Zsuzsanna Benkő (Editor of Series)
Peter Paulus and Thomas Petzel
(Editors of the Voume)

HEALTH PROMOTION

Szeged – Crewe – Lüneburg
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CONCEPTUAL OVERVIEW

Zsuzsanna Benkő (Hungary)

Key concepts of the 21st century are change and globalisation. As Anthony Giddens argues in several of his publications, in the 21st century only one thing is certain: permanent change. For centuries, tradition was the basis and defining feature of the life-style, behaviour, culture and psychological life of families, individuals and communities. In our present world change pervades every aspect of our existence. Thus it is understandable, and no coincidence, that these changes affect education so strongly, both at the higher and earlier levels. In this particular project, with its orientation towards the professionalisation of teachers and educators, the themes that were the focus of the higher education teams of Britain, Germany and Hungary between 2002 and 2005 are inevitable – health promotion, multicultural education and social inclusion/exclusion of children and young people – all of which are connected so closely to contemporary concerns about equal opportunities.

We inhabit a Europe whose geographical and political borders are shifting, whose population migrates within and among the continents, where women participate in every domain of the division of labour to an extent history has never seen, and where it is natural that people of different cultures, nationalities, ethnic origin and religion, that is all of us, are in everyday contact with those thinking and living differently than we do.

This Europe strives for transferability among its different nation states that is not only economic, legal and institutional but also cultural in the broadest sense. However, the notion of globalisation that has become at the centre of economic development, specialist literature, public debate and analysis since the 1980s is more than that; in some way globalisation impacts on the lives of us all because we exist in the same world. But how is this so? Whilst the cosmopolitan can welcome and embrace this cultural complexity, the fundamentalist finds the same embarrassing and dangerous. However, we can trust, with reason, in the victory of a cosmopolitan perspective.

Cultural diversity and democracy are closely related, and democracy is now spreading all over the world. Globalisation lies behind the spread of democracy. It is inaccurate to think that globalisation just affects large systems. Globalisation is not only about what happens "out there" in the distance, at the same time it resonates with the "here inside", the phenomena that affect our continual

socialisation through our families, education, immediate work environments and friends etc. Globalisation is, then, a complex system of processes that works through contradictions and conflicting effects. Whilst nations may lose a great part of power they once owned, at the same time there is more potential for increased local autonomy. Local cultural identities revive for example in different parts of the world as a result of globalisation. Globalisation shifts sideways as well; it creates new economic and cultural zones within or across nations.

The topic of multiculturalism, multicultural education, the striving for equal opportunities and the question of social inclusion are key issues in the work of educators in the European Union. The idea of multiculturalism is present at every level of society, in the education system, its policies, structures, evaluation mechanisms and school ethos. It is by ensuring equal opportunities that we can make it possible for pupils to perform according to their abilities, and prevent social disadvantage that leads to failure in school, whilst making learning a positive experience. Alongside, and in close relation to the multicultural perspective, the other important factor is health and its promotion. Health is a multidimensional concept where physical, mental and social elements are inseparable, so natural and social environments, the available resources, the combating of problems, the experience of success, satisfaction and positive self-image form health opportunities in every society. The healthy school is at the same time a successful school which can fully perform its role according to social expectations in the structure of social sub-systems. The reinforcement of equal opportunities and the improvement of social inclusion within school entail a change in perspective and authority of traditional professions, and the creation of new opportunities for partnership and cooperation. This innovative approach leads to the conclusion that well-intentioned individual efforts are insufficient in themselves; there is also a need for well-planned organisational changes. The main method of these organisational changes is organisational development; its main means is through the project.

An important element of health equality is the access to health opportunities and their promotion. This involves addressing the considerable differences between the developing and the developed world and between the developed countries as well. Thus in Europe, there are not only disparities between but also within countries. This is illustrated by differences in life expectancy at birth which can be up to 10-14 years among European nations or even within a given country.

This international team aims to assist educators engaged in socialisation processes by placing the values of multicultural education, social inclusion for children and young people and health promotion into the foreground. In the development of the teaching material and the topics chosen we have formulated a

twofold objective for ourselves. On the one hand, all three themes aim to introduce universal and general values, trends and processes; on the other hand, we have striven to introduce different examples of their practical realisation illustrating the possibilities and methods in each case. The teaching materials created contain English, German and Hungarian case studies, and by so doing, these exemplify the effect of historical, national, cultural and religious versatility on the settings of everyday life.

On behalf of the teaching material developing team, I hope that these volumes will be useful to educators, and, indeed, all professionals engaged in education and human service, in their application of a broader, social dimension and values to successful practice!

INTRODUCTION

Peter Paulus and Thomas Petzel (Germany)

This book offers an introduction to health promotion with a special emphasise on health promotion in educational settings like schools. The importance of the concept has grown over the years since 1986 when it was introduced to a wider audience for the first time at the 1. International Conference on Health Promotion in Ottawa (Canada). You will find this and all the other important features of this approach in the forthcoming chapters. In the introductory chapter you will find basic notions of health and health promotion in the perspective of the World Health Organization. Principles and values of health promotion – the second chapter – will present the wider context in which the concept is embedded and why it is seen as an innovative one. Strategies of the introduction, support and management of health promoting activities in different social and cultural settings is the main part of the chapter three that focuses on how health promotion can get started. How to change skills and how to foster skills development in a more traditional way compared to modern conceptions of health promotion is the topic of chapter four. Communication skills, teaching skills and group dynamics are aspects of this more person-centred view of health promotion. Environments and settings as targets of health promotion are the focus of chapter 5. Examples will show, that health promotion is in its essence a setting based approach to health development. In one of the sub-chapters you as a reader will be asked to develop your own ideas and projects. This is done because health promotion is an approach which very much depends on the empowerment of the people for whom or better with whom better and healthier living conditions are created. Evaluation and using informational sources is the title of the 6th and last chapter. Without evaluation there will be no good health promotion. Evaluation helps to find out if the project or the initiative which someone started will yield the expected result. It helps those who are practicing health promotion to do better. And this is what we all want: To help people to lead a healthier life to help them to make health the easier choice. The internet with a huge amount of information with sometimes doubtful quality is a resource which can be of great help in planning health promotion activities. To find about good sources of information is the crucial task. This chapter will help to find them.

STUDY GUIDE

Gaye Heathcote

INTRODUCTION

Welcome to CANDOR and congratulations on choosing to study for your professional qualification and/or in-service development through distance education!

Distance education may sound a rather isolated experience and you may already have some anxiety that you will be studying alone, on your own, without a great deal of educational or social contact. Not at all! Distance education involves regular exchanges with your tutors (sometimes face to face, by telephone or by e-mail) and participation in a network of scholars and practitioners who, in one way or other, are there to support, help and encourage you towards successful completion of your studies. Moreover, distance education offers you a great deal of flexibility and control over your own learning because you can study as much or as little as you wish in one study session (provided, of course, that you keep to the general guidelines about submitting assignments, attending tutorials and observing the intermittent 'milestones' of the course). Meanwhile, as an adult learner with other responsibilities and commitments at home and at work, you will develop your own study strategies which allow you to juggle the different parts of your life more easily with distance education. (Contrast this with having to get up at 4.00 am on a dark and cold winter's morning for a class in Budapest or in Manchester or in Berlin that begins at 9.00 am!)

Origin, purpose and overall structure of the course

The course is one of the major outcomes of a project entitled 'Changing the Attitudes of Teachers through Normal and Distance Learning in Open Human Relationships' known as CANDOR. This project is funded by the European Union's SOCRATES programme. Co-ordinated by academics and practitioners from the University of Szeged, it arises from a collaboration with colleagues from the Manchester Metropolitan University (UK) and the University of Lüneburg (Germany). Each University has, according to its particular specialisms, played an expert role in relation to each of the three defining themes of the course:

- Health Promotion
- Diversity and Multicultural Education
- Childhood, Young People and Social Inclusion

These themes underpin the curricular content and offer an organizational framework for the course as a whole.

This is offered as a series of interconnecting modules, divided into 'general' and 'unique' topics.

'General' topics aim to offer an introduction to, and overview of the module as a whole and, as such, offer key concepts, ideas, theories and methodologies. The 'unique' topics aim to complement these by providing illustrations, examples and a practical approach to the more theoretical focus of the 'general' topic. All modules contain activities, exercises, assignments and other practical things for you to undertake in between your reading of the texts. This is explained later in more detail in this Guide.

