

BACKGROUND PAPER ON HEALTH PROMOTING SCHOOLS
PREPARED FOR THE MINISTRY OF HEALTH AND LONG-TERM CARE BY
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INTRODUCTION

The Health Promoting School movement has its roots in the Ottawa Charter for Health Promotion (1986) and in the subsequent Healthy Cities and Healthy Communities movements of the early 90's supported by the WHO Regional Office for Europe. It is also aligned with similar, more recent movements supported by the WHO such as "Health Promoting Hospitals", Healthy Prisons, Healthy Workplaces, Agencies, Universities, etc.

The World Health Organization (WHO) describes the health promoting school as "a school that is constantly strengthening its capacity as a healthy setting for living, learning and working." Furthermore, a Health-Promoting School:

- Fosters health and learning with all the measures at its disposal.
- Engages health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders in efforts to make the school a healthy place.
- Strives to provide a healthy environment, school health education, and school health services along with school/community projects and outreach.
- Implements policies and practices that respect an individual's well-being and dignity, provides multiple opportunities for success, and acknowledges good efforts and intentions as well as personal achievements.
- Strives to improve the health of school personnel, families and community members as well as pupils; and works with community leaders to help them understand how the community contributes to, or undermines, health and education.

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THE EUROPEAN NETWORK OF HEALTH PROMOTING SCHOOLS, 1990

The concept of a European Network of Health Promoting Schools was conceived at a 1990 conference on health education sponsored by the European Commission, the

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Council of Europe and the WHO Regional Office for Europe. These three organizations agreed to work together to organize such a network. They started in 1991 with pilot schools in four countries of central and eastern Europe: the Czech Republic, Hungary, Poland and Slovakia. The network has since expanded to 41 countries with over 5,000 schools, 10,000 teachers and 500,000 pupils involved. Countries wishing to join the network are required to have support from both their Ministers of Education and of Health and ten designated pilot schools willing and able to collaborate. Most networks have grown considerably, with other schools in the country joining and learning from the practices of the model pioneering schools. To join the ENHPS each country produces:

- a signed commitment from people at the highest political level of the ministries of health and education
- the name and curriculum vitae of a designated national coordinator approved by both ministries
- a list of about 10-20 pilot schools, representing all levels of education and ensuring equal representation from different parts of the country
- a project plan for a period of at least three years
- a national support centre for the project
- plans for evaluation; and
- a fundraising strategy

According to a recent survey, of 14 European Commission countries involved, 12 were funded and/or led by both the ministries of Health and Education, and two, Germany and Denmark, had funding and participation only by the Ministry of Education. The support centre for HPS was located in the education ministry (national or regional level) in eight cases, and in a teacher training institute in one case (Ireland). Five support centres were located in a national or regional health promotion agency and four others in another health institution. Two were situated within a university.²

A useful update and case studies from the European initiative can be found at <http://www.who.dk/document/e62361.pdf>

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THE WHO GLOBAL SCHOOL HEALTH INITIATIVE, 1995

WHO launched a Global School Health Initiative (GSHI) to build on the success of the ENHPS in 1995. WHO's GSHI used several strategies to disseminate its initiative globally including: 1) Research. 2) Building capacities to advocate for Health Promoting Schools. 3) An award system. 4) Strengthening collaboration between the ministries of education and health, community organizations, and national capacities to assess, plan and implement programs to improve health through schools. 5) Creating networks and

² Piette, D. et. al. Tracking down ENHPS successes for sustainable development and dissemination: The EVA2 project, Final Report.

alliances, including regional networks for the developing of Health Promoting Schools and international alliances, such as between WHO, UNESCO, UNAIDS, CDC, EDC.

In 1995, 27 countries in the Western Pacific responded to a WHO invitation to collaborate in the development of health promoting schools. Australia and New Zealand adopted the HPS vision and principles of the WHO in 1997. The Australian Health Promoting School Association (AHPSA) now has a national structure with representatives in each state and territory who are involved in ongoing activities to raise awareness and support school communities to adopt and implement the HPS model. The NSW Health collaborated with health units, AHPSA, Area Health Services and the Health and Education government sectors, and consulted with non-government organizations, Catholic Education Commission and senior officers from the education sector, plus several other key stakeholders to produce a policy document called "Health Promotion in Schools, A Policy for Health Systems in 2000". Diverse HPS policy initiatives are occurring at different levels. At the national level, health-related policies are being developed within the health and education sectors. State and territory-level policies are also being developed in priority areas. At the local level, schools and their communities are active in the formulation of policies on specific local issues. Further information about progress in Australia can be found at:

<http://www.edfac.usyd.edu.au/projects/ahpsa/report1/report1.pdf>. The Australian Health Promoting Schools Association website can be found at www.hlth.qut.edu.au/ph/ahpsa/.

