poland).

Health topics worked regularly in Health Promoting Schools

When SHE national coordinators were asked to indicate the approximate percentage of health promoting schools in their country that regularly work with a set of listed topics / health problems, it was found that more than half did not know or did not answer the question (Table 7). This result shows how pertinent it is to discuss in the future in SHE, how the issues / problems to initiate the process of change to promote health in the school community, or where the school acts as a catalyst for change, are chosen and what is the importance of national monitoring to understand if health promoting schools are working with real problems and responding to their real health promotion priorities.

Table 7. *Health topics worked regularly in Health Promoting Schools*

(n=24)

Health topics	No school		< 25%		26-50%		51-75%		76-99%		All schools		I don't know		No answer	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Physical activity/ sports	--	--	1	4.2	--	--	--	--	3	12.5	8	33.3	7	29.2	5	20.8
Healthy eating	--	--	1	4.2	--	--	--	--	1	4.2	10	41.7	7	29.2	5	20.8
Obesity	--	--	1	4.2	--	--	2	8.3	2	4.2	4	16.7	10	41.7	6	25.0
Anorexia /Bulimia	2	8.3	1	4.2	--	--	1	4.2	1	4.2	1	4.2	10	41.7	8	33.3
Illegal psychoactive substances	--	--	1	4.2	--	--	--	--	3	12.5	7	29.2	8	33.3	5	20.8
Smoking	--	--	1	4.2	--	--	--	--	3	12.5	7	29.2	8	33.3	5	20.8
Alcohol	--	--	1	4.2	--	--	--	--	3	12.5	7	29.2	8	33.3	5	20.8
Mental health	--	--	1	4.2	1	4.2	2	8.3	2	8.3	5	20.8	8	33.3	5	20.8
Safety	1	4.2	--	--	--	--	1	4.2	2	8.3	8	33.3	7	29.2	5	20.8
Environment	--	--	--	--	1	4.2	2	8.3	2	8.3	5	20.8	9	37.5	5	20.8
Sustainable Development	3	12.5	--	--	1	4.2	--	--	3	12.5	2	8.3	10	41.7	5	20.8
Hygiene	1	4.2	--	--	--	--	--	--	2	8.3	8	33.3	8	33.3	5	20.8
Oral health	2	8.3	--	--	--	--	1	4.2	2	8.3	6	25.0	8	33.3	5	20.8
Vaccination	1	4.2	1	4.2	--	--	2	8.3	2	8.3	3	12.5	9	37.5	6	25.0
Wellbeing	1	4.2	--	--	1	4.2	1	4.2	3	12.5	3	12.5	10	41.7	5	20.8
Sexuality	1	4.2	1	4.2	--	--	3	12.5	1	4.2	4	16.7	9	37.5	5	20.8
Dating violence	1	4.2	2	8.3	1	4.2	1	4.2	1	4.2	2	8.3	10	41.7	6	25.0
Violence in schools	--	--	1	4.2	2	8.3	1	4.2	2	8.3	4	16.7	9	37.5	5	20.8
Gender equality	1	4.2	2	8.3	1	4.2	1	4.2	2	8.3	2	8.3	9	37.5	6	25.0
Inequities in health	1	4.2	2	8.3	--	--	1	4.2	2	8.3	3	12.5	10	41.7	5	20.8
Non-communicable diseases	3	12.5	--	--	--	--	1	4.2	2	8.3	4	16.7	9	37.5	5	20.8
Social competencies	1	4.2	1	4.2	--	--	1	4.2	3	12.5	3	12.5	10	41.7	5	20.8

It is interesting to note that health topics worked in more countries in more than 76% of schools, are related to health promotion, such as physical activity / sports (45.8% of countries work in more than 76% of schools), healthy eating (45.9% of countries work in more than 76% of schools), safety (41.6% of countries work in more than 76% of schools) and hygiene (41.6% of countries work in more than 76% of schools) and not with prevention of illness or negative health conditions.

However, psychoactive substances are the issues that are being worked on in more countries in more than 76% of schools, namely Illegal psychoactive substances (41.7% of countries work in more than 76% of schools), smoking (41.7% of countries work in more than 76% of schools) and alcohol (41.7% of countries work in more than 76% of schools). This could represent new data for future reflection on SHE: do these issues start from identifying the priorities for intervention in the school? Are they worked from a health promotion perspective and based on the whole school approach? Working with these issues includes their interception with the promotion of mental health (see, for example, World Health Organization, 2004,

2013a), and the increased risk of dying from a non -communicable disease? (see for example McQueen (ed.), 2013; World Health Organization, 2013b)

It can be seen that some current challenges for health promoting schools are apparently underdeveloped in SHE member countries. For example, the environment (29.1% of countries work in more than 76% of schools) and sustainable development (20.8% of countries work in more than 76% of schools). In the Moscow Statement - "Recommendations for action" – of the 5th European Conference on Health Promoting Schools (SHE, 2019), it was recognized that environment, climate and health are closely intertwined and cannot be considered in isolation because climate and environmental problems affect health, and health choices and actions affect climate and the environment. In this Statement it is argued that environmental, climate and health issues are driven by the same fundamental structural determinants in societies and as a result, health promotion and education for sustainable development or climate change have common goals and fields of action. Therefore, these results give rise to a new challenge for SHE in the future that is: How to incorporate environmental sustainability and sustainable development into the whole school approach? (see for example Simovska, & Mannix-McNamara, 2015).