Aims and objectives of the course

So what exactly is the course about? The aim of course is to change attitudes, values, beliefs and ultimately the behaviour of teachers and other educators (ie professionals who have an educative function in their jobs). All teachers increasingly find themselves teaching multiracial, multifaith, multi-ability, multicultural groups of students; many teachers increasingly are being asked to educate, generally or through their subject specialisms, about social inclusion/exclusion, about social and cultural diversity, about equality of access to education, jobs and training – and about the barriers. These are racism, xenophobia, prejudice and stereotyping which serve to compound disadvantage and exclusion, and result in increasing numbers of young people becoming disenfranchised and socially disruptive. Thus:

CANDOR'S Aim
To change the attitudes and values of teachers and educators in ways which promote social inclusion, diversity and equal opportunities for their students.

CANDOR'S Objectives
To promote awareness among teachers of the theoretical and practical issues around different forms of social, cultural, ethnic and religious diversity.

To enable teachers to recognise discrimination when it occurs in the context and curricular content of schooling, and to develop strategies for themselves and others to combat this.

To impart values, beliefs and ways of behaving to their students which challenge barriers to social inclusion and support them in their attempts with family and social networks to influence negative behaviour on the part of others.

To enhance the professional development of teachers by exposing them to current socially inclusive debates and actions in Europe and beyond through the study of health promotion, multiculturalism and equality of opportunity, with particular reference to children and young people.

TUTORS' AND STUDENTS' ROLES

We see teaching, learning and professional development as a partnership, involving mutual support and exchanges of ideas. This relationship is particularly important in distance education which, as we have seen, is an approach with its own defining characteristics. Some trained teachers sometimes find it a bit difficult taking the role of the student again and acknowledging that someone else is the teacher or tutor! However, in adult education, it is always recognized that both tutors and "students" have a huge amount of life-experience, self-knowledge, motivation and existing knowledge, all of which prepare them very well for more learning experiences.

Distance education, whilst presenting its own challenges, also offers substantial benefits. You will find that the flexibility and autonomy described earlier suits you well, and that the impact of multimedia communication, as well as the social networking you enjoy with your fellow students, all makes for an excellent distance education experience.

When you look at the different modules your tutor will be giving you, you will see that they are divided up into small 'bites' of content which take into account the fact that even geniuses cannot study for very long periods without a break or some kind of distraction!

So, you will see that the text is broken up into manageable sections and punctuated with 'things to do'. This may be a direction to look at a chapter in a book, or something on the web, or a question to ask your friend or family, or some other short, sometimes practical activity. The text will also give you cues,

milestones and instructions about attending a tutorial, contacting some other student(s) or your tutor, submitting an assignment or preparing a presentation to the group next time it meets.

It is very important that you read the modules and study their content thoroughly. It is also important that you follow the instructions.

If you have doubts, anxieties, problems or difficulties, or you anticipate these at some future date, do contact your tutor at the earliest opportunity to ensure that you do not fall behind with your studies and consequently become de-motivated. Remember, help is always at hand, from your tutor, your family, your friends and fellow students.

Tutors, of course, cannot be available 24 hours a day, with the best will in the world. However, he/she will give you a clear idea as to when and where they can be contacted. The tutor has a number of different roles to play – teaching, supporting, guiding, counselling, assessing, organizing and networking. You will find that your tutor is experienced in all these dimensions.

Networking with others

Do not forget, either, that the student group, once organized in terms of contact addresses and once developed into a socially cohesive and supportive network, can be a great source of help of all kinds. You will be able to discuss ideas, assignments and practitioner activity, either on the ‘phone or, in informal local groups (get together for a meal, do some mutual baby-sitting, exchange ‘phone numbers).

Workshops

It is very important that you put these dates in your diary before the course begins and that you attend these workshops. This is because the workshops provide the opportunity to get together with

your student group and your tutor(s) in a face-to-face, interactive context. These workshops, you will find, really bring the course to life for you, socially, educationally and professionally. You will be able to discuss and apply the things you have learned on the course to your professional practice, to hear the views of other people, to work collaboratively on group assignments and to experience a variety of teaching and learning methods.

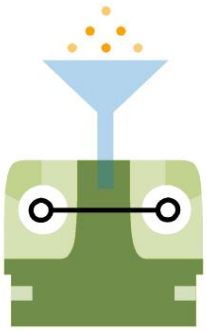
If, for whatever reasons (illness, etc) you find you are unable to attend a workshop, it is most important to have early communication with your tutor and to discuss how you can make up for what you have missed. Please remember, the course is designed so that the workshops are an integral aspect of the course, and not an 'optional extra' to supplement the distance education component.

Assignments

There are assignments which occur at different stages of the course. Here, we are referring to those items of assessed work which together constitute your final grade and hence whether or not you successfully pass the course. These assignments will be set out in the text of the modules, with cross-referencing to this Guide for further detailing. These assignments are obligatory: you cannot pass the course unless you submit them all satisfactorily. Of course, on occasion, there will be extenuating circumstances for non-submission but again, it is vital that you contact your tutor at the earliest opportunity to discuss any problem of this nature.

In addition to these assignments, there will be activities, indicated in the module text, which are not assessed. It is strongly recommended that you undertake all of these as they have been specifically designed to clarify, elaborate, operationalise or illustrate theories and ideas in a more practical way that has direct relevance to your work as a teacher.

Learning methods



The CANDOR course has been designed to be interactive, even though much of your time spent studying will be with a computer and a monitor. Remember, the intention is to make maximum use of a wide variety of communication media to make the course come alive for you. Working through the text, you will be directed to use other forms of interaction – reading a book, 'phoning a colleague, e-mailing or texting a tutor, researching on the web or at a local library, trying something out at school with your colleagues or your students, collecting information locally or from your family, attending tutorials, seminars, discussions groups and even

relaxation sessions! The choice of learning methods is not random either. Each has been chosen and so positioned in the course to allow you to match your particular learning styles and strategies to maximum effect, as well as provide variety and diversity to maintain interest and motivation. So, be innovative, open to new methodologies, creative, receptive – and stay positive!

Reflection on learning

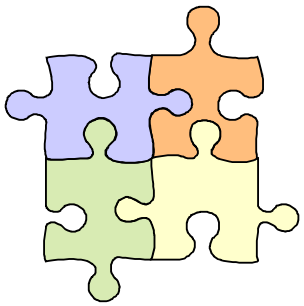
You will, no doubt, know about the increasing importance which contemporary research into learning and teaching attaches to the role of reflection. Much professional development in teaching, medicine, nursing and social work is grounded in the notion of 'the reflective practitioner' or 'the knowledgeable doer'. The same goes for practitioner research, undertaken to inform and improve practice. This is all about giving yourself time to think about your studies, to think through the relationship between what you are learning and how this affect your work in your school, to re-evaluate yourself, your relationships with others and with your work. This reflection not only helps you to link thought to action more effectively, but can help you see the implications of theory in everyday life, and to enable you to develop 'personal theory' from practical situations. Finally, it gives you the space and opportunity to do things even better the next time around! So, build in time to absorb and think more about all the new ideas, values and challenges that the CANDOR course is offering you, and use the 'spaces' in between work, study, family, etc to advantage.

HEALTH PROMOTORS AS FACILITATORS

Some of you initially may not see yourselves as health promoters. Others may be uncertain what being a facilitator actually means. However, we are all health promoters and facilitators, even people who are not teachers. This is because health is all about the ability to function effectively as a human being and the topics of the CANDOR course are all about promoting that potential in ourselves and others. Some of the barriers to health such as discrimination, prejudice, social exclusion or unequal opportunities for certain individuals or groups, are challenges which we all should be undertaking, whether on our own account or for others. To be a facilitator is to be concerned about the problems which people face in terms of educational or job opportunities, and to work to enable those barriers to be removed or those negative attitudes, values and behaviours to be changed for the greater societal good.

Outcomes of the course

Successful completion here means:



- study of all modules of the course
- completion of all in-text activities and tasks, and evidence thereof
- attendance at all course workshops
- successful completion of all course (graded) assignments
- a personal statement relating to networking (eg contact with other students, staff, involvement in partnerships, informal student meetings, etc)

For suitably qualified applicants, credit exemption will be considered on a case by case basis. Variables here will include:

- nature, type, relevance, level and recency of previous study

Applicants will need to apply formally for credit exemption to be considered and may be required to pay a fee accordingly. Please ask your tutor to explain the procedures for such an application.

Note: Your tutor may suggest that you collect all the above documentation relating to your study and your progress in a portfolio which can be made available to your tutor.

SUPPORT MECHANISMS

Support for your studies comes in many forms, from people, media and from your own personal resources. Students studying through distance education are known to be committed, resourceful, flexible and hard working, but in new situations like further study, particularly in new areas, everyone needs help from time to time. As already indicated, your tutors will outline what support is available through, eg the workshops, tutorials, web-sites, bulletin boards, interactive facilities and activities, a range of communication channels (telephone, computer face-to-face); other students, colleagues at work, friends and family will be there to listen to you and suggest ideas, study strategies and tips about life-work balance!