Regional Networks for the Development of Health-Promoting Schools have also been started through joint efforts by WHO/HQ and the respective WHO Regional Offices in Latin America (1996) and Southern Africa (1996). In 1997, meetings were held to develop Networks in South-East Asia and the northern countries of the Western Pacific. Each Network is composed of public and private organizations interested in planning and working together toward the goal of helping schools become Health-Promoting Schools. More information on the GSHI can be found at <http://www.who.int/inf-fs/en/fact092.html>

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GUIDING PRINCIPLES FOR THE ENHPS, 1997

The following "Guiding Principles" for health promoting schools were put forward by the European Network of Health Promoting Schools at an international summit in Greece in 1997 with representation from the 43 countries involved (see <http://www.who.dk/tech/inv/resolution.htm>). These principles have proven to be enduring and have been translated into many languages:

1. **Democracy.** The health promoting school is founded on democratic principles conducive to the promotion of learning, personal and social development and health.
2. **Equity.** Healthy schools ensure that the principle of equity is enshrined within the educational experience. This guarantees that schools are free from oppression, fear and ridicule. Healthy schools provide equal access for all to the full range of educational opportunities. The aim of healthy schools is to foster the emotional and

social development of every individual, enabling each to attain his or her full potential free from discrimination.

3. **Empowerment and Action Competence.** Health promoting schools improve young people's abilities to take action, cope and generate change. It provides a setting within which they, working with their teachers and others, can gain a sense of achievement. Young people's empowerment, linked to their visions and ideas, enables them to influence their lives and living conditions. This is achieved through quality educational policies and practices, which provide opportunities for participation and critical decision-making.
4. **School environment.** Health promoting schools place emphasis on the school environment, both physical and social, as a crucial factor in promoting and sustaining health. The environment becomes an invaluable resource for effective health promotion, through the nurturing of policies and practices that promote well-being. This includes the formulation and monitoring of health and safety measures and the introduction of appropriate management structures.
5. **Curriculum.** A healthy schools curriculum provides opportunities for young people to gain knowledge and insight and to acquire essential life skills. The curriculum must be relevant to the needs of young people, both now and in the future, as well as stimulating their creativity, encouraging them to learn and providing them with necessary learning skills. The curriculum of a healthy school also is an inspiration to teachers and others working in the school. It also acts as a stimulus for their own personal and professional development.
6. **Teachers' training.** Teacher education (pre-service and in-service) is an investment in health as well as education. Legislation, together with appropriate incentives, must guide the structures of teacher learning using the conceptual framework of the health promoting school.
7. **Measuring success.** Health promoting schools assess the effectiveness of their actions upon the school and the community. Measuring success is viewed as a means of support and empowerment, and a process through which health promoting school principles can be applied to their most effective ends. In other words, assessment and evaluation are an integral part of instruction and planning.
8. **Collaboration.** Shared responsibility and close collaboration between schools, parents and communities is a central requirement in the strategic planning of healthy schools. Roles, responsibilities and lines of accountability must be established and clarified for all parties.
9. **Communities.** Parents and the school community have a vital role to play in leading, supporting and re-enforcing the concept of school health promotion. Working in partnership, schools, parents, NGO's and the local community, represent a powerful force for positive change. Similarly, young people themselves are more likely to become active citizens in their local communities. Jointly, the school and the community will have a positive impact in creating a social and physical environment conducive to better health.
10. **Sustainability.** All levels of government must commit resources, both financial and human, to health promotion. This commitment will contribute to the long-term sustainable development of the wider community.

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IN ENGLAND–

The Department of Health and The Department for Education and Employment have recently given a boost to the healthy school movement by launching a healthy school pilot in each of eight regions in September 1998. Each pilot school has received 150,000£ in funding. Marilyn Toft, national healthy schools coordinator, says the new initiative represents a significant change in approach to developing healthy schools -- "We are looking at education outcomes as well as health outcomes," she says. The idea is that by driving up educational standards, the aim of reducing health inequalities will also be achieved -- "In a healthy school that has a 'supportive but challenging learning environment,' that values positive relationships, makes learning a priority, and encourages pupils to have higher self-esteem and confidence, pupils will achieve more -- not just academically, but personally and socially" (Moore, p.14).