There are other important challenges to the contribution of health promoting schools to the 2030 Agenda (United Nations General Assembly, 2015), which apparently are not being valued much by SHE member countries, such as sexuality (20.9% of countries work in more than 76% of schools), gender equality (16.6% of countries work in more than 76% of schools) and inequities in health (20.8% of countries work in more than 76% of schools).

Learning methods / strategies in Health Promoting Schools

One component of the whole school approach is to use learning methods / strategies through the curriculum, such as in the school health education and in activities that develop knowledge and skills which enable pupils to build competencies and take action related to health, wellbeing and educational attainment, in order to develop their individual health skills and action competencies (*Create healthy and supporting environments*, n.d.).

In this survey, SHE national coordinators were asked to indicate in a list of learning methods / strategies the five that were most used in health promoting schools in their countries. Although overall passive learning methods are less commonly used in the SHE member countries than possible actions on health promotion, and discussion methods, lectures with invited experts were the most appointed (45.8%). Therefore, if this lecture is not interactive it will put pupils in a state of passive learning and their gains in learning outcomes are of little relevance (see for example Silberman, 2006).

Table 8. *Learning methods / strategies in Health Promoting Schools*

(n=24)

Learning methods / strategies	f	%
Passive learning strategies / methods		
Lectures with invited experts	11	45.8
Lecture, conveying information via one-way communication (very little dialog if any)	6	25.0
Demonstration	4	16.7
Discussion strategies methods		
Debate/ Dialectic (Students learn from interacting and understanding different points of view)	8	33.3
Cooperative group discussions (e.g. Think-Pair-Share, Fishbowl, Jigsaw)	8	33.3
Workshops	8	33.3
Lecture/ exposition with interaction	6	25.0
Teachable Moment (teacher utilizes an event caused, initiated, or discovered by students to share insight and information)	5	20.8
Games to teach facts, ideas, or concepts	3	12.5
Student investigation		
Guided discovery or exploratory learning	4	16.7
Open inquiry-based learning (teacher presents a starting problem, students work toward solution)	4	16.7
Scientific actions (resolve scientific problems, e.g. lab work)	5	20.8
Community Studies / Case Studies / Issue Analysis (pupils study real life situations that they can learn from)	2	8.3
Social inquiry (e.g. pupils apply questionnaires, interviews)	4	16.7
Problem-based learning (selection of a real or simulated problem and develop a project to contribute to solve it)	7	29.2
Experiential methods		
Role-play	7	29.2
Forum theatre	3	12.5
Possible action-oriented approach on health promotion		
Action learning (a real problem that is important, critical, and usually complex; a diverse problem-solving student team; an inquiry and reflexive process; the discussion of possible solutions; acting to implement a solution, and a commitment to learning)	5	20.8
Health Education campaigns	7	29.2
Peer education	8	33.3
Participatory strategies/ methods		8.3
Co-creation activities (e.g. the Cube, Q-Sort, Lego activity)	2	8.3
Story-telling	2	8.3
Other		
Participating in disease prevention screening	2	8.3
Visits to places of educational interest (e.g. Health Centres, gyms)	6	25.0
Moral dilemmas	2	8.3
No answer	8	33.3

It was observed that some discussion methods are used in many countries, namely debate / dialectic (33.3%), cooperative group discussions (33.3%), workshops (33.3%), and interactive lectures (25.0%). These methods have been shown to be effective in promoting organization, learning, problem solving and content understanding (see for example Brookfield, & Preskill, 2005), as a key feature of the discussion is that pupils have considerable involvement in the construction of knowledge, understanding or interpretation, in other words, they have considerable "interpretive authority" to assess the plausibility or validity of responses (see for example Svinivki, Mckeachie et al., 2011).

Problem-based learning, which implies the presentation of a scenario (problem-situation) to the pupils, followed by brainstorming to promote the identification of topics and emerging issues associated with the theme presented, and finding solutions through the promotion of research activities (see for example Dahlgren & Oberg, 2001), is the most used method in SHE member countries involving pupil investigation and problem solving (29.2%).

Experiential methods such as role-play (29.2%) and forum theatre (12.5%) were named by ten SHE National Coordinators as being among the five most used health promotion methods / strategies in their health promoting schools. These methods emphasize the role of practical experience and personal experience in the construction of knowledge, because from concrete personal experiences pupils make observations and reflect on these observations, construct abstract concepts and generalizations based on their observations and interpretations and can then, test these concepts and generalizations in new situations (see for example Kolb, 2015). Role-playing (see for example Shankar, 2008; Halstead; & Reiss, 2003) and forum theatre (see for example, Boal, 2006) are two such learning methods as they allow students to apply the content they know immediately, as they are put into the role of a character who must make a decision about a policy, a personal decision, or some other simulated problem situation. The criticism that the work in schools is artificial, using "as if" situations (e.g. role playing, case studies), created for the occasion, have led to the increasing requests of authenticity and, consequently, to the participation in the reality of society as being part of education (Simovska & Jensen, 2003).

