Health promotion in Danish schools: local priorities, policies and practices

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Summary

This article discusses the findings from a study mapping out the priorities, policies and practices of local authorities concerning health promotion (HP) and health education (HE) in primary and lower secondary schools in Denmark. The aim of the study was to identify the gaps, tensions and possibilities associated with the demand to increase the quality and effectiveness of HP in schools. The recent national school reform, which emphasizes the importance of health and well-being while simultaneously increasing the focus on performance and accountability in terms of subject proficiency and narrowly defined academic attainment, provides the broader political context for the study. Data were generated through a structured online survey administered to all 98 Danish municipalities. Respondents were educational consultants or others representing the administrative units responsible for the municipality’s schools. The findings were discussed within the conceptual framework of Health Promoting Schools. The study points to a potential tension between the health and education sectors, despite evidence of intersectoral collaboration. While there is a strong policy focus on health and well-being in schools, it is disconnected from the utilization of the HE curriculum by the municipal consultants. The study also points to a lack of professional development opportunities for teachers in the field of HP in schools. On the basis of these findings and theoretical perspectives used, we argue that HP in schools needs to (re)connect with the core task of the school, education, and to integrate both health and education goals in local priorities, policies and practices.

Key words: health education, health promoting schools, policy and implementation

INTRODUCTION

Health and well-being are repeatedly identified among the greatest global challenges facing societies. As such, schools have a responsibility to support and develop children’s competences and their commitment to dealing with these challenges in socially responsible and imaginative ways. The field of school-based health promotion (HP) is underpinned by high level policy documents, declarations and agreements between and within governments. International organizations, such as the World Health Organization, have long called upon governments throughout Europe and globally to incorporate health-related knowledge, skills and attitudes in their education systems from an early age and to provide a foundation for the promotion of lifelong health and well-being (e.g. WHO, 1986, 1991, 1997, 1999, 2014). One question that could be asked in this respect is what happens when these political initiatives are translated into national and...
local practices? What gets ‘lost in translation’, and what is added? The purpose of this article is to contribute to the body of knowledge and dialogue concerning these translation processes. The study is part of a larger research examining the trajectories of policies related to HP and health education (HE) from global through national to local (municipal) and to classroom practices. Within this larger research, we have previously focused on mapping international policies related to HP and education and on their transformations at national level in Denmark (Madsen et al., 2015). In this article, based on a nationwide survey, and building on the broader policy framework, we discuss municipal perspectives on policies, priorities and practices related to HP and HE in primary and lower secondary schools, for pupils aged 6–16.

In Denmark, local authorities, that is, municipal boards, have governance responsibility for schools. In addition, following a municipal reform in 2007, municipalities have also assumed responsibility for HP among all citizens within their jurisdiction, including school-aged children. While the overall educational aims, as stated in the curriculum guidelines for HE, are determined at the national level (Danish Ministry of Education, 2014), responsibility for the specific planning and implementation of HE and HP is retained by the local authorities and the individual schools. This places local authorities in a fairly central position when it comes to HP in schools and allows a considerable degree of autonomy and flexibility at local level. The local flexibility and the division of responsibilities at the municipal level between the health sector and the education sector are often perceived as challenges when it comes to connecting health goals and education goals. Indicative for the challenge is recent research demonstrating that, although HE is a compulsory cross-curricular topic in Denmark, many teachers are not aware of the existence of the national curriculum guidelines ‘Health, sexual and family education’ (Danish Ministry of Education, 2009, 2014), and, even when they are, they are not familiar with their content (Nordin, 2013; Smidt, 2012). Rather than building on HE curriculum guidelines, HP practice in schools has mainly developed through health interventions instigated by local authorities (Nordin, 2013), by local community organizations following the national HP recommendations (Justiniano et al. 2010) or by international projects (Simovska et al., 2012; Simovska, 2013). More often than not, the aims and desired outcomes in such interventions clash with the education agenda; most school-based interventions set out clear objectives regarding improved health status or health behaviour among pupils which are to be achieved over the course of a limited period of time, reducing the possibilities for working with pedagogical strategies aimed at empowerment, competence development, social values and engagement which apply a socio-ecological approach. The consequence is either a lack of effectiveness or poor sustainability of the achieved effects (e.g. Samdal and Rowling, 2013; Nordin, 2013).