Study tips

Your modules are set out as though you are a traveller in a land which is sometimes unfamiliar. To help you get started on your ‘journey, each module has a

common format which initially acts as a source of self-orientation. For example, each module has an introduction, telling you what the module is about and, through the statement of aims and objectives, what you expect to know, understand or do by the time you have worked your way through the module.

As you travel through the module, you will meet signs, icons and sometimes cartoons in the margin. These will indicate 'milestones' activity points, assessment points and even advice about de-stressing! You will quickly learn what these cues mean and how to respond. Some of the information about how best to study and relax will be demonstrated to you in your first workshop.

Remember, most people can only study for short periods before having a break of some kind. Try to organize your work so that, at most you work for 30 minutes at a time (most people only manage about 20 minutes!).

At the end of each module, you will find a short summary of the content you have just studied. Some people find it useful to have a look at this before they start as well as at the end. It is a good way to 'signpost' the important messages and ideas.

We have already discussed the relationship between the 'general' and 'unique' topics. When you come to work through the course, however, you may wish to change the order in which you study so that instead of going from the more general and mainly more theoretical perspective, you start with the more practical, illustrative 'unique' topics and then go on to the 'general' topic. This will depend on how you best learn (which you will quickly discover if you do not already have a sense of this) and how much you already know and understand about the topic. The choice is yours!

Finally, in order to give you a synoptic overview of what the course looks like and asks of you, we offer, module by module, some information/curricular content which will be further explained in a step-by-step approach when you come to study in modules in more depth.

TOPIC 1

INTRODUCTION TO HEALTH PROMOTION

GENERAL TOPIC:

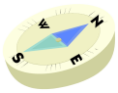
1.1 INTRODUCTION TO HEALTH PROMOTION

Peter Paulus and Thomas Petzel

- WHAT DOES HEALTH MEAN TO YOU?
- WHAT IS HEALTH?
- WHAT IS HEALTH PROMOTION?

1.1 INTRODUCTION TO HEALTH PROMOTION

OUTLINE



In the following you will find a brief summary of the modern understanding of health and health promotion. Concepts concerning areas important in the field of health promotion will be discussed, such as modern definitions of health, health promotion, prevention methods and health education.

OBJECTIVES

- Reflection of your own understanding of health and health promotion
- Gaining knowledge about modern scientific conceptions and definitions of health and health promotion
- Comparison of your own understanding with contemporary scientific views

CONTENT PART

Task 1.1.1

Health affects all of us. Before reading and thinking about the views of various „experts", it may be useful for you to think about what health means to you.
Please consider three things that make you healthy: 1. …….. 2. …….. 3. ……..
…. and three things that prevent you from being healthy: 1. …….. 2. …….. 3. ……..

Please read the following materials.

The modern understanding of *health*

The modern understanding of health can be defined using various characteristics. These also point at the development of the understanding of the term *health* over the last 60 years.

The Present Understanding of *HEALTH*
From an absence of illness to a positive description of health: The term *health*, as the linguistic counterpart for *illness*, has long been understood as the absence of illness. This came from the orientation on medical paradigms: healthy as not ill. In 1946 the WHO (World Health Organization) redefined the term *health*, turning away from the medical viewpoint, and defining health in a positive way.
From a one-dimensional to a multi-dimensional understanding of *health*: Today there is a consensus that health is a multi-dimensional construction, including physical, psychological and social well-being. Further discussion has expanded it further to include both life circumstances / situations (ecological aspects[1]) and sense-dimensions (spiritual aspects[2]) of persons.
From an objective approach about absence of illness to a subjective approach of health: Today, health is not objectively defined. Rather, health can be achieved subjectively by anyone. In other words, it is not an objective pronouncement of illness that determines whether someone is ill or not, but rather a person's subjective experience.
From an organic to a personal assumption of health: The core of health is not the organism, but the living person, who experiences subjectively being healthy. This living person is understood to be capable of self-contemplation, planning a goal-oriented action and, also, judging his or her own behavior.
From an individual- to a situational understanding of health: A person's health should always be understood in context with his or her life circumstances, which are, in turn, in constant communication with his or her social and material environment. A person can be healthy only in reference to his or her circumstances.
From a static to a dynamic understanding of health: Health is a dynamic process, in which well-being is both a prerequisite and a result of an active exchange between person and environment. In the balance created between the demands of the (immediate) environment and one's own needs and wishes, a person demonstrates whether he or she is more or less healthy. However, this balance must be continually re-established. When health is understood in this manner, it promotes an individual's active advancement to successfully and harmoniously accommodates various demands.

Table 1.1.1 *The present understanding of health*

The Definition of Health from the World Health Organization (WHO) from 1946

[1] In 1988 the WHO also cited **ecological aspects** of health in the recommendations for the 2nd International Conference for Health Promotion (See FRANZKOWIAK and SABO, 1993).
[2] In 1991 the WHO also cited **spiritual aspects** of health in a statement at the 3rd International Conference for health promotion in living situations (ibid).

The WHO's definition from 1946 of health is vital for the new understanding of health. The WHO formulated the positive aspects of health and views the term as a multi-dimensional and multi-determined occurrence. Health in and of itself is not the focal point, but rather *being* healthy, the individual healthy condition of each person. The subjectivity is emphasized in the WHO's definition. Being healthy is connected with how a person experiences health.

There are certain indicators of health and being healthy, which are found in the single dimensions of being healthy, as the following diagram indicates.

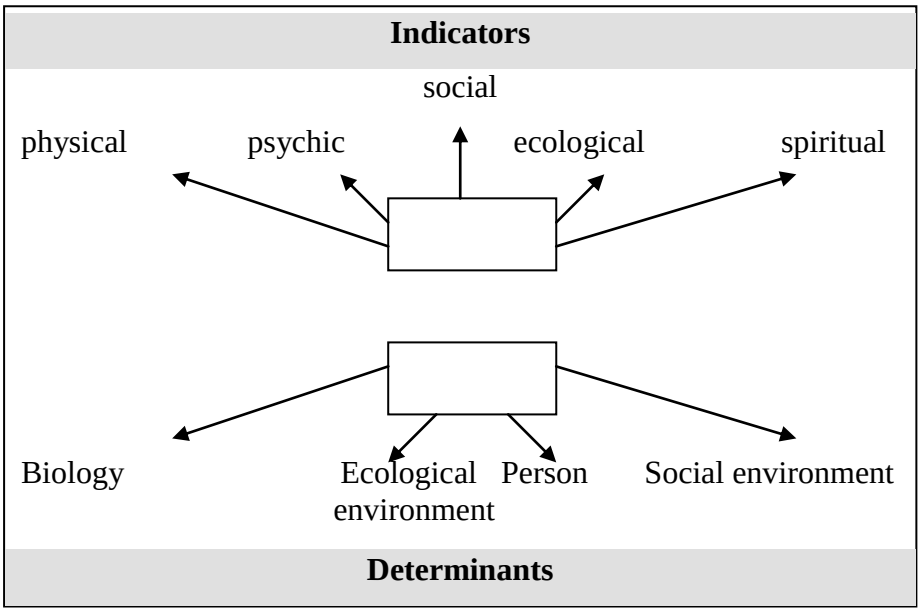


Figure 1.1.1 *Being Healthy and Health as Complex Structures of Connected Indicators and Determinants*

Dimensions	***Indicators***
Physical	An objective meaning of health can be created with bio-chemical, cellular, organic and cerebral characteristics. This meaning is difficult, however, simply because these aspects border on illness. Furthermore, there is an arbitrary effect on the background knowledge of psychosomatic influences and often a lack of diverse norms for various sub-groups.
Psychological	BECKER and MINSEL (1986, pp. 8.) have contributed a large amount to the clarification of the term *health*. They refer to **inner health**, which is described in their research in seven characteristics. 1. **Positive emotional conditions or well-being of a person**. 2. **High physical and psychological energy** (curiosity, activity, vitality, interest) 3. **Scope** (spontaneity, expressiveness, self-assuredness) 4. **Optimal effectiveness and performance** level (social aptitude, creativeness, resolve, realistic) 5. **Self-effacing** (the ability to shift one's focus from self to environment) 6. **Autonomy or self-sufficiency** (independence and the ability to take action) 7. **High self-confidence / self-respect**
Social	The presence of an intact social network makes a difference in a person's **performance within a social context** (for example, through emotional support, assistance in resisting daily stress and in crises, practical assistance and offering helpful information, giving one a feeling of belonging)
Ecological	Here **clean air and clean water, safe and secure living arrangements and employment, places of rest and recuperation, safe and exciting playgrounds, hygienic waste disposal**, for example, are important.
Spiritual	References to the spiritual dimension of health are seldom found in literature. Only recently has this dimension been accepted and coupled with the **reason / sense-dimension** of life. Processes of sense-experience humans can have parallels with, for example, coherence-sense from ANTONOVSKY (see below). Spiritual health also respects trans-personal experiences, which go beyond an understanding of health oriented on the material and life itself.