Action learning, was presented to the SHE National Coordinators in the questionnaire as a process of learning that starts with a real problem that is important, critical, and usually complex for pupils, who work in small teams to solve the problem through an investigation and reflexive process, discussion of possible solutions, acting to implement a solution, and a commitment to learning. This method was appointed by 20.8% of respondents as one of the most used methods in health promoting schools in their countries. Various SHE researchers argue for the importance of the participatory dimension of pupils in this process and the clarification of the concept of action (see for example Jensen, Schnack & Simovska (Eds.), 2000; Jensen, Simovska, Larsen, & Holm, 2005; Reid, Nikel, Jensen, & Simovska, (eds), 2008; Simovska & Jensen, 2003). Action has two key characteristics within the democratic paradigm of health education: it must be premeditatedly directed at solving a problem, and it must be decided by those who take action, in other words, action is aimed at changing our own lifestyle, school, local society or global society (Jensen, 1997). Therefore, health education campaigns (29.2%) and peer education (33.3%) may or may not be considered health promotion actions. Action-oriented learning is a complex interdisciplinary learning built on a shared process of critical dialogue, reflection, vision development, planning and action taking as part of the teaching and learning process (Simovska & Jensen, 2003).

The co-design process emphasises the importance to support the culture of action-oriented and self-organised learning in co-created projects (see for example Vilaça, Darlington, Velasco, Martinis, & Masson, 2019). In this survey, co-creation activities are only considered a priority in two SHE member countries and story-telling in two other countries. Story-telling is a participatory method that could be applied in co-created projects and story dialogue evaluation to increase students' ability to assess existing practices and develop new ideas (to increase critical thinking) (see Paakkari, Simovska, Pedersen, & Schulz, 2019).

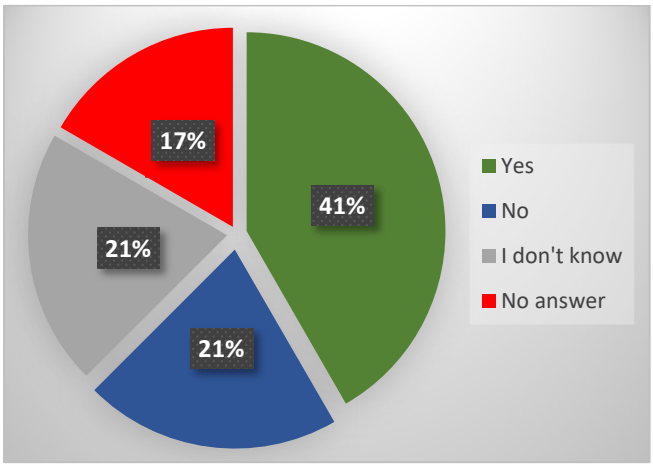
Learning methods / strategies in Health Promoting Schools are explained in detail by the Hungarian National SHE Coordinator as follows:

> In Hungary we see the teaching/learning methods as one (and maybe the most important) of the four everyday health promoting tasks of HHP for teachers. We see principal that teachers should change their "old-fashioned" pedagogic methods to those, which will enhance both mental health and academic achievement. The appropriate methods are those mentioned here in the questionnaire, with the exception of passive, frontal teaching (lecture). That means, that we want these "good" methods to be used not only in health education, but in the whole life of the school, in all subjects and classrooms. To achieve this change of methods it is very important to motivate teachers to do the big work of required changes. To enhance mental health in the classroom is an important universal health promoting tool of teachers in preventing early drop out and several mental problems as dependencies, aggression, bullying, etc. (Hungary, SHE national coordinator)

The principal lesson learnt from these results is the necessity to know and discuss critically the potentials and limits of each method and strategy most used in the health promoting schools and (re)thinking the intentional school action plan to develop individual health skills and student action-competence.

Practices and suggestions for the SHE School Manual and its two accompanying tools

The SHE school manual is used by health promoting schools in at least ten SHE member countries (41%). However, there were nine SHE national coordinators who did not respond or did not know whether HPS use it or not (Figure 23).