In some Nordic countries, for example Finland and Iceland, HE is an independent compulsory subject in the curriculum for primary and lower secondary schools. However, in Denmark, while HE is a mandatory topic, it is not a separate subject with centrally allocated teaching time. As a result, the way it is taught is dependent on local decisions within the municipality and at the school level. For example, health can be included as a perspective in a number of curriculum subjects (e.g. home economics, Danish, science or physical activity); it can be integrated in an interdisciplinary project, typically involving a team of teachers from different subjects (e.g. a health project week); finally, it can take the form of classroom-based teaching with invited guests (e.g. the school nurse, consultants from the municipality or another local community organization). In August 2014, the Danish government implemented a comprehensive reform of primary and lower secondary education. While this reform is primarily focused on academic attainment within core subjects (e.g. mathematics and Danish), health and well-being are also highlighted in the reform documents and related political agreements (Danish Ministry of Education, 2013, 2014). For example, the reform requires 45 min of daily physical activity for all pupils, as well as stipulating the promotion of pupil well-being as a key objective. It also underlines the importance of the school as an inclusive learning environment for all pupils. The reform’s emphasis on health and well-being, although open to interpretation, could lead to renewed importance being placed on HP and HE in schools. Meanwhile, the question is whether this emphasis will be aligned with the conceptualization suggested by Green and Tones (2010), that HP is a function of health policy conjoined with HE, and thereby with the school’s core educational task, rather than solely endorsing the health agenda in schools.

It is against this backdrop that this article discusses the findings from a study which mapped municipal policies, priorities and practices in terms of HP and HE in Danish schools. The study sought to identify the gaps, tensions, challenges and possibilities associated with the drive to increase the quality and effectiveness of HP in schools while remaining loyal to the main principles of the critical, socio-ecological paradigm of the Health Promoting Schools Initiative (Green and Tones, 2010). In the following, we first present the conceptual framework, context and methodological approach of the study. We then present and
discuss the findings, before offering conclusions and perspectives for future research and development.

CONCEPTUAL FRAMEWORK AND CONTEXT

Health promoting schools

The study is conceptually embedded within the paradigm of Health Promoting Schools, which combines efforts from within both the health and education sectors to improve, respectively, both health outcomes and learning outcomes related to health and well-being. The notion of ‘health promoting schools’ emerged in Europe in the early 1980s before being fleshed out at the WHO Health Promoting Schools Symposium in Scotland in 1986 and, later, in the publication ‘The Healthy School’ (Young and Williams, 1989). In accordance with the developments in the area of general HP (WHO, 1986), HP in schools was construed as a social process of individual and community empowerment. The European Network of Health Promoting Schools (ENHPS) was established in 1992, drawing on the five principles of the Ottawa Charter. Within the Health Promoting Schools, these principles are translated as follows (adapted from WHO, 1991):

- Health promotion policy: developing a coherent and interdisciplinary HE curriculum that embraces the social and ecological dimensions of health
- Creating supportive environments: creating and encouraging social connectedness in the school by improving the school’s psychosocial and physical environment and establishing supportive relationships between pupils, school staff and parents
- Strengthening community action: connecting the school with the local community through active participation, mutuality and collaboration
- Developing personal skills: providing opportunities for all individuals in the school setting to enhance their capabilities, that is to be empowered and enabled to act competently for health in a democratic society
- Re-orienting health services: broadening collaboration with community health services and health professionals by creating active links across society

Thus, a health-promoting school is defined as an educational setting that attempts to develop its capacity for healthy learning, working and living, in close partnership with the local community (WHO, 1999; CBO, 2013). The emphasis is not exclusively on teaching and learning processes in the classroom but rather on the whole-school culture or ethos, i.e. on interpersonal relationships, school leadership and policy structures, as well as the physical environment. It is considered important that a health promoting school is a ‘growing’ community, where students learn, develop their identities and enhance knowledge and competences in the classroom, as well as in everyday school life. This understanding of health promoting schools reflects the socio-ecological approach to health and emphasizes the significance of settings for HP.