Table 1.1.2 *Indicators of health*

There are also indicators for the determinates of health:

Dimension	***Determinants***
Physical	Good constitutional (i.e. inborn) and dispositional (i.e. learned) characteristics, including biological-medical criteria of "normal functions"
Psychological	Personality characteristics such as **dependability, self-consciousness, internal (controlling) beliefs, self-confidence and emotional stability, as well as general life-skills** and the **ability to take action to overcome obstacles or problems** are important. In addition to these skills, there are also prerequisites, such as **healthy behaviors / healthy actions**[3] and **health-relevant knowledge**.
Social	For example, **love, recognition,** and especially **social support, a satisfying career or job, sufficient health care, sufficient educational possibilities** and **appropriate living arrangements**.
Ecological	For example, **plant and animal species protection availability of organic raw materials and hygienic waste disposal, the use of environmentally friendly technologies** and **safety from chemicals.**

Table 1.1.3 *Health determinants*

The Sense of Coherence as an Important Determinant of Health

One of the most important concepts in the discussion about the factors which aid in the protection against illness and health maintenance, is the concept of a "Sense of Coherence" suggested by AARON ANTONOVSKY. Also called the "feeling of coherence", this notion consists of three main characteristics, which are briefly described in the following table.

[3] The term *health behavior* means all reactions and behavior forms which are obviously in connection with health and illness (see WALLER, 1995. pp. 29.). He belongs to the traditional behaviorist approach and is associated with the adaptation aspect of health instruction in the health-education discussion. In contrast, *healthy action*, is associated with purposeful activities (see BLÄTTNER, 1994. p. 65.). The partial term action can be understood as a person's conscious and rational action.

What keeps a person healthy? **The Sense of Coherence – Aaron Antonovsky**
The sense of comprehensibility: As a cognitive-emotional competence aspect, this refers to the confidence a person has in his or her own intelligence, in order to understand and manage stimuli or demanding / stressful situations.
The sense of manageability: As a cognitive-emotional competence aspect, this refers to the confidence a person has in his or her own abilities to handle artificial stimuli or demands / stress, as well as the ability to accept help from others.
The sense of meaningfulness: As motivational competence, this refers to the confidence a person has that his or her own life and actions have a purpose.

Table 1.1.4 *The Sense of Coherence according to the model of salutogenesis from Aaron Antonovsky*

It is important to hold onto the fact that the coherence feeling is not the same as the different coping strategies, which a person has. The coherence feeling is more a superordinant principle, which has a certain steering function. The similarities with other psychological constructs, which are concerned with health maintenance (for example, the constructs "self-effective", "inner (controlling) beliefs", "resilience", "inner health"), are notable. These embody the salutogenetic perspective in health research, diverging from the pathological perspective, which tries to explain how illness occurs (and how to prevent illness).

Please read the following materials.

Health Promotion – the Concept of the WHO

At the 1st International Conference on Health Promotion in November 1986 in Ottawa, Canada, the attending experts from over 60 countries formed the Ottawa-Charter of Health Promotion. The Ottawa-Charter became the most important political document for the development of Health Promotion and gave the scientific research decisive impulses, as well as having a new effect on the practice of Health Promotion.

The first sentence of the Ottawa-Charter defines Health Promotion as follows: "Health promotion is the process of enabling people to increase control over, and to improve, their health." This sentence shows what the Ottawa-Charter later unfolds: it is about people and their abilities and about their living situations and autonomy. The most important aspects of the Charter are presented in the following summary:

A: The concept of the Ottawa-Charter for Health Promotion

Health Promotion
"Health Promotion's goal is to make it possible for people to have more autonomy over their own health and to enable them to have a better over-all health."
Health Understanding
Quality of Life Social, economical and personal development
Health Bio-psycho-socio-ecological well-being, Satisfaction of needs, Making wishes and hopes come true, Mastering one's environment and making a difference

Table 1.1.5. *Health promotion and health understanding*

Areas of Health Promotion Actions	
Society "Building healthy public policy"	To make health a key criteria for political decisions, not only in public health issues. Practical applications are, for example, the initiation of laws or acts, taxation measures; equality in health, income and social politics; organization-structural changes.
Living environments "Creating supportive environments"	To develop health in connection with socio-ecological environmental situations according to the interest of public and personal health. Practical applications involve, for example, the protection and maintenance of natural environments; the creation of safe, inspiring and comfortable work and living conditions; seizing healthy results especially in the areas of technology, working environments, transportation and city development.
Groups "Strengthening community action"	To include community citizens in health-related activities and to support the making of social networks. Practical applications consist of, for example, strengthening from neighbourhoods and communities; supporting self-help, public participation and involvement in political decisions; appropriate financial support for community initiatives.
Individuals "Developing personal skills"	To develop personal skills for the autonomy of one's own health. Practical applications include, for example, supporting the development of personal and social skills through information and health education; improving social skills and practical abilities for life (life skills); helping persons with the different phases of life and, when necessary, dealing with chronic illness.

Table 1.1.6 *Areas of health promotion actions – I.*

Areas of Health Promotion Actions (II)	
Organization "Re-orienting health services"	To persuade health services to develop a health care system that moves beyond the traditional medical services (health maintenance) and into an inter-lateral cooperation between health sectors, and to make other social, economical and political health-related organizations and institutions develop new structures. Practical applications can be composed of, for example, paying more attention to health-related research; improvement of the cooperation between health sectors and other areas; changes in professional and vocational education and training.

Table 1.1.7 *Areas of health promotion actions – II.*

Methods for Health Promotion[4]	
Creating abilities and possibilities "Enabling"	Skill promotion by organizing and conducting possibilities for individuals and groups to realize their health potential, as well as enabling them to find a way of having control over their own health. Practical application involves, for example, expanding personal resources by obtaining access to information and developing personal, social and life skills. ***Principle / Goal: Empowerment***
Advocating interests	Working on public awareness and the representation of citizens' interests with the assistance of legal intervention. The goal here is to influence health-related political, social, cultural, biological, ecological and behavioural factors. Practical application includes, for example, public awareness measures (shows, for example); work in/on committees, collecting signatures (petitions). ***Principle / Goal: Participation***

Table 1.1.8 *Methods for health promotion – I.*

[4] The three methods for Health Promotion in GROSSMANN and SCALA (1994. p. 45.) can be expanded by two other principles of methods (quoted in PAULUS, 1998. p. 25.). **1. Scientific work**: the surveying, assessment and publication of health-related connection (the evaluation of health promotion projects or professional counseling). **2. Creating and maintaining developments**: institutional establishment and continued support of long-term inter-sector cooperation.

Methods for Health Promotion[5] **(II)**	
Mediation and Networking "Mediating"	Moderating between different interest groups and areas of society. Practical application is found in the joining of and mediation between state and non-state health-related organizations, initiatives and representatives from health, social and business sectors, as well as citizens. ***Principles / Goals: Network Promotion, Cooperation***

Table 1.1.9 *Methods for health promotion – II.*

This summary also makes the WHO's concept for Health Promotion clear. The following aspects are of importance:

Characteristics of the WHO's approach to Health Promotion

1. Health Promotion is founded in a **subjective-oriented and holistic understanding of the term *health*** and a **salutogenetic perspective**, with which health resources are central.
2. Health Promotion endeavors to **make health a socially comprehensive criterion for decision-making**, which is equal to criteria, such as economical and legal factors.
3. Health Promotion is a **social and socio-political concept**. It concentrates on the socio-culturally influenced life styles of people. It also focuses on the changes in circumstances that influence persons' health and is not excessively oriented around individual behaviour.
4. Health Promotion is a **setting-related concept**, which concentrates on the life circumstances of persons in specific areas of life.
5. The WHO concept is not directed only toward healthy persons, but toward **all persons in every age group** in all of their struggles in daily life, expressly toward **ill and handicapped persons**.
6. It is of supreme interest to reduce the inequalities in health and **to promote health equality**.
7. On a professional level Health Promotion demands the existence of **numerous professional groups** from areas in health, social work, education, as well as in political, business and environmental areas.
8. Furthermore, Health Promotion is a process, which enables the addressees to actively participate and to act independently. Principles of **participation** and **empowerment** take a central position.
9. Health Promotion follows a **democratic-emancipating approach**, which focuses on self-rule (autonomy) over one's own health.

Table. 1.1.10 *Characteristics of the WHO's approach to Health Promotion*

[5] The three methods for Health Promotion in GROSSMANN and SCALA (1994. p. 45.) can be expanded by two other principles of methods (quoted in PAULUS, 1998. p. 25.). **1. Scientific work**: the surveying, assessment and publication of health-related connection (the evaluation of health promotion projects or professional counseling). **2. Creating and maintaining developments**: institutional establishment and continued support of long-term inter-sector cooperation.