(n=24)

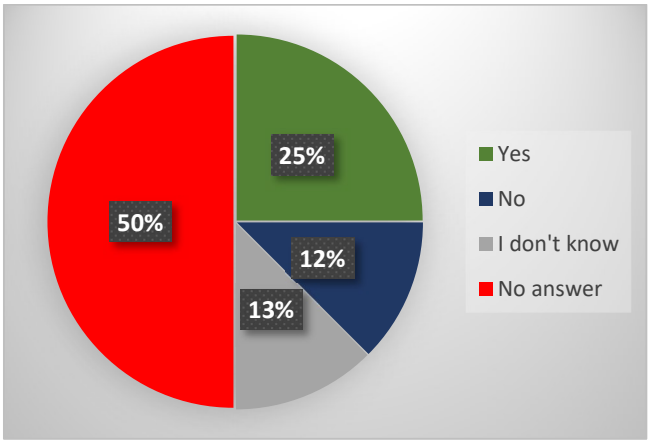
Figure 23. *Countries where the SHE school Manual is used by health promoting schools*

In Belgium, Finland, Iceland and Poland, health promoting schools don´t use the SHE School Manual because they use their own healthy school framework that is based on the SHE principles and the SHE School Manual.

The Lithuanian SHE National Coordinator recommends that the SHE Schools Manual should be used for start-up health promoting schools. The Hungarian SHE national coordinator thinks that this Manual should

put more emphasis on the daily health promoting tasks of teachers, and the Finnish SHE national coordinator thinks that the Manual is good but, it is necessary to encourage and give support to schools to use the guide more actively. In the opinion of the Portuguese SHE national coordinator the manual is used very actively in health promoting schools, however he thinks that is important to simplify the texts and the contents in order to make it more understandable to all caregivers, educators and teachers. These documents should be developed, transformed in a more visual and user-friendly way, to be used by school coordinators and teachers. The Latvian national coordinator agrees that the content should be more concise, but in her opinion, the design of this manual could have a more visual presentation and infographics.

Only health promoting schools from six countries usually use the SHE Rapid Assessment Tool (Figure 24).



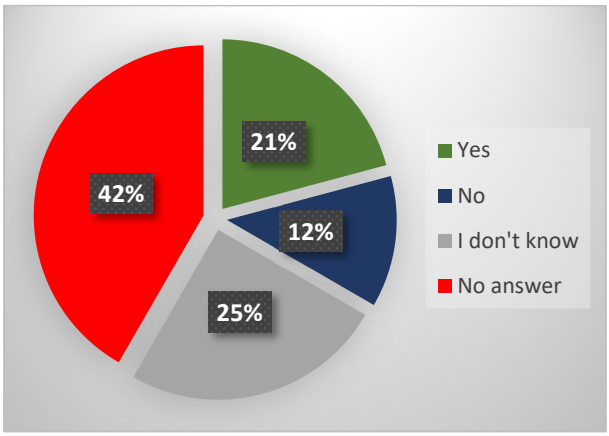
(n=24)

Figure 24. *Countries where the SHE Rapid Assessment Tool is used by health promoting schools*

In Belgium they do not use this SHE tool because they are developing an online tool, My Healthy School, to help schools to evolve from single actions to a coherent health policy. In Poland, they do not use it because there are national HPS standards and tools. However, the Finnish SHE national coordinator considers that the SHE Rapid Assessment tool activates health promoting schools and gives them support.

In Iceland the SHE national coordinator explains that they have their own interactive website for health promoting schools that is similar to the SHE Rapid Assessment Tool and other SHE material.

The SHE School Action Planner is usually used in five SHE member countries (Figure 25).



(n=24)

Figure 25. *Countries where the SHE School Action Planner Tool is used by health promoting schools*

The SHE national coordinators made the same comments they had already made to the SHE School Manual.

The small number of countries using the SHE School Manual and its two accompanying tools, as well as the number of non-responses, show the need to further disseminate of these tools and to evaluate the effects of their implementation on health promoting schools.

Facilitating factors and barriers faced by health promoting schools in the SHE member countries

The most referred to facilitating factors for the implementation of health promoting schools are the collaboration between health and education sectors (25.0%) and intersectoral collaboration (16.7%), the national educational policies and curriculum (20.8%), becoming obligatory schools working with health and wellbeing (16.7%), receiving support from the Ministry of Health / Education(16.7%), the existence of training and support for health school coordinators (12.5%), having sufficient funding (12.5%), the interest of schools in health promotion (12.5%), the active involvement of students (12.5%), and the motivation of teachers (12.5%).

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Table 9. *Facilitating factors for the implementation of Health Promoting Schools*

(n=24)

Facilitating factors	f	%
Collaboration between health and education sectors	6	25.0
Intersectoral collaboration	4	16.7
The national educational policies and curriculum	5	20.8
Becoming obligatory schools working with health and well-being	4	16.7
Receiving support from the Ministry of Health / Education	4	16.7
Training and support for health school coordinators	3	12.5
Sufficient funding	3	12.5
Interest of schools in health promotion	3	12.5
Active involvement of students	3	12.5
Motivation of teachers	3	12.5
Support from school management	2	8.3
Support from parents	2	8.3
Participatory processes	1	4.2
Exchange of good practices	1	4.2
Support from local authority	1	4.2
Country coordinators network	1	4.2
Existence of supporting guidelines	1	4.2
Health behaviour in School-Aged Children Survey	1	4.2

The following statements give voice to some SHE national coordinators who discuss the facilitating factors in health-promoting schools in their country:

> The frameworks in education (new attainment targets, new decree on pupil guidance and new reference framework on quality of education) that supports our work. (Belgium, SHE national coordinator)
>
> Prescription by law since 2012, according to the high-level political commitment and to a very practical and well-working intersectorial cooperation at the Governmental level. (Hungary, SHE national coordinator)
>
> The curriculum provides a good basis for it. The promotion of wellbeing at school has a strong emphasis in Finland's new government program. (Finland, SHE national coordinator)
>
> All documents of the education policy published recently have reflected the matters related with health education, and health and wellbeing promotion, integrating them as best as possible in the national curriculum. Interaction between the Ministries of Education and Health has strived to strengthen relations and partnerships benefitting the students. (Portugal, SHE national coordinator)
>
> Schools are interested in Healthy school programme activities and are motivated to raise understanding and awareness between the students about various health promotion themes. They see the benefits from participating in the HPS programme and also consider that they receive many valuable materials and training options for coordinators and students. (Latvia, SHE national coordinator)
>
> Health and wellbeing are one of the six pillars of the national school curriculum for 2-19 years old. In the Public Health policy, all communities (municipalities) and schools should become health promoting. There is a "positive vibe" for health promotion and public health among many sectors in Iceland. (Iceland, SHE national coordinator)

The main potential barriers for the implementation of health promoting schools in the SHE member countries are the following: lack of time and energy of school staff (29.2%), lack of funding (16.7%),

and the fact that health promoting schools function like volunteers (16.7%), and there are simultaneous "competing", not collaborative, projects in schools (12.5%).

Table 10. *Potential barriers for the implementation of Health Promoting Schools*

(n=24)

Potential barriers	f	%
Lack of time and energy of school staff	7	29.2
Lack of funding	4	16.7
Functioning like volunteers	4	16.7
Many simultaneous "competing", not collaborative, projects in schools	3	12.5
There are not enough specialists from different health thematic areas to support HPS	2	8.3
Health promoting being considered by many schools as an additional activity	2	8.3
Deficient interaction between the Ministries of Education and Health	2	8.3
Schools lack of understanding about the benefits from participating in HPS activities	2	8.3
Absence of support from school administration	2	8.3
Lack of support from parents	2	8.3
Absence of support from local authority	2	8.3
Existence of a lot of bureaucracy	1	4.2
Teachers are or feel themselves overloaded	1	4.2
Low health literacy level of parents	1	4.2
School coordinators work is voluntary, it`s not paid.	1	4.2
Actions, good practices and standard should be better defined	1	4.2
Frequent changes of regional coordinators		4.2
Lack of teacher/ regional coordinator training in certain regions	2	4.2
Lack of political will in the agenda	1	4.2
There are no barriers	2	8.3

According to the SHE National Coordinator in Moldova it is premature to make conclusions at the pilot stage of the Health Promoting Schools implementation.

The SHE national coordinators was also asked how these barriers impact the health promoting school process in their country. The answers were so different, that is interesting to give voice to them:

> The process is progressing slowly (Croatia, SHE national coordinator)
>
> Previous mentioned barriers have impact on motivation to become a member of Healthy schools' program and to actively engage in the programme. We have to work on raising the popularity and recognition of HPS. (Finland, SHE national coordinator)
>
> They actually made our HPS network extinct and took it out of the national agenda. (Greece, SHE national coordinator)
>
> At the governmental level, we are working on better motivation of teachers and on enhancing the supporting involvement of parents. (Hungary, SHE national coordinator)
>
> Lack of resources like human resources causes a slower process and non-specific-all focus even though the will is to do well. (Iceland, SHE national coordinator)
>
> A complete knowledge of what HPS really does lacking. A long process is necessary to involve new schools. (Italy-Lombardy region, SHE regional coordinator)

Slow down the process of implementing HPS principals in Kazakhstan. (Kazakhstan, SHE national coordinator)

There is a need to constantly look for arguments to promote schools. (Lithuania, SHE national coordinator)

HP is not implementing sufficiently (North Macedonia, SHE national coordinator)

Not very much. HPS thinking should be marketed as a gathering model for other programs. (Norway, SHE national coordinator)

There is no rapid increase in the number of health promoting schools (Poland, SHE national coordinator)

A small number of schools (30%) are HPS (Russian Federation, SHE national coordinator)

Improving financing. (Uzbekistan, SHE national coordinator)

Not significant (Wales (UK), SHE national coordinator).

Four categories emerged when the answers of the SHE national coordinators regarding what schools usually do to overcome these barriers in their country were analyzed:

Developing evidence-based regional programmes. In Italy an important resource is the evidence-based regional programmes and good practice collections. The sharing of the best practices was also referred to by the SHE national coordinator of Lithuania.