The current work on school HP in Europe is organized through the Schools for Health in Europe (SHE) network with 43 participating countries represented by a national coordinator (Buijs, 2009; CBO, 2013). Building on the previous work within ENHPS and the International Union of Health Promotion and Education (e.g. Clift and Jensen, 2005; IUHPE 2009; St. Leger et al., 2010), the SHE network endorses five core values (equity, sustainability, inclusion, empowerment and action competence and democracy) and five pillars (whole-school approach to health, participation, school quality, evidence, schools and communities) as a common basis for school-based HP.

The Danish context

Denmark joined the ENHPS in 1992 and has since been active in the development of practice, empirical research and theoretical concepts focusing on critical educational dimension of HP in schools and emphasizing pupil participation and the development of pupil action competence related to health (Jensen, 1997, 2000; Simovska, 2007). This work has been essential in shaping the national curriculum guidelines for HE. The key concepts developed within the Danish health promoting schools initiative have been integrated in the curriculum guidelines for ‘health, sexuality and family education’ (Danish Ministry of Education, 2009). As part of the recent school reform, the curriculum guidelines have been revised, but the overall aims and expected outcomes remain within the same discourse of critical HE and health promoting schools. The new national curriculum guidelines formulate the main objective of HE as follows:

[. . .] Pupils should gain knowledge and skills and develop competences to promote health and wellbeing for themselves and others. [. . .] Teaching should contribute to the development of pupils’ engagement, will and courage to build bridges between knowledge and action related to health and wellbeing in the everyday life. Central to the teaching process is dialogue with pupils concerning desire, quality of life, values and norms, rights, responsibilities and action possibilities. (Danish Ministry of Education, 2014)

Evidently, this passage frames HE within a critical HE approach within the paradigm of health promoting
schools (Green and Tones, 2010; Carlsson and Simovska, 2012). First, it stresses the importance of pupils’ ability to act to promote health and well-being, whether individually or as part of a community; the focus is on competence development and empowerment in support of better health. Second, the excerpt signifies a positive view on health; well-being and health are given equal billing, and the positive aspects of health and well-being are affirmed, such as desires and quality of life, rather than risks. Finally, it highlights the socio-ecological approach, including social determinants of health; this is visible in the emphasis on rights, responsibilities and action possibilities, rather than solely on individual, health-related behaviour.

Furthermore, the curriculum guidelines suggest participatory teaching and learning methods and a high degree of pupil involvement as key pedagogical principles (The Danish Ministry of Education, 2014). These are also strongly advocated within the European health-promoting schools initiative; research related to the initiative demonstrates positive effects of pupils’ participation in school-based HP both in terms of health and education outcomes (e.g. de Róiste et al., 2012; Griebler and Nowak, 2012; Griebler et al., 2014).

Hence, national policy in terms of HE curriculum as well as the allocation of responsibility for HP of school-aged children to local authorities level can be seen as supportive of critical education and health promoting schools. The question at the core of our study is how these policies are (re)interpreted and (re)prioritized at a municipal level.

METHODOLOGY

The aim of the study was to provide an overview of the ways in which HP and education in Danish schools is prioritized, articulated in policy documents and implemented in practice by local authorities. Data were generated through a structured online questionnaire, developed and piloted for the purpose of the study. The questionnaire also included questions concerning education for sustainable development, but in this article we focus solely on HP and education. The questionnaire contained 14 questions where respondents were asked to choose between a number of possible responses concerning HP and education in schools. For example: How important do you consider the role of the school in relation to HP? (a) very important; (b) important; (c) less important; (d) not important. Additionally, there were a few open questions where respondents had the opportunity to add comments and reflections.

The questionnaire was sent to all 98 Danish municipalities. The intended respondents were the educational consultants or managerial coordinators in the municipal departments responsible for schools. E-mails were sent to contact persons at the relevant departments outlining the research aims, focus and ethics, and asking for consent to participate in the study. If needed, this initial contact was followed up by telephone. The contact person would then direct us to an appropriate respondent within the department. The same procedure was repeated with the respondent, additionally emphasizing the principles of informed consent, anonymity, confidentiality and the right not to participate, prior to sending the link to the online survey. Any necessary reminders or follow-up contact were made by telephone or e-mail.