We were informed in a recent email communication from Marilyn Toft that a "National Healthy School Standard" (NHSS), launched in October 1999, is sponsored and funded by both the Department of Health and the Department for Education and Skills. NHSS is based on the premise that there is a symbiotic relationship between health and education, an hypothesis increasingly supported by research evidence. The three aims of the NHSS are to:

- help raise achievement
- help reduce health inequalities
- help promote social inclusion

This partnership at national level is echoed at the local level where there are nationally accredited local healthy school partnerships in every area, between the Local Education Authority and the new Primary Care Trusts, which have replaced the previous Health Authorities. Each Partnership runs a programme that supports its local schools to become healthy schools, and has a local co-ordinator working with a network of supporting agencies. Schools are not obliged to become involved in the NHSS; they decide to do so for a variety of reasons, but mainly because they are interested in the development of the 'whole child' in an environment conducive to learning and because they feel that this may well be an effective route to school improvement. At the moment about 8,000 schools are involved at the most intensive level and overall approximately 14,000 in total are accessing training and support. Toft believes that the NHSS is effective because of the whole school approach it adopts, which is composed of 10 elements:

- leadership, management and managing change
- policy development
- curriculum planning and resourcing, including working with external agencies
- teaching and learning
- school culture and environment
- giving pupils a voice
- provision of pupils' support services

- staff professional development needs, health and welfare
- partnerships with parents/caregivers and local communities
- assessing, recording and reporting pupils' achievements

This approach is used by schools to address a number of health and education themes e.g. sex and relationships education, drug education, citizenship. Equality issues, social inclusion, participation and consultation inform all the structures and processes of the NHSS.

The NHSS was developed using an extensive amount of research, and it is subject to on-going research projects as it begins its fourth year. The early focus was on the effective formation of partnership and a vital national and local base if support to schools is to be maintained. Now the focus is very much on the work in schools. Two departments (Education and Health) recently agreed on the target that by 2006 every school serving a deprived area (7,000 schools with 20% plus Free School Meal Claimants) will become a healthy school - showing impact of the NHSS in the everyday experiences of pupils and the school community. More information about the NHSS can be found by accessing <http://www.wiredforhealth.gov.uk> that details recent publications as well as teaching and learning resources.

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IN THE U.S. –

The term "Comprehensive School Health" is used more commonly than the term "Health Promoting School" but the underlying principles are essentially the same. The concept of a "Comprehensive School Health Program [CSHP]," also referred to as "Coordinated School Health Program," originated in the United States in the 1980's and was intended to address many of the health-related problems of children and youth to improve health and educational outcomes.

The "Action for Healthy Kids Initiative" is now underway across the United States, led by education and child-health experts and supporters on 50 "Action for Healthy Kids" State Teams. Representatives from almost every state attended the Initiative's kick-off event – the "Healthy Schools Summit" – on October 7 and 8, 2002 in Washington, D.C. chaired by Dr. David Satcher, M.D., Ph.D., former U.S. Surgeon General. Mrs. Laura Bush acted as honorary chair of the Summit. Information shared at the Summit with national experts, state administrators, successful local principals and others is now publicly available online at the Action for Healthy Kids website (<http://www.actionforhealthykids.org>).

This Initiative builds on much previous work. For example, a large network of schools striving for positive change in the U.S. is led by an organization called Communities in Schools (formerly known as Cities in Schools - <http://www.cisnet.org>) in conjunction with an organization called America's Promise supported through the leadership of Colin Powell (<http://www.americaspromise.org>). America's Promise has identified five resources that every child must have for health, success, and well-being:

- An ongoing relationship with a caring adult.
- Safe places and structured activities during nonschool hours.
- A healthy start with a potential for a healthy future.
- Marketable skills through effective education.
- The opportunity to give back through community service.