Developing a networking system. Different examples of networking were done by SHE national coordinator. In Russia, a significant number of Russian health promoting schools cooperate with medical, pedagogical universities, regional institutes of education development. Networking systems between Russian health promoting schools where the Russian Federation seeks sponsors and engages relevant ministries. In Iceland, schools get special support from the municipality (e.g. fees), schools organise their structure for the HP work (e.g. coordinators get more time to do their work or get extra paid to do it) and the role of the head master is essential regarding how the HP school structure is prioritised. In Kazakhstan, the school administration interacts with stakeholders regularly, and national coordinators includes HPS principals into the policy of all levels. The SHE regional coordinator of Italy- -Lombardy region valued the interaction between health and education professionals and this interaction increases the potentials to create a link between EU key learning competences, educational curriculum and health promotion. The SHE national coordinator of Uzbekistan also emphasises the importance of looking for partners. In Greece, teachers and health professionals implement health promotion projects in a grass-roots level.

Active role of school principals, health school coordinators and teachers. The SHE Finnish National Coordinator explained that HPS requires active teachers and principals who understand the whole school approach, want to commit with it and participate in discussions about it. In Latvia, the activity in the HPS mainly depends on the school coordinator's interest and motivation, also his/her understanding and awareness about the health promotion themes. In her opinion, in every school the interest is to choose an active and motivated coordinator, with a strong motivation to share gained knowledge and skills between the students and other school staff in order to get the most valuable impact form of participation in HPS.

Teacher and health professionals' training. The SHE national coordinator of Poland emphasises the value of teacher and health professionals' training for the implementation of HPS and the Hungarian SHE national coordinator thinks that they try to improve HPS with the professional help of the public health sector. In North Macedonia, the SHE national coordinator defends the preparation of teachers and health professionals to work through projects.

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Chapter 4. Summary and implications

Introduction

This report presents the preliminary findings from the first Schools for Health in Europe Network Foundation mapping (SHE mapping). It provides detailed information regarding the policies and practices of the SHE member countries. In this survey, as outlined in the first chapter all SHE national and regional coordinators were invited to participate and, if they did not have conditions to complete the online survey they could invite a relevant key informant to complete it. From the 37 SHE member countries, 28 countries answered the online questionnaire (75.7%). In Poland, the national and regional coordinator completed the online questionnaire and two regional coordinators replied in Italy, one from Lombardia and one from Friuli Venezia Giulia, prefacing a total of 30 questionnaires. Four questionnaires were incomplete and because of this, they were removed from the data analysis. When two SHE regional coordinators responded in the same country to the questionnaire, after the characterization of respondents only the first respondent of each country was chosen, because it was not possible to gather information from regions as there were only three regional coordinators who answered this survey. Therefore, in total, data was collected from 24 countries (64.9% of the SHE member countries. Despite the limitations of this study related to the sample and the use of an online questionnaire as the only source of data, the results of this study have a number of important implications for improving the quality of health promoting schools and (re) thinking the SHE internal policies and practice to support SHE member countries. Therefore, in the following section the main findings are summarized and strategies are suggested that might be implemented to reorganize the support to SHE member countries and deepen the international reflection on the potentials of the SHE Network Foundation to operationalize networking among both researchers and stakeholders working on health promoting schools.

Summary of findings

1.Growing up unequal: contextual and political factors in health promoting schools

Almost 63% of countries have incorporated HPS policy into three or more national policies. In the majority of countries, the HPS policy is included in national education and public health policies.

In this survey, in almost 70% of SHE member countries, national policies frame school practices in the whole school approach of HPS, and contribute to a healthy physical environment in school settings, namely regulating school physical activity facilities and students' physical education, school canteens and school shop and vending machines, and requiring or recommending that all buildings in the school be kept at a comfortable temperature, are well-lit and ventilated. However, in 50% of countries, legislation does not take into account that school facilities must be gender appropriate and that routes to school should be safe and designed to encourage students to engage in physical activity.

The aspect required by most countries in their national policies that contributes to a health promoting environment in the school setting is the legislation regarding students with special learning, developmental and physical needs. However, only 50% of the countries involved in this study require that health professionals be involved in individual and whole school health promotion in the school setting.

In 73% of SHE member countries involved in this survey, there are national or regional guidelines for a school to become a health promoting school and 82% of countries have national or regional institutional tools or/ and resources for becoming a health promoting school. Half of these countries do not perform any national or regional actions to encourage schools to use the SHE school manual, the SHE Rapid Assessment Tool and the SHE School Action Planner.

In 58% of SHE member countries that participate in this survey, a national process to monitor/ evaluate health promoting schools exists.

Although 50% or more of SHE member countries value continuing professional development of education professionals and psychologists as a priority for the development of health promoting schools, only about 40% consider the continuing professional development of health professionals for this purpose to be important.

Almost 88% of SHE member countries involved in this survey include in their national HPS policy 10 or more specific health topics. Topics included in the national policies of over 73% of SHE member countries are: physical activity / sports, healthy eating, mental health, smoking, alcohol, hygiene, illegal psychoactive substances, safety and environment. In 80% of SHE member countries, national policies require or recommend that this topic be developed based in a whole school approach.

Ten countries report that there is a health promoting school label in their country, however the processes to attribute this label are very different between countries.

More than 60% of the SHE national coordinators report that funding for HPS is limited or insufficient.