The response rate for the online survey was 71%. The majority, 54% of the respondents reported working as education consultants, administrative consultants or development consultants in the municipality; the rest were health consultants, environmental consultants or other. Municipalities from each of the five regional administrative divisions are represented in the response, indicating fairly good geographical coverage of the findings. The Capital Region of Denmark and the Region of Southern Denmark are represented with the largest number of respondents (31 and 27%, respectively), while the North Denmark Region constituted the smallest group (6%). The Central Denmark Region provided 20% of respondents and Region Zealand 17%. It is worth noting that the five regions do not contain an equal number of municipalities; i.e. this split does not skew results as much as it may appear as there are 29 municipalities in Capital and only 11 in Northern Denmark, hence fewer potential respondents.

Data management comprised outlining response rates for each question in percentages. The analysis looked for tensions and contradictions in the responses, guided by the questions in the survey combined together to map policies, priorities and practices. The responses to the open questions were analysed qualitatively to elaborate on challenges and potentials.

FINDINGS

Priorities

Nearly all respondents (94%) stated that they consider the school to have either a very important (52%) or an important (42%) role to play in HP. Table 1 shows the responses to a group of five questions related to municipal priorities concerning HP in schools. The responses show that, although most municipalities report that school-based HP is an area of particular focus (82% for question A) and that policies concerning HP in schools have been developed (86% for question B), only 49% report that
the municipality was aware of the school’s choice to adopt the national curriculum guidelines for HE (C), and only 48% report providing professional development opportunities for teachers concerning HP (E).

It is also interesting that, although 23% of the respondents state that the municipality has not discussed the schools’ choice to follow national curriculum guidelines (D), only 11% report approving locally developed HE curricula, which is mandatory if schools decide to develop their own curriculum. This means that while 60% of the respondents state that some kind of HE curricula have been discussed by the municipality, there is still 40% that have not taken a stand in this respect. Moreover, there seems to be a lack of knowledge as to municipal practice concerning the curriculum with a relatively large number responding ‘I do not know’ to these two questions (C: 28% and D: 23%), which is noteworthy given the governance responsibility of municipalities for schools’ education as well as HP. Similarly, 25% of the respondents answer ‘I don’t know’ when asked whether the municipality has offered in-service professional development for teachers within the area of HE and HP in school (E).

On a more positive note, Table 2 shows that the majority of the respondents (77%) expect that the recent national school reform will have a positive impact on HE and HP in schools. This is important because at the time of the survey the reform had still not been implemented but was heavily debated in the media and among the professionals in the field.

**Policy content-focus and links with international and national policy**

Only a very small number of respondents reported links between municipal policies regarding HE and promotion in schools and international policy frameworks (figures ranged from 3 to 10% for different content areas).

A closer look at the relation to policy at national level (Table 3) and the content-focus of existing municipal policies shows that the latter are mostly linked with national policies in relation to traditional public health concerns (i.e. physical activity, diet, alcohol, smoking and overweight, known in Denmark as KRAM-factors). The one exception is psychological well-being, which is also widely reported (90%) as an area with strong links between national and municipal policy content areas. Along with the partly overlapping focus on mental health in schools (65%), this demonstrates that well-being in schools has found a place within municipal policies alongside more traditional health behaviour topics. For the remaining areas of health inequity, social competences and sexuality education, reported links to national policies are reported as being somewhat lower (59, 58 and 56%, respectively).

**Practices**

The findings concerning specific practices (HE and HP interventions), presented in Table 4, demonstrate the same trend: in terms of content, existing interventions in schools initiated by the municipalities are predominantly traditional, topic based and lifestyle oriented (77%) or focused on
well-being (73%). It is important to note that the acronym ‘KRAM’ used in the survey indicates lifestyle-oriented interventions (the acronym stands from Diet, Smoking, Alcohol and Physical Activity in Danish) consistent with national policy (Danish Government, 2002). The survey data do not provide qualitative insight into the specific content and methods used in these interventions, but it is fair to note that in addition to their dominance, 73% of the respondents report focus on well-being. Specific interventions concerning sexuality education and social competences are reported slightly more often (54 and 52%) than interventions concerning mental health and inequity (42 and 34%, respectively).