In 1988, the Centers for Disease Control and Prevention [CDC] established the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), within which it created the Division of Adolescent and School Health (DASH). The mission of the CDC Division of Adolescent and School Health can be viewed at:

<http://www.cdc.gov/nccdphp/dash/about/mission.htm> In 1990 the Centers for Disease Control began its program to support a “coordinated school health” infrastructure in the United States. CDC currently supports coordinated school health programs in 20 states (see http://www.cdc.gov/nccdphp/aag/aag_dash.htm).

In 1994, an Institute of Medicine [IOM] committee carried out an extensive study of comprehensive school health programs culminating in the publication of the book, *“Schools & Health: Our Nation’s Investment”* in 1997. This book, edited by Allensworth, Lawson, Nicholson and Wyche, presents a strong theoretical base to the field and documents an extensive amount of work in this area in the U.S. including three critical areas and recommendations for a national infrastructure.³ The IOM working definition of a CSHP consisted of the following:

³ The three critical areas the IOM feel should be considered in designing a CSHP are:

- the school environment (e.g. physical, psychosocial, and policy and administrative environment)
- education (e.g. physical and health education and promotion of healthful behaviours in other curricular areas)
- services (e.g. health, counselling, psychological, social, nutrition and foodservices)

The IOM made several key recommendations regarding the need for CSHP infrastructure

- at the national level: That the mission of the federal Interagency Committee on School Health (established in 1994) be revitalized so it can provide national leadership and carry out critical new national initiatives in school health, and that the National Coordinating Committee on School Health serve as an official advisory body to the ICSH.

- at the state level: That an official state interagency coordinating council for school health be established in each state as well as an advisory committee of representatives from relevant public and private sector agencies. “The state coordinating council should coordinate state programs and funding streams, propose appropriate state policies and legislation, and provide assistance to local districts” (p.10).

- at the community or district level: That a formal organization with broad representation--a coordinating council for school health--should be established in every school district. “Among its duties, the district coordinating council should involve the community in conducting a needs and resource assessment, developing plans and policies, coordinating programs and resources, and providing assistance to individual schools” (p. 10).

- at the school level: That individual schools should establish a school health committee and appoint a school health coordinator to oversee the school health program. “Under this leadership, schools should

A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students. The program involves and is supportive of families and is determined by the local community, based on community needs, resources, standards, and requirements. It is coordinated by a multidisciplinary team and accountable to the community for program quality and effectiveness. (p. 2)

Two School Health Policies and Programs Studies [SHPPS] were done in 1994 and 2000, and the 2000 statistics summarized by Kann, Brener and Allenswoth (2001) indicate that:

- Eighty-eight percent of states and 63.8% of districts have someone who oversees or coordinates health education. (p. 270).
- During the 12 months preceding the study, state health education staff worked on health education activities with state-level health services staff in 90% of states, with mental health or social services staff in 80% of states, physical education staff in 77.1% of states, and food service staff in 75.5% of states (p. 269).
- In addition, district health education staff worked with local health organization staff in 60.3% of districts, local health department staff in 53% of districts, local mental health or social service agency staff in 49.3% of districts, and local hospital staff in 40.7% of districts (p. 270).
- About two-thirds of schools have one or more groups that develop policies or coordinate activities on health issues. These groups, typically called school health councils, include school staff, parents, and other interested members (p. 257).
- From 1994 to 2000, the percentage of middle/junior and senior high schools with a part-time or full-time school nurse increased from 65% to 74.2% and the percentage of middle/junior and senior high schools with a nurse-student ratio of 1:750 or better increased from 28.2% to 52.8% (Note: the 1994 percentage includes only RNs, the 2000 percentage includes RNs and LPNs). (p. 258)
- About one-half of states, two-thirds of districts, and three-fourths of schools have a person who oversees or coordinates mental health and social services. In addition, three-fourths of schools have a part-time or full-time guidance counselor, two-thirds of schools have a psychologist, and less than one-half of schools have a social worker who provides mental health or social services to students. Most states and districts offer or provide funding for staff development for mental health and social services staff (p. 255).
- The responsibility for coordinating and directing physical education may be moving from the state to the district level...[or perhaps to non-governmental organizations, such as here in Ontario with Ophea--the Ontario Physical and Health Education Association]. The percentage of states with someone to oversee or coordinate physical education decreased from 76.5% in 1994 to 68.6% in 2000 and the percentage of districts with someone to oversee or coordinate physical education increased from 51.4% to 62.2% during this same time period (p. 258).

address the major issues facing students and/or the components of the CSHP, develop policies, coordinate activities and resources, and seek the active involvement of students and families in designing and implementing programs” (p. 11).