Main expectations of the SHE national coordinators for their national HPS scheme are increasing the number/ recognition of HPS, the use of the whole school approach and the funding. Networking and collaboration among stakeholders, parents, and regional and school coordinators was other main expectation of 21% of the respondents.

2.Practices, barriers and facilitating factors in health promoting schools

At least 36632 schools including 7200 pre-schools, 6530 primary schools, 18577 secondary schools and 525 vocational schools exist in the SHE member countries. Globally, the number of health promoting schools have increased throughout schooling. Over 76% of health promoting schools are public schools.

Although the national policies of 90% of SHE member countries promote a healthy physical environment, only 67% of SHE national coordinators stated that HPS in their countries have a playground and 63% a gym and a canteen. The potential spaces to promote socialization and wellbeing of the school community, such as pupils' and teachers' and staff' lounges exist in fewer health promoting schools.

In this survey, 58% of the SHE member countries have more than two types of curricular inclusion of health promotion. In over 70% of countries, health issues are integrated into cross-curricular teaching and non-curricular activities.

More than half of SHE national coordinators did not know or did not answer the question regarding the health topics that schools in their countries regularly work with. Health topics worked in more countries, in more than 76% of schools, are related with health promotion, such as physical activity/ sports, healthy eating, safety and hygiene. Some current challenges for health promoting schools are apparently underdeveloped in the SHE member countries, such as environment and sustainable development.

Regarding the learning methods / strategies in health promoting schools, overall, passive learning methods are less commonly used in the SHE member countries than possible actions on health promotion and discussion methods. The methodologies that have shown more potential for the development of student action competence, such as action-learning, co-creation activities and story-telling are used by few SHE member countries.

A large number of SHE National Coordinators did not respond or did not know if their country's HPS uses the SHE school manual, the SHE Rapid Assessment Tool, and the SHE School Action Planner.

The SHE national coordinators mentioned a large number of facilitating factors for the implementation of health promoting schools, especially the collaboration between health and education sectors and the national educational policies and national curriculum.

The main potential barriers for the implementation of health promoting schools in the SHE member countries are the school staff's lack of time and energy, lack of funding, the fact that health promoting schools function like volunteers and the simultaneous different competitive, not collaborative projects in schools.

To overcome all barriers identified, the SHE national coordinators developing evidence-based regional programmes, developing a networking system, the active role of school principals, health school coordinators and teachers, and the development of teacher and health professionals' training.

Implications for future

Data suggests a group of challenges for the SHE Network Foundation in the future, namely:

- Discussing how to act to promote in the SHE member countries the integration of national HPS policy into more national policies, including youth, social, solidarity and social affairs policies.
- Promoting a reflection on gender issues, namely regarding school policies of facilities.
- Encouraging countries to (re)think the routes to school in order to be safe and designed to encourage students to engage in physical activity.
- Strengthening the role of the SHE Network Foundation and SHE national / regional coordinators in enhancing an inclusive, participatory and democratic social school environment in all countries.
- Strengthening the role of the SHE Network Foundation in training SHE national/ regional coordinators to use SHE School Manual and its accompanying tools to reflect on their potentials for their countries.

- Strengthening the role of the SHE Network Foundation to reflect on national processes to monitor/ evaluate health promoting schools and on attributing to schools a health promoting school label.
- The SHE Network Foundation could act in order to understand more deeply why most countries consider that the education professionals' and psychologists' continuing professional development is more prioritized than those of health professionals.
- The SHE Network Foundation could encourage SHE national/ regional coordinators to help schools to think critically if school physical environment promotes socialization and wellbeing of the school community (for example applying the SHE Rapid Assessment Tool).
- It is pertinent discussing how health topics/ problems to initiate the process of change to promote health in the school community are chosen and what is the importance of national monitoring to understand if health promoting schools are working with real problems and responding to their real health promotion priorities.
- It is a challenge for the SHE Network Foundation in the future to discuss how to incorporate environmental sustainability and sustainable development into the whole school approach.
- The results also suggest that it may be interesting to organize training modules, for example webinars, on the potentialities and constraints of different teaching methods / strategies in the development of students' individual health skills and action competence.

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Appendix 1 - SHE Coordinators