In contrast to the classical prevention measures (prophylaxis, prevention) there are many points to be identified, which establish a discrepancy between the two concepts: The classic prevention approach focuses on illness and tries to identify risk factors; while the health promotion approach tries to make health possible and pays careful attention to ways of making a person healthy. However, the differences are also very complex, as the following table illustrates:

Prevention	***Characteristics***	***Health Promotion***
- Primarily medicaloriented (close to "Old Public Health")	**Field of Orientation**	- Social-scientifically oriented (close to "New Public Health")
- Objective definition of health - Primarily one-dimensional - Health defined as the absence of illness - Pathological orientation	**Description of Health**	- Subjective definition of health - Multi-dimensional - Health defined positively as well-being, creation and coping skills - Solutogenetic orientation
- Maintaining health - Avoiding and reducing illness - Reducing risk factors - Avoiding and rejecting health risks - Decreasing harmful socio-ecological influences on health	**Goals**	- Improving health - Building up resources - Learning health promoting strategies and life styles - Establishing health promoting living environments - Establishing health promoting health services and political circumstances
- Individuals - Risk groups - Environmental socio-ecological risks	**Intended targets**	- Individuals and groups - Living situations / environments, society - Health services - Settings
- "Medicalization" of health - Privatization and individualization of health risks Top-down approach - Compliance - Hierarchical action - Direct action - Professional domination (monopolization)	**Steps / Actions**	- "Politization" of health - Public responsibility for health Bottom-up approach - Emancipation (autonomy); respect of "beginner" (non-professional) skills (self-help) - Enable autonomous action (empowerment) - Citizen participation - Cooperating representation of interests (network promotion)
- Particularly health professionals	**Initiators**	- Health professionals, social workers (including instructors and educators), environmental professionals, business professionals (inter-sectional steps) - Addressees themselves

Table 1.1.11 *Characteristics of prevention and health promotion*

Task 1.1.2

Draw what you mean by health! After having finished your drawing, send a half-page long description of your work to your tutor. (Please, don't throw you're your drawing, because you will also use it at the workshop!)

SUMMARY

In this introduction a brief overview on concepts of health and health promotion was presented. In the perspective of the WHO-concept of health dimensions and determinantes of well-being were elaborated. Health promotion as it was conceptualized in the Ottawa-Charta from 1986 was analyzed in detail and compared with the concept of prevention. Thus the innovative perspective of this new concepts of health resp. health promotion to understand health and influence health and health conditions became apparent.

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KEY CONCEPTS

❖ "Empowerment" as a principle of health promotion	❖ Ottawa Charter
❖ Health	❖ "Participation" as a principle of health promotion
❖ Health Promotion	❖ Salutogenesis
❖ Indicators of Health	❖ Sense of Coherence
❖ "Network Promotion" as a principle of health promotion	❖ WHO (World Health Organisation)

TOPIC 2

PRINCIPLES AND VALUES OF HEALTH PROMOTION

GENERAL TOPIC:

2.1 HEALTH EDUCATION – PRINCIPLES AND VALUES OF HEALTH PROMOTION

Peter Paulus and Thomas Petzel

UNIQUE TOPICS:

2.2 EQUITY, EMPOWERMENT, PARTICIPATION

Peter Paulus and Thomas Petzel

2.3 INFLUENCE OF VARYING CULTURAL AND RELIGIOUS VALUES

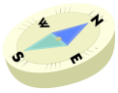
Zsuzsanna Benkő

2.4 ETHICS

Colin Wringe

2.1 HEALTH EDUCATION – PRINCIPLES AND VALUES OF HEALTH PROMOTION

OUTLINE



In the following you will find a brief introduction to the basic values of modern health promotion and a code of ethics for health promotion. It is discussed how these values match with commonly shared values in modern democratic societies.

OBJECTIVES

- Reflection of the match between the concept of health promotion and general values of modern democratic societies
- Gaining knowledge of the principle values underlying moder concepts of health promotion

CONTENT PART

Please read the following materials.

Values of health promotion and modern democratic societies

Health and health promotion are value-loaded concepts and deeply anchored in our western civilisation and its basic values. Health is a human right. It is established in the basic rights of the United Nations and is expressly mentioned in the preamble of the constitution of the World Health Organisation passed in 1946:

„The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition“

Health promotion has to do with democracy, with everbody's individuality and with the personal responsibility of the citizen. This all has already been expressed in the quoted first sentence of the Ottawa-Charter. The control of the conditions of health shall free the humans in the field of health from their mental immaturity (being their own fault). It wants them to overcome their alienation from their own selves and from their circumstances of life in order to lead an active and self-determined life. These ideas are linked with the ideas of solidarity, because the moments of danger to health are finally seen as rooted in the social conditions.

The human being is – properly speaking – good and health is mostly a self-regulating process of the individual with himself/herself and his/her environment, which can partly be achieved by learning processes thus becoming psychically effective and/or which can be disturbed by genetic conditions. Therefore health promotion does not lead to the isolation of solipsistical subjects, but to a community with others who have got the same problem and who want to change and improve their living conditions. Therefore the concept or the value of participation is so important. In a group of like-minded people health is to be restored (again).

So the power of experts, who always know what is good for the persons affected, is minimized.

Participation: Involvement of concerned persons in important decisions and in definitions of problems (for them). The form of participation is not specified. It ranges from publishing plans with the possibility of raining objectives, to active forms of participation like coordinating working teams. Participation is an essential element of the setting approach of health promotion and WHO. The vague interpretation of this term is criticised. There is a distinction between collective participation and collective involvement in expert-led measures (European Commission, undated, p. 229.).

The persons affected become participants in a participatively organised process whose aim is to distribute health risks and health chances more fairly respectively to work towards this aim. Here, too, the value system of our democratically organised community is openly visible in an ideal way. Empowerment, the central concept of health promotion, again points at the value-linked concept of health promotion.

"The aim of empowerment is the development and improvement of the humans' ability to determine their social world and their life and not to have it determined. Health promoters shall contribute by their work to create such conditions which fosters the "empowerment" of the persons concerned and enables them to lead a self-responsible and self-determined life" (Stark, 2003. p. 28.).

By controlling one's own power the human being finds to himself and can free himself from the alienation. He will regain natural strength empowering him and he will feel balanced. When this balance has been achieved, being healthy is experienced as a forward thriving potential. The process is led by the imagination of an integrated coherence, in which life is united in all its variety and organisingly coordinates the actions of life. This idea of a successful human life,

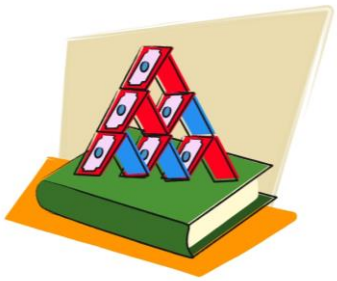
which has very much in common with our democratic society and the ideal of an independent citizen who is an active member for the organization of the community, is the basis of health promotion in the version of Ottawa and is proclaimed worldwide by the WHO. But in the world we find various forms how human beings in communities have organized themselves into states and communities of states. Partly they have developed different values for their individual and social welfare. How are they compatible with the concept of the Ottawa Charter? Is it possible that they fit into the Charter or do we need different charters to make health promotion work for all human being according to their values, standards and principles of life?

Task 2.1.1

1.) Work out the basic values of the Ottawa Charter and examine the basic moral concepts of health promotion mentioned above. If there are other ones which you have in mind we ask you to add them. Compare the Ottawa Charter of 1986 with the Carribean Charter for Health Promotion of 1993, which was passed in Port-of-Spain (Trinidad).
2.) 2.1 Are there any differences in the fields of action?
2.2 Are there any differences concerning the principles and values?
2.3 What do the differences suggest?
2.4 Can the differences be overcome?

Please read the following materials.

“A code of ethics for health promotion"



Those moral concepts have consequences for the practical work in health promotion, because health promotion must contain them. If not, health promotion would become implausible. Kelly (1996) developed a "code of ethics for health promotion" for the professional practice, which we want to present here for discussion:

„An ethical code for health promotion: protecting the public from unproven and ambitious health promotion schemes. This leads, in conclusion, to the suggestion of six principles for professional practice:

1. Health promotion should not harm populations or individuals by wilful deception, knowingly misinforming people, or making claims in respect of health gain which are insubstantiatable either on the basis of evidence, or on the basis of theoretical understanding;
2. Health promotion must not harm populations or individuals by providing information or materials that may be damaging or inappropriate;
3. Health promotion practitioners should not engage in activities which they have not been trained including those based on theoretical knowledge about societies as well as on biological knowledge about organisms;
4. Health promotion practitioners must not engage in activities which cut across the principles of fairness and equality and this includes discriminatory practices or breaching confidentiality and privacy;
5. Health Promotion interventions on populations and individuals must have the prime objective of meeting health needs;
6. Health promotion interventions on populations and individuals must not involve the withholding of information which contradicts conventional wisdom about health gain. This is especially important where there is contradictory or inconclusive evidence.