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IN CANADA–

The Canadian Association for School Health (CASH), the Canadian Association for Health, Physical Education, Recreation and Dance (CAHPERD), and Health Canada are successfully championing this cause in many provinces. Supported by Health Canada funding derived from three separate health issues, delegates from every jurisdiction came together in Winnipeg in 1988 to form a national association (CASH) and to create provincial/territorial associations for school health (ASH). This conference coincided with Health Canada’s Health for All policy, reflecting Canada’s follow-up to the Ottawa Charter on Health Promotion. Following this successful national conference, 25 national organizations developed and then endorsed a national consensus statement on Comprehensive School Health (CSH). This framework benefited from new thinking about school health in the research journals (it was no longer considered to be only instruction). The new definition emphasized a multi-issue, multi-intervention, multi-level, comprehensive approach. Significant commitments to school health programs were made in many provinces and territories. Curricula were upgraded and made mandatory, student activity programs were funded, and employee health became a concern for many school systems. CAPHERD published a special issue on Healthy Active Schools in its Spring, 1999 journal, and has been an influential leader in the Canadian Healthy School movement.

Recently a concern about specific health issues has reemerged, with funding now going to topics such as tobacco, diabetes, obesity, chronic disease, mental health, drugs, physical activity, healthy eating and injury prevention. At the same time, there is increased interest among policy-makers in how integrated, coordinated approaches can be implemented effectively. The Atlantic Provinces are just starting a joint curriculum initiative on wellness that will have a significant potential impact on school-based programs. The Council of Ministers of Education, Canada (CMEC) has expressed interest in and support for student and school health issues in a variety of ways. A policy paper has been accepted by all health deputy ministers (federal, provincial/territorial) recommending “settings-based health promotion strategies”, including schools. CASH participated in a think tank on chronic disease prevention that led to this paper. It has also participated in the development of a new Gateway Web Site on CSH (www.safehealthyschools.org), launched an email school health “clippings” service, developed “Student WebQuests” templates enabling teachers to create online student health projects involving specific websites and off-line activities, and worked on sexuality education, substance abuse and diabetes prevention projects, among other activities.

Basic information on Comprehensive School Health has been posted on Health Canada’s website. (<http://www.hc-sc.gc.ca/hppb/children/english>). This site is set up to disseminate information on school health lesson prototypes, the workplace health system student model, health behaviors in school-aged children (from an international survey), health promoting school environments, health promoting school policies, related services and contacts. Recently, an online student health needs assessment tool (called “Voices

and Choices”) that provides a profile back to responding schools has been launched through this website.

IN BRITISH COLUMBIA–

A healthy school initiative was launched in the early nineties through the combined work of the Ministry of Health and Ministry Responsible for Seniors. By 1994, 300 schools in 42 school districts were involved. Many resources were produced and circulated on schools and health, and diverse projects were initiated by students involving such issues as nutrition, recycling, parent-student and teacher-student relationships, etc.

Today, the school health coalition in BC, The Directorate of Agencies for School Health (DASH), is very active with their current priorities including the development of a comprehensive explanatory document on CSH, a web site, new brochure and a project on school meals with the Canadian Living Foundation. The BC Healthy Schools initiative has survived the regionalization of public health in the province, but is able to maintain only a tenuous presence in several of the province’s regions. A recent review of the CAPP (health, wellness, career education program) found strong support for maintaining the healthy schools program. As part of that review, the education ministry is committed to updating the resources that support the CAPP program.

IN ALBERTA–

The Alberta Coalition for Healthy School Communities (ACHSC) is very active, with an annual conference being its major activity each year. The ACHSC web site is found at: www.achsc.org. The latest newsletter is available at: <http://www.achsc.org/Newsletter.pdf>. ACHSC is co-hosting the CAHPERD conference next year. The province has recently updated the health and physical education curriculum and a new consultant has been hired at the education ministry. The health ministry has funded early intervention programs for young children under its healthy schools program. The province is host to two excellent web sites on teaching physical education and teaching sexual health education. The Alberta Teachers Association (ATA) manages a large-scale program on Safe & Caring Schools that uses a CSH approach. The Physical Education teachers group, HPEC, operates the EverActive Schools program.