	Country	Name:	SHE Position	Position:	Organisation:
1	Armenia	Nune Pashayan	National Coordinator	Head of children health care unit	Ministry of health, Mother and child health care department
2	Austria	Beatrix Haller	National Coordinator	Deputy of Department for School Psychology, Health Promotion and Career Guidance	Austrian Federal Ministry of Education, Science and Research
3	Azerbaijan	Sabina Babazade	National Coordinator	Head of Projects Coordination Department	Public Health and Reforms Center Ministry of Health of Azerbaijan Republic
4	Belarus	Elena Guzik	National Coordinator	Head of the department of Hygiene and Medical Ecology	Belarusian Medical Academy of Postgraduate Education
5	Belgium	Tineke Vansteenkiste	National Coordinator	Senior staff member healthy school	Vlaams Instituut, Gezond Leven
6	Bulgaria	Anina Chileva	National coordinator		National Centre of Public Health and Analyses
7	Croatia	Ivana Pavic Simetin	National coordinator	Deputy director	Croatian Institute of Public Health
8	Denmark	Børge Koch	National coordinator	Head of Research Centre for Health Promotion	University College South Denmark
9	Estonia	Tiia Pertel	National coordinator	Head of Centre for Health and Welfare Promotion	National Institute for Health Development
10	Finland	Päivi Nykyri	National coordinator	Senior Advisor	Finnish Federation for Social Affairs and Health
11	France	Véronique Gasté	National coordinator	Head of the office for school and social action Director General for schools	Ministry of National Education and Youth
12	Greece	Electra Bada	National coordinator	Coordinator of Health Promotion Programmes	Institute of Child Health, Department of Social and Developmental Pediactrics
13	Hungary	Annamaria Somhegyi	National coordinator	Director for prevention	National Center for Spinal Disorders
14	Iceland	Ingibjörg Guðmundsdóttir	National coordinator	Project manager	The Directorate of Health
15	Ireland	Méabh McGuinness	National coordinator	Project Manager for Education, Strategic Planning and Transformation	Ireland Health Services
16	Israel	Irit Livne	National coordinator	Representative	Ministry of Education, Health and Health education
17	Italy	Veronica Velasco	Regional coordinator Lombardia-Milano		Health Promotion and NCDs Prevention Division, DG Welfare, Lombardy Region
		Liliana Coppola	Regional coordinator Friuli Venezia Giulia	Head of Health Promotion Division, DG Welfare Lombardy Region	Lombardy Region – DG Welfare
18	Kazakhstan	Akbota Abildina	National coordinator	Head of the Department of Health Promotion for Youth and Children	National Center for Public Health

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19	Kosovo	Leonora Shala	National coordinator	National Health promotion school koordinator	Ministry of Education, Science and Technology
20	Kyrgyzstan	Maria Kushbakova		Specialist on hygiene of children and adolescents	Ministry of Health , Department of disease prevention and sanitary and epidemiological surveillance
		Gulshan Abduldaeva		Chief specialist of department of pre-school, school and extra school education	Ministry of Education and Science
21	Latvia	Lienīte Bebriša	National Coordinator	Health promotion coordinator	Centre for Disease Prevention and Control
22	Lithuania	Daiva Zeromskiene	National Coordinator	Head of Children Health Division	Center for Health Education and Diseases Prevention
	Country	Name:	SHE Position	Position:	Organisation:
23	Malta	Charmaine Gauci	National Coordinator	Superintendent of Public Health	Superintendence of Public Health
24	Moldova	Natalia Silitrari	National Coordinator	Health promotion department	National Agency for Public Health Ministry of Health, Labour and Social Protection of the Republic of Moldova
25	Nederlands	Marije van Koperen	National Coordinator	Senior advisor with a focus on the international network and the planned integrated approach of the Healthy Schools Program and Project Leader of Monitoring and Evaluation	RIVM Centrum Gezond Leven
26	North Macedonia	Elena Kjosevska	National Coordinator	Professor, Head of Department for Health Promotion, Analysis and NCD Prevention	Institute for Public Health of the Republic of North Macedonia
27	Norway	Nina Grieg Viig	National Coordinator	Associate Professor in Pedagogy & Vice Dean for Education	Western Norway University of Applied Sciences (HVL)
28	Poland	Valentina Todorovska-Sokołowska	National Coordinator	Specialist of health promotion in schools	Centre of Education Development
29	Portugal	José Carlos Sousa	National Coordinator	Projects Team Coordinator	General Direction of Education of the Ministry of Education
30	Russian Federation	Vladislav Kuchma	National Coordinator	Coordinator Schools for Health in Russia	Scientific Centre of Children's Health
31	Scotland (UK)	Suzanne Hargreaves	National Coordinator	Senior Education Officer	Education Scotland, The Optima
32	Slovenia	Mojca Bevc	National Coordinator	The National Coordinator of Slovenian Network of HPS	National Institut of Public Health (NIJZ)
33	Spain	Nuria Manzano Soto	National Coordinator	Director at the ational Center for Innovation and Research in Educación (CNIIE)	Ministry of Education and Vocational Training (Spain)
34	Switzerland	Cornelia Conrad	National Coordinator	Member of strategic team	RADIX, c/o éducation21
	Country	Name:	SHE Position	Position:	Organisation:
35	Tajikistan	Zohir Nabiev		Head of department of maternal and child health	Ministry of Health and Social Protection of Population
		Qutbiddin Muhiddinzoda		Head of school and pre-schooling department	Ministry of Education and Science
36	Uzbekistan	Dilorom Akhmedova	?????	Chef pediatrician	Ministry of Health

		Qodir Oqilov	?????	Deputy Head	Department for Coordination of Activities in General Secondary Education
37	Wales (UK)	Gemma Cox	National Coordinator	Principal Lead for Welsh Network of Healthy Schools	Public Health Wales

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