Further, nearly all the respondents (94%) state that there is a good interdepartmental collaboration within the municipality concerning HP interventions in schools. Collaboration is primarily between the health and education departments, but other units are also mentioned in response to this open question such as the departments for family, culture, day-care, leisure, and tourism. The findings also indicate widespread collaboration with other partners in the local community, with sports organizations mentioned by the majority of respondents (76%), followed by Non-Governmental Organizations (56%), universities and university colleges (39%) and the private sector (37%). A smaller number of respondents (10%) report collaboration with international organizations.

Challenges
Content analysis of responses to the open questions included in the survey identified two recurrent challenges. The first of these challenges points to the difficulties of integrating a HP agenda with the core educational task of the school, as illustrated by the following two extracts:

It is difficult for HP to find its place in school—we often hear remarks that the purpose of the school is to teach pupils Danish and maths, and that health is a responsibility of the parents. Unfortunately, the parents cannot do this alone.

In my experience, schools face too many challenges these days. It is difficult to introduce initiatives from ‘above’ [i.e. via municipal policy]. We are totally dependent on local, school-based champions ‘standard-bearers’, or enthusiasts, for HP.

The first excerpt points to the dilemma of school-based HP related to the question of who bears responsibility for pupils’ health. Health promotion is often perceived as an additional task for the schools rather than integrated in the core task of the school. The second excerpt elaborates this point by emphasizing that the schools are overwhelmed with competing agendas and that it is difficult for the municipal authorities to impose top down interventions. Therefore, the role of individual teachers who are motivated and enthusiastic about HP, so called ‘champions’ or ‘fiery souls’ is seen as very important.

The second challenge points to the decentralization of the school system, beyond even the local authority (municipal) level, and to the autonomy that schools in Denmark have, as highlighted in the following passage:

The governance of the schools is decentralized, so HP initiatives and interventions depend on the decisions in individual schools [. . .]. Only on rare occasions are
This response shows that, although the municipalities are responsible for school governance, the schools have considerable autonomy and can make decisions independently. Thus HP might be initiated by an individual school or several schools teaming up with local partners, which in turn means that interventions are only rarely broad in scope, comprehensive and coordinated by the municipality itself, which make it more difficult to sustain.

**DISCUSSION**

Research shows that policy and institutional anchoring form one of the eight key constituents of sustainable implementation of HP in schools, helping to bridge the gap between discourse and practice (Deschehesnes et al., 2003; Samdal and Rowling, 2013, 2015). In this respect, our findings are encouraging. The study demonstrates that municipalities across all five regions in Denmark have clear policies and priorities concerning HP in schools. These policies are in accordance with the national health and education policy frameworks in terms of content-focus. Furthermore, although the findings point to a rather narrow content-focus within municipal policies, emphasizing traditional health-related behaviour and lifestyle (diet, smoking, alcohol and physical activity), there also seems to be considerable focus on mental health and well-being. This could be interpreted as an attempt to broaden the concept of health found in municipal policies, moving away from a bio-medical, risk-focused perspective and towards a more comprehensive and socio-ecological perspective, more in tune with the discourse of health promoting schools (WHO, 1999; Green and Tones, 2010; Barnekow et al. 2013; Simovska and McNamara, 2015). Further indication of such a trend is the focus on the issues of sexuality education, social competences and inequity in health within both policy and existing practice.

A less encouraging finding is the limited awareness about the curriculum guidelines for HE among the respondents, and the low provision of possibilities for professional development of teachers in the field of HE and promotion in schools. Although the school boards have the primary responsibility for developing a local syllabus for HE, if the school decides to deviate from the national curriculum guidelines, it is the task of the municipalities to approve the local syllabus. As such, one would expect the municipalities to have more substantial knowledge and to play a more pro-active role in supporting schools in this respect. It is fair to leave room for doubt in relation to these findings and to follow up with qualitative research, as one could also assume that the high percentage of ‘I do not know’ responses on the questions concerning the curriculum is due the fact that the study relied on the municipality contact person to suggest the relevant respondent for the survey and as a result only 54% of the respondents were educational consultants. Nevertheless, given that knowledge development and support for teachers’ attitudes, skills and behaviour is another key component of the implementation emphasized in the literature (Samdal and Rowling, 2013, 2015), there seems to be room for improvement in this respect in Denmark; even more so, if we take into account that the very core of HP is constituted by the interplay between public policy and HE (Green and Tones, 2010). This means that also the health and other consultants working with HP in schools would do well to integrate the HE curriculum in their work.