IN SASKATCHEWAN–

Several school health initiatives are underway. The most significant of these is the “School Plus” initiative that seeks to have the school placed as the hub to a variety of children and family services. The province also has a significant Safe & Respectful School initiative underway. There is now a provincial network of “Catalyst Teachers” in health education. Some educational leaders have been working in parallel with schools in the Ukraine who are undertaking school health promotion linked to the international movement. The “Physically Active Saskatchewan Roundtable” provided an opportunity for over 80 leaders from health, education, recreation, and sport sectors to discuss possible solutions in addressing the physical inactivity crisis in their province.

IN MANITOBA–

The Manitoba ASH group has been operating well for several years as a meeting place for all of the health groups. Meetings are held every month. Current priorities include

teacher education and advocating for a health teachers specialist group within the Manitoba Teachers Society. There is an active coalition of groups working on chronic disease prevention. The ASH group has been working extensively on the implementation of the new curriculum. The ASH group also has a web site.

IN QUEBEC –

The education ministry has decided to phase out the personal and social development curriculum (FPS) in the next few years. The physical aspects of health will be covered in a combined program with Physical Education and the social aspects will be integrated into the provinces moral education and moral/religion curriculum. Sensitive issues such as sexuality are supposed to be part of a “program of programs” (i.e. a cross-curriculum approach).

IN NEW BRUNSWICK–

Health and education ministry officials are developing a formal CSH policy and the province has several school health initiatives underway, including a Healthy Learners program funded by public health, more health nurses in schools, a comprehensive guidance program, a comprehensive safe schools program and several other activities. The tobacco strategy also uses a CSH approach. School Communities In ACTION, a recently announced strategy for promoting physical activity through a CSH approach has just been launched.

IN NOVA SCOTIA–

There are some CSH activities underway in the province and the health curriculum has recently been updated. A provincial strategy on physical activity has just been announced. There is an active alliance of groups working on chronic disease prevention.

IN PRINCE EDWARD ISLAND–

Health and education ministry officials are working on an Active and Healthy Schools initiative. A recent meeting of tobacco, physical activity and nutrition groups has targeted schools as part of a coordinated approach to chronic disease prevention.

IN NEWFOUNDLAND–

The CSH approach is well supported by the education and health ministries. The curriculum is being updated. The province has a large-scale anti-bullying program underway. The province monitors the social climate of the schools through a mandatory Quality of School Life and a mandatory Student Activities survey to verify that student health concerns are being met. The data from these two surveys is published as part of a “profile” for every school that is available on the Internet.

IN THE YUKON–

The focus on the CAPP (Health program) has increased and the education ministry has hired a coordinator. The “Active Yukon Schools” working group has just been formed to work on promoting physical activity through a CSH approach.

IN THE NWT–

A formal CSH policy and program has existed for several years. The ASH group works through the ministry officials who continue to be supportive of CSH. The education, health and sports/recreation departments are developing an Active Living Strategy for the NWT that will have an active schools component. The Department of Education, Culture and Employment is currently adopting new curriculum for physical education for the elementary schools in the NWT.

IN NUNAVUT–

The territory is developing a community-based health promotion strategy. No ASH group has been formed yet. The education ministry has launched an anti-bullying program. The ministry is also working on a comprehensive wellness curriculum.

IN ONTARIO–

Some success stories for comprehensive school health have been reported in diverse school regions including Peel, Ottawa, Durham, Windsor, Middlesex-London, Elgin, Thunder Bay, Simcoe and others. Middlesex-London was an early champion of the student “School Health Model”, now adopted by Health Canada as “Voices and Choices.” The mandatory guidelines for public health require that public health units do health promotion programming with schools on designated health issues. Special grants have been allocated to NGO’s and other groups for such issues as body image and healthy eating, and injury prevention. The province has just announced a two million dollar campaign that will be led by Ophea, the Ontario Physical and Health Education Association, to prevent diabetes and obesity. Ophea has operated a physical activity incentive program, the Active Schools Program, for several years. Significant obstacles in collaborating with schools have been experienced, but the school board-health unit “School Community Action Partnership” teams hold promise for enhanced collaboration.