These principles may appear modest and general. But the reader is asked to inspect recent health promotion initiatives from prestigious national and international institutions and ask how many would pass such a test of ethics. Health promotion is then a possibility. However the thesis of this report is that such benefits as may be derived from it must be based on evidence or on theoretical understanding, must be disentangled from over-grand political agendas, and must be based on caution. Above all, they should be based on a set of principles whose function is to protect the general public from the unproven and the over-ambitious" (Kelly, 1996. p. 25f.).

SUMMARY

Health promotion is loaden with value concepts. Empowerment and Participation were presented as basic principles of health promotion and related to values of democratic societies (see also next section 2.2.). Ethical aspects of applied health promotion are presented for discussion as a code of ethics for health promotion

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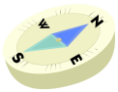
KEY CONCEPTS

❖ Empowerment ❖ Ethics	❖ Participation ❖ Values

2.2 EQUITY, EMPOWERMENT, PARTICIPATION

OUTLINE



The next part will introduce you to the three core values of modern health promotion: equity, empowerment, and participation. These values are defined, and their significance is illustrated by a comparison of modern health promotion, basing on these principles, and the behaviour-change-model going along with traditional health education concepts. After a look at Hart's so-called "Ladder of Youth Participation" which shows different possibilities how participation may actually take place, the difference between the meanings of "equity" and "equality" is the scope of the last part of the present study unit.

OBJECTIVES

- Gaining knowledge about the definition and the importance of the values of equity, empowerment, and participation for modern conceptions of health promotion.
- Reflection of your own experiences with the realisation of equity, empowerment, and participation.
- Reflection of the political and societal implications of the realization of equity, empowerment, and participation.

CONTENT PART

Please read the following materials.

The definition of the core values of health promotion: equity, empowerment, and participation

The values of empowerment, participaton and equity are at the heart of health promotion. Without the notion of empowerment, participation and equity health promotion is impossible, it would rather be merely prevention. These values are often stressed when health promotion is defined or explained in textbooks:

"Health promotion is a vital part of the global social progress agenda. Specifically, the term 'health promotion' refers to planned actions which aim to empower people to control their own health by gaining control over its determinants (the underlying factors which influence health). The main determinants of health are people's cultural, social, economic and environmental conditions and

the social and personal behaviours which are strongly influenced by those conditions. (…) Health promoters vary in many ways, but virtually all share a few core values that define the 'soul' of health promotion: the primacy of equity and social justice, empowerment and participative methods" (Mittelmark & Hagard, 2003).

But why are these values so important? It has to do with the anthropo-logical assumption or the image of man that builds the foundation of health promotion. It is the image of man as a person who has a social identity and individuality and who is capable of reflective action. This value base is expressed in the following passage:

- Individuals are treated with dignity and their innate self-worth, intelligence and capacity of choice are respected.
- Individual liberties are respected, but priority is given to the common good when conflict arises.
- Participation is supported on policy decision-making to identify what constitutes the common good.
- Priority is given to people whose living conditions, especially a lack of wealth and power, place them at greater risk.
- Social justice is pursued to prevent systemic discrimination and to reduce health inequities.
- Health of the present generation is not purchased at the expense of future generations.

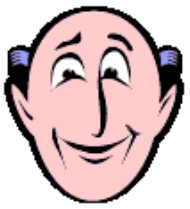
Please read the following materials.

A comparison of modern health promotion with traditional conceptions of health education

To gain control is an important characteristic of health promotion. And, from a psychological perspective, control does not only mean to have control over your behaviour. It is understood in a much broader sense and includes the social, material, economic as well as the political context of that behaviour. To exert control, then, has much to do with to be empowered to have personal strength to stand up and have a voice and act in accordance with your needs and aspirations. Empowerment therefore refers to processes of social interaction of individuals and groups, which aim at enabling them to enhance their individual and collective skills and the scope and range of controlling their lives in a given community.

Therefore in conceptualizing empowerment very often a differentiation is made between individual and community empowerment. The following tables show this differentiation (New Zealand Ministry of Education, 2004). To make it more clear what empowerment is all about it is compared with the traditional behaviour change model of health education.

Behavioural change model of health education
• Focuses on health professionals' perceptions of health needs – suggests that 'experts' know best. • Transmits knowledge – increases people's knowledge of the factors that improve and enhance health. • Educates 'about' health. • Uses health campaigns. • Uses the transmission approach to teaching – the learners are largely passive. • Often reflects 'healthism'[1]. • May have a 'moralistic' tone. • Emphasises disease and other medical problems, so tends to be negative and deficit-focused. • Focuses on risks rather than on protective or preventive factors and takes a 'band-aid' approach. • Tends not to reflect the socio-ecological perspective. • Does not take into account determinants of health or consider who is responsible for health. • May imply 'victim blaming'.
Self-empowerment model
• Develops a sense of identity. • Promotes reflection in relation to others and society. • Encourages people to reflect and change their views. • Clarifies values. • Helps people to know where, when, why, and how to seek help. • Encourages independence. • Uses critical thinking and critical action in relation to oneself.



[1] „Healthism" is a set of assumptions, based on the belief that health is solely an individual responsibility, that embrace a conception of the body as a machine that must be maintained and kept in tune in a similar way to a car or motorbike.

• Uses the action competence process for the individual, recognising determinants that may be beyond their control. • Fosters resilience and empowerment at a personal level. • Enhances self-awareness. • Focuses largely on the individual. • Gives opportunities to celebrate individuality 
Community–empowerment model
• Encourages democratic processes and participation 'by all for all'. • Takes a constructivist approach to learning. • Takes determinants of health into consideration. • Emphasises empowerment for all participants. • Educates 'for' health. • Uses a social action or action competence process to work with others. • Uses a whole community development approach. • Views people as social agents. • Uses critical thinking and critical action in relation to the individual, others, and society. • Takes a holistic approach. • Is based on authentic needs. • Fosters resilience at wider community and societal levels – not just at an individual level.

Table 2.2.1 *Behavioural change model of health education*

The next table shows examples of using these models in the context of smoking

How the **behavioural change model** would be likely to be used in the context of smoking: using slogans, media messages, and pamphlets.
How the **self-empowerment model** would be likely to be used in the context of smoking: providing access to medication, to telephone counselling, or to 'quit smoking' programmes and support groups to help people quit smoking.
How the **community empowerment model** would be likely to be used in the context of smoking: working with vulnerable groups to analyse the issues according to the relevant determinants of health (for example, the impact of colonisation, cultural deprivation, poverty, and social exclusion); engaging with a range of individuals and groups, including those affected, to identify needs, plan actions, and develop policies and support structures designed to address smoking across the population, providing support for identified groups.

Table 2.2.2 *Examples of using health educational models in the context of smoking*

Please read the following materials.

If empowerment refers to a constant process of enabling individuals and groups to take part in collective action, then participation comes into play: To be involved, to be meant personally as an actor together with other like-minded people is therefore also at the core of health promotion.

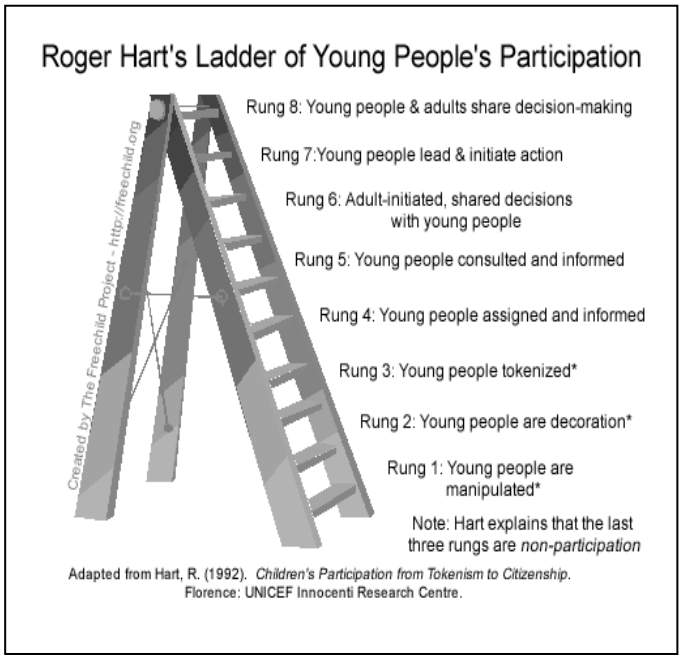
Participation in its broadest sense refers to taking part in a process of social interaction. There are enormous variations in the type and manner of participation. To give an impression of this the following table represents a "Ladder of Participation" which shows different steps and examples of participation which range from very poor to very elaborated concepts of participation. It is constructed around children's participation.