At the time of the study, the national school reform was yet to be implemented. Nevertheless, respondents
expressed positive expectations in terms of better structural support for HE and HP in schools. While the reform could therefore be seen as a positive development, it remains to be seen whether the hopes will be realized in practice. The reform provides an increased focus on the common educational objectives and learning outcomes in the national curriculum (Danish Ministry of Education, 2014) which are consistent with the principles of health promoting schools and critical HE, focusing on the socio-ecological concept of health, social determinants in health, children’s participation and action competence emphasized in the literature within the field (e.g. Simovska, 2007, 2012; Carlsson and Simovska, 2012). The reform also places emphasis on pupils’ well-being and physical activity, but it is not clear if these aspects will be integrated in the whole-school approach or whether they will remain on the level of behaviour regulation and monitoring. Schools are required to ensure that pupils participate in 45 min of daily physical activity, and to map and document the pupils’ well-being at the end of the school year (Danish Ministry of Education, 2014). However, from the comprehensive health promoting schools perspective, these requirements are not sufficient unless accompanied by initiatives at a whole-school level focusing on the promotion of mental health as well as on improving the structural conditions for physical activity at the school and within the local community. Moreover, within the health promoting schools paradigm, these initiatives need to actively involve pupils (Samdal and Rowling, 2013; Simovska, 2013), not only in engaging in health-related behaviour, but also in changing their environment at the school and local community level. There is no indication in the reform documents that these factors are taken into account.

The study shows that interdepartmental collaboration concerning HP in schools is well developed within Danish municipalities. This can be seen as a positive development, given that, from the very beginning, HP in schools within Europe has been emphasized as a cross-sectoral collaboration between health and education (WHO, 1991), but has predominantly been the domain of the health sector. The importance of collaboration is also supported by research emphasizing partnerships as one of the key dimensions of a sustainable implementation of health promoting schools (Deschehesnes et al., 2003; Clarke and Barry, 2015; Samdal and Rowling, 2015).

Finally, the findings indicate that the decentralization of school governance seems to constitute a challenge for municipalities when it comes to initiating and coordinating HE and HP interventions in schools. It could be argued that this challenge is worth taking up, as ownership and partnership among stakeholders is one of the main values in the health promoting schools paradigm.

CONCLUSIONS AND IMPLICATIONS

In this article we discussed research findings mapping out municipal policies, priorities and practices concerning HP and education in schools with a view to identifying the gaps, tensions, challenges and possibilities within the framework of the health promoting schools paradigm. The study points to a potential tension between the health and education sectors, despite the reported intersectoral collaboration. While there is a strong policy focus on health and well-being in schools, there exists a disconnect in relation to knowledge about and use of the HE curriculum to support schools in their work. Furthermore, the study points to a shortage of professional development opportunities for teachers in the field of HE and HP in schools. Alongside the challenges resulting from decentralized school governance, i.e. a fragmentation of HP initiatives and the lack of a comprehensive and consistent approach, these factors could be interpreted as hindering the implementation of school-based HP and HE. The most important imperatives for practice include

- Building partnerships between the health and education sectors on a local/municipal level in terms of integrating health objectives with the educational objectives in schools
- Linking health and well-being promotion with the whole-school development plans
- Raising awareness about the national curriculum guidelines for HE among professionals working with school-based HP within the municipality
- Ensuring the professional development of teachers

In summary if HP is to be implemented effectively and sustainably in schools, local authorities (municipalities) need to ensure that HP aims and expected outcomes are clearly connected with the core task of the school—education, teaching and learning. More research is needed in this respect, particularly research able to unpack implementation processes in schools and effective forms of collaboration between local authorities and schools.

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