Three groups came together in 2000 to form the Ontario Healthy Schools Coalition: The Ontario Public Health Association Healthy Schools Workgroup, the School Health Interest Group of the Centre for Health Promotion at the University of Toronto, and the Coalition of Ontario Agencies for School Health (COASH). Their goals are to: 1) Raise awareness of the benefits and need for ‘healthy schools’; 2) Influence policy development and the provision of adequate public funding to guide the implementation of the ‘healthy schools’ approach; and 3) To provide a forum to share new and ongoing initiatives across the health, education and related sectors. This coalition of 175 members from health units, school boards, hospitals, mental health agencies, universities, health-related organizations, education-related organizations, parents and students should also be part of the solution for better inter-ministerial, and multi-sectoral collaboration.

A website on "Improving Student Health and Learning through Comprehensive School Health" has been prepared through the leadership of Andy Anderson at OISE/UT with Hospital for Sick Children's Foundation and OISE/UT funding. It provides, in a vibrant, interactive format, basic information on the meaning of health, health literacy and Comprehensive School Health as well as case stories.

(<http://www.oise.utoronto.ca/~jstathakos/schools>). Dr. Anderson and his team have also

prepared a text for teacher preparation on health promotion in schools called “*Better Health, Better Schools, Better Futures*” and prepared a special issue on Health Promoting Schools in OISE’s journal, *Orbit*, vol. 31, no. 4, 2001.

It is essential that Ontario take steps to make Health Promoting Schools a reality in our province. International experience with CSH/HPS has shown that top-down (provincial) inter-ministerial support is crucial to provide a mandate to the various sectors to engage in these collaborative approaches, to effectively plan the resources that are required to disseminate the concept of CSH, and to provide ongoing support to school boards and schools with implementation. Inter-ministerial support contributes to the sustainability of initiatives and to giving every child the opportunity to be educated in a health-promoting school.

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USEFUL SCHOOL HEALTH WEB SITES

Health Canada

www.hc-sc.gc.ca/hppb/children/english Select "What is Comprehensive School Health?" and then select item 1.1 "The Comprehensive School Health Model"

Canadian Association for School Health Executive Director: Doug McCall
School Health Listserve: email dmccall@netcom.ca
Safe and Healthy Schools Web-Site: www.safehealthyschools.org

Canadian Association for Health, Physical Education, Recreation and Dance [CAHPERD] www.cahperd.ca (see www.cahperd.ca/e/gsh/research.htm for Partners in Health: Schools, Communities and Young People Working Together)

The Ontario Institute for Studies in Education of the University of Toronto
Comprehensive School Health Web-Site:
www.oise.utoronto.ca/~aanderson/csh/index.htm

World Health Organization
www.who.int Select "School Health"

European Network of Health Promoting Schools
www.euro.who.int/eprise/main/WHO/Progs/ENHPS/Home

Australian Health Promoting Schools Association
www.hlth.gut.edu.au/ph/ahpsa/about

Healthy Physical Environments in Schools
www.healthyschools.com

British Columbia Ministry for Children and Families “Healthy Schools Resource Guide”
www.mcf.gov.bc.ca Search for “Healthy Schools”

Alberta Centre for Active Living
www.centre4activeliving.ca Look for “Wellspring” Fall 2001 Newsletter

Saskatchewan School Plus: A Vision for Children and Youth—Toward a New School,
Community and Human Service Partnership in Saskatchewan
www.sasked.gov.sk.ca/k/pecs/policy/docs/RoleofSchools

The Center for Health and Health Care in Schools—The George Washington University
School of Public Health and Health Services (U.S. information)
www.healthinschools.org

SchoolNurse—U.S. Monthly Newsletter
www.schoolnurse.com
(see http://www.schoolnurse.com/med_info/Compreh_school_health.html)

National Healthy School Standard, UK
<http://www.wiredforhealth.gov.uk/>

New South Wales “Health Promotion with Schools: a policy for the health system”
<http://www.mhcs.health.nsw.gov.au/public-health/healthpromotion/hpss/schools/schools.htm>

Ontario Physical and Health Education Association (OPHEA)
www.ophea.net

Ontario Healthy Schools Coalition / Ontario Public Health Association Healthy Schools
Workgroup
www.opha.on.ca under Activities, Workgroups, Healthy Schools Workgroup

Voices for Children
www.voicesforchildren.ca

Education and Health in Partnership: A European Conference on Linking Education with
the Promotion of Health in Schools September 25-27, 2002
Egmond aan Zee, the Netherlands
www.egmondconference.nl

U.S. Healthy Schools Summit October 7-8, 2002 Washington, D.C.
<http://www.actionforhealthykids.org>