Hart's Ladder
of Young People's Participation

This groundbreaking work put the work of young people and adult allies around the world in the context of a global movement for participation, offering needed guidance and criticism of many efforts. The "Ladder of Children's Participation, also called the "Ladder of Youth Participation", is one lasting tool from the book.

Degrees of Participation

8) Young people-initiated, shared decisions with adults
This happens when projects or programs are initiated by young people and decision-making is shared between young people and adults.
These projects empower young people while at the same time enabling them to access and learn from the life experience and expertise of adults.



7) Young people-initiated and directed
This step is when young people initiate and direct a project or program. Adults are involved only in a supportive role.

6) Adult-initiated, shared decisions with young people
Occurs when projects or programs are initiated by adults but the decision-making is shared with the young people.

5) Consulted and informed
Happens when young people give advice on projects or programs designed and run by adults. The young people are informed about how their input will be used and the outcomes of the decisions made by adults.

4) Assigned but informed
This is where young people are assigned a specific role and informed about how and why they are being involved.

3) Tokenism
When young people appear to be given a voice, but in fact have little or no choice about what they do or how they participate.

2) Decoration
Happens when young people are used to help or "bolster" a cause in a relatively indirect way, although adults do not pretend that the cause is inspired by young people.

1) Manipulation
Happens where adults use young people to support causes and pretend that the causes are inspired by young people.

Table 2.2.3 *Hart's Ladder of Participation.* Adapted from the Freechild Project (2004) (info@freechild.org)

The "7 or 8 Debate"

Roger Hart's Ladder of Participation shows young people-initiated, shared decisions with adults as the top form of young people's participation, followed immediately by young people-initiated and directed. This is somewhat controversial an issue for many people working with and around young people. Essentially, the debate is which of these levels of participation is actually the most meaningful?

Many believe that shared decision making is most beneficial to both young people and adults. Others believe that young people are most empowered when they are making decisions without the influence of adults. Most often, this does not exclude adults but reduces their role to that of support.

Both arguments have merit; ultimately, it is up the each group to determine which form of decision-making best fits with the group's needs.

Task 2.2.1

Please, identify at least four school situations, where your pupils are involved in empowerment- and participation-oriented activities! If there are not any, create possibilities!

Empowerment-oriented activities:

1) ……

2) ……

Participation-oriented activities:

3) ……

4) ……

Please, explain your decision! (approximately half page).

Please read the following materials.

Political and societal implications of realising the values of equity, empowerment, and participation

It is easy to see, that the degree to which children participate will depend on their maturity, understanding and ability, as well as the social and political context in which they live. Therefore participation of children has to be seen as a process of children's involvement in the decisions which affect them and the community in which they live. It involves nurturing their strengths, interests and abilities through the provision of meaningful opportunities to contribute to their own development and that of their peers, families and communities.

Participation makes it possible that you will have power to act not only for the benefit of yourself but for your social group as well. Equity is the overall goal of those actions. To overcome barriers to minimize the burden of inequity is the

most ambitious task of health promotion. To get control over the determinants of your life has its justification in this fundamental aim: To give people equal rights and opportunities means to include them and connect them with social life and welfare.

A closer look on the concept of equity shows that it means fairness in the first place: People's needs guide the distribution of opportunities for well-being in an equity concept. This implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity which result, for example in unequal access to health services, to nutritious food, adequate housing and so on. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life. Therefore one working definition would be:

Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition, the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level and quality of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair.

Task 2.2.2

Please, find a traditional programme of health education in your school documentation! (in workbooks or educational programmes etc.). Bring it to the workshop

Some final study questions

Equity, participation and empowerment are the most common basic values of health promotion. How do they compare with basic values of the society you are

living in? Is there a congruence or are there tensions? Please imagine what consequences this match or mismatch could have for population health?

SUMMARY

The values that underlie equity, empowerment and participation are the fundament of health promotion, This is shown by comparing empowering methods of health promotion compared to older approaches of health education. It was also shown by presenting the concept of participation in the model of Roger Hart. The realization of equity, empowerment and participation in the perspective of its political implications is also discussed.

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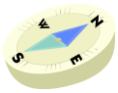
KEY CONCEPTS

❖ Empowerment	❖ Health Education
❖ Equity	❖ Participation

2.3 INFLUENCE OF VARYING CULTURAL AND RELIGIOUS VALUES

OUTLINE



In this chapter we will discuss the sociological concept of culture and healthy life-style. After the review of concepts we will define the factors determining healthy life-style. After identifying the possible social, economic, cultural, psychological and biological factors we will illustrate, with the help of the Hungarian Romany's example, the effect social position and culture exercises on the health state.

OBJECTIVES

- During studying the present chapter you can acquire the up-to-date approach of culture and healthy life-style. To know this approach is inevitable during any health promotion activity.
- You will have the possibility to practice the identification of cultural and social factors defining healthy life-style on real examples.
- You will be able to identify those defining cultural and social factors that affect the health of minority group members.

CONTENT PART

Please read the following materials.

The concept of culture and healthy life-style

The term *culture* as it is used in Sociology is not limited to the consumption of intellectual goods but contains the characteristics of life-style as well. Culture is more than the system of values, culture is practice: it is a collection of those beliefs, apprehensions and opinions that are accepted by a given group and the group uses to identify and handle the problems of its everyday life. To consider it even more broadly, it contains history with its established material and artistic pieces.

Life-style means not only the satisfaction of needs, but a form of the self-identity of the individual as well.

We can place healthy life-style between the concepts of life-choice and life-possibilities. In case of decisions referring to healthy life-style the man of our age is more probable to strive at internal control than relying on external forces. Healthy life-style becomes an accomplishment that the individual achieves him- or herself. The Media has an outstanding role in this process. The *possibilities* can

affect choice. The different social classes follow different routes to health concerning the quality, extent and characteristics of healthy life-style.

The factors determining healthy life-style are as follows:

- economic/social
- biological
- cultural
- psychological

We will list the variables influencing, defining health grouped along the above factors:

- *Variables of economic/social factors (the so called life-possibilities):*
  education, occupational status, income.
- *Biological factors (the so called life-conditions):*
  gender, race, the state of physical health valued by the individual.
- *Cultural factors (the so called form of life dimension)*
  nationality, ethnic origin, value orientation, religion
- *Psychological factors (the so called life-perception dimension):*
  External – internal sense of control, stress management mechanisms.

Structural, ethnic and cultural connections of factors affecting health

According to the *Black Report* created in Great Britain: the reason behind the health inequalities of ethnic minorities is in their different *class backgrounds* compared to the members of majority European society (Inequalities in Health, Middlesex, Penguin, 1982).

An other research compared the *physical and mental state* of ethnic minorities and whites (Na 22 roo IY: The health of Britain's Ethnic Minorities, 1997). This research came to the conclusion, that one of the main components of health inequalities is the socio-economic status, but *ethnicity* is also an important component, meaning not the class differences only.

An other simplification of ethnic and cultural differences is the approach of *"the culture of poverty"* (Lewis, 1968) (today in the concept of „underclass"). Peculiar characteristic life-style feature appears: feeling of inferiority; passive resignation.

The American „head start" program put the emphasis for example on changing *cultural habits* instead of providing financial support for the poor: they strived at raising the motivation level of marginalised children (the basis of comparison was the middle class).

In the western world the term ethnicity refers to the ethnic minorities, meaning the system of relationships between identity and social structure.

One possible approach to ethnicity is the *"external" aspect*, when it is studied in terms of majority definition. Ethnicity is the "other", that can be the means of exclusion, elimination, and building hierarchical relations. Looking at it "from the inside" – it is about de facto existing communities that are characterised by a way of thinking and forms of behaviour different from the majority's – they have different language, different customs, religion, that is, they have a different culture. *With the help of this so called internal definition individuals and groups build their own identity.* In this approach to ethnicity we should concentrate not on changing the power relations, but it should strive at the *worthy representation of the given ethnic minority, at the just admittance to resources and at giving countenance in front of the public*.

Ethnicity is not a static, constant category, *but it can change throughout history* influenced by time, space and the individual fate of the person. There can be a conflict between gender, class status and other identities.

Ethnicity and culture should be viewed in a complex way.

– common ethnic origin does not result in identical cultural conditions

– does not result in identical social status and form of behaviour

Several researchers have come to the result, that *the class approach should be supplemented by the theory of ethnicity*, understanding ethnicity as a "sleeping" collective contract that is activated when the given group realises its common interests.

Ethnic differences are such constructed differences that have at least as much to do with the groups themselves that build the borders of their communities among themselves and the others, as with the dominant group that considers them to be "Different".

An example: the health state of the Hungarian Romany

The life expectancy of the Hungarian Romany at birth is even worse than the unfavourable data of the Hungarian population. In 1993 the life expectancy of Romany men was 53,4 years, of Romany women was 62,5 years: this is 12,5 years less in case of men and 11,5 years less in case of women than the country average (KSH, 1993).

Mainly the catastrophic social status of the Romany is responsible for this large gap. Researches before the Change of Regime had also shown that the health state of the Romany population was worse at that period as well. For example, Joubert had stated on the basis of a research done in 1978 that "the physical development of the newborn of Romany speaking parents who live under very unfavourable social, cultural, hygienic and health conditions is more

disparaging than the country average. Decisive reasons can be the unfavourable social and hygienic conditions and the insufficient health culture that often accompanies low education" (Joubert, 1990). The biggest losers of the Change of Regime are the Romany. The unemployment rate is high among them. The decline of their social status might have influenced their health state unfavourably. Social and economic disadvantages lead to the deterioration of health state, often through depression (Kopp, Skrabski, 1995). This fact seems to be enforced by a national research among young women in 1999 (Gyukits at al., 2000).

Task 2.3.1

In the (Annex 1-3) you find three interview excerptions made with the help of focus-group technique. The focus-group is a qualitative research method that to a certain extent – by keeping to certain methodological principles – can be suitable for revealing the feelings and ideas of ethnic and national groups.

Your task is to study the three record excerptions and highlight those elements that support and imperil healthy life-style! During your analysis please take into account the dimensions influencing life-style explained in the theoretical introduction! Complete your task on tasksheet 2.3.1!

Task sheet 2.3.1

1. focus-group		
The element influencing healthy life-style	Promoting or risky?	Argument
1)		
2)		
3)		

2. focus-group		
The element influencing healthy life-style	Promoting or risky?	Argument
1)		
2)		
3)		

3. focus-group		
The element influencing healthy life-style	Promoting or risky?	Argument
1)		
2)		
3)		

Task 2.3.2

Look for a family in your surroundings belonging to a national or ethnic minority and introduce the family along the life-style – culture characteristics! The essay should be about one typed page long.

SUMMARY

Knowledge and exact identification of factors influencing healthy life-style is inevitable during the modern health promoting activities. Especially when we would like to improve the health opportunities of groups that are in a minority position, different from the majority culture.

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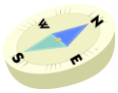
KEY CONCEPTS

❖ Cultura	❖ Ethnicism
❖ Healthy life-style	❖ Focus-group

2.4 ETHICS. The ethical question: Is health promotion really a good thing?

OUTLINE



It is usually assumed that health is a good thing and that promoting it must therefore be a good thing too. As a result, much of what is written about health promotion is about how this activity is carried on rather than whether or not anyone should be doing it at all. (Buchanan, 1994; Seedhouse, 1997). Some writers, however, have suggested that things are less straight forward than this may make it seem. In particular, it has been suggested that people who simply assume that health promotion is a good thing:

1. do not make it sufficiently clear what they mean by health or health promotion;
2. do not take sufficient account of the limits placed upon health promotion by the social and political contexts in which it takes place;
3. do not give sufficient thought to the unintended consequences of health promotion.

OBJECTIVES

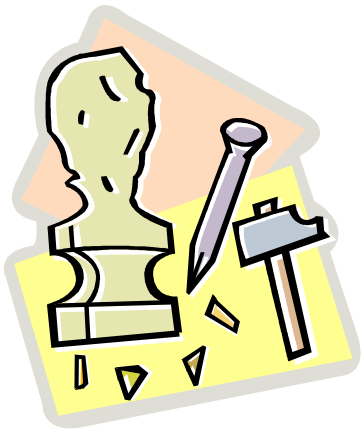
- Get a deeper understanding of ethical implications of health promotion.
- Learn to argue from different perspectives.
- Learn to reflect from ethical points of view on applying health promotion.

CONTENT PART

Please read the following materials.

Do we all mean the same thing by health and health promotion?

Seedhouse complains that most authors in the health promotion field have no well worked out or consistent theory about the meaning of the word ‘health’. (Seedhouse, 1997. pp. 27-32.) while others regard these concerns as unimportant and unworthy of discussion. (Adams and Armstrong, 1996). These authors describe the term as ‘contested’, offering this as a reason for refusing to discuss what they mean by health at all. (*ibid*. 1996. p. 113.) They then go on to produce their own lists of ‘values’ and ‘principles’ which try to define what health promotion is all about.



We have to agree with Seedhouse's remark that if two people use the same term for different activities they may appear to agree when they do not. This might happen, for example, if one person used the term 'soerpostomy' to mean measures to combat certain tropical diseases while another took it to mean providing the finance to make possible the employment of young African children as domestic servants. The confusion would be important in any moral discussion of the activity, or in deciding whether it should be subject to government support, or a police investigation.

It is also true that there are certain widely-used and valuable terms such as democracy, education, Christianity, art, literature, Philosophy and so on, sometimes referred to as 'essentially contested concepts' (Gallie, 1956), and that rival groups claiming to practise these activities may attempt to define them in ways that would deny their opponents a claim to be practising them at all as, e.g., 'I don't call a country where the press is controlled by capitalists a democracy', 'I don't call playing with sand and water education'. Alternatively, the fact that something is supposedly, by definition, democratic, educational, artistic or whatever may be put forward as a reason for supporting it without further examination: 'You cannot ban this painting. It is a work of art.'

Arguably, health, and more especially health promotion, are in a similar position – that is, they are essentially contested concepts. There are certainly some who wish to define health or its absence explicitly in terms of disease and dysfunction (Boorse, 1977; 1997). They may also see health promotion in terms of hygiene and, perhaps, all about attending to problems of malnutrition, or noxious working or living conditions that give rise to disease and dysfunction. Someone following this so-called 'medical' model of health or health promotion would regard the World Health Organisation's definition of health in terms of psychological, social, cultural or spiritual well being (World Health Organisation, 1946) as much too broad, too ideological or even politically offensive. The fact that the terms health and health promotion are (inevitably) defined ideologically is not a reason for refusing to

make it clear what you mean by them or for saying that this is a trivial or semantic issue.

However varied the meanings be given to these terms, there is necessarily what Wittgenstein (1953) refers to as a 'family resemblance' between them. Someone who claims to be promoting health is it least trying to bring about a change in someone else's condition, mental or physical, which he or she thinks will, in some obvious way, be an improvement from that client or patient's point of view. Whether or not health promotion is an unjustifiable waste of time and money (Seedhouse, op. cit.) depends not on discovering some essential meaning in the term 'health', (for there is no such intrinsic meaning) but on whether the activity actually will bring about the change envisaged and whether there are good reasons for regarding the change as an improvement. The first of these is an empirical question, i.e. any answer to it requires evidence that can be generated by the methods of the Social Sciences.

The second is a genuinely ethical one which may be clearly specified and put up for debate using rational arguments of a certain kind. Of course, it is impossible in this short unit to provide a full discussion of the various ethical approaches we can use here. Briefly, these would include a consideration of the likely consequences of the activity envisaged (Consequentialism), the obligations which rationality demands in relation to rational beings (Deontology and also Rights Theory), the good or bad qualities inherent in the actions making up the activity (Virtue Ethics), the care we should offer those to whom we stand in certain relationships (the Ethics of Care) and the respect or reverence some postmodernists (Levinas, 1978) claim we owe to all in the universe that is not oneself. We frequently have to balance the issues arising from these various approaches. Are the benefits to the community at large sufficient to outweigh some relatively unimportant obligation or right? Which particular virtues would

we wish to see health promoters exercising here? Determination and rigour or, perhaps, patience and flexibility? Should our care for those around us override more general concerns for distributive justice, or vice-versa? These issues cannot be decided by referring to further principles but depend on the detailed circumstances of individual cases. Moral judgement is required, not additional moral reasoning.

These are emphatically not *in themselves* issues of meaning. What the health promoter needs to specify is not *the* meaning of health – there is no such thing – but what he or she intends to mean by it, bearing in mind, or course, that meanings cannot be definitively fixed but rather develop from utterance to utterance through debate, or from speaker to speaker, or listener to listener in the light of their experience (Derrida, 1974).

Task 2.4.1

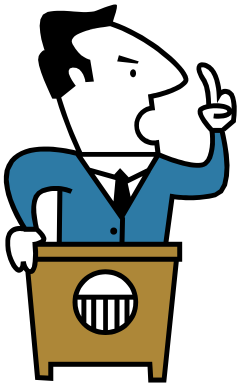
Discuss the following issue, either in pairs or in small groups.
(As you discuss this issue and those suggested in the activities below, bear in mind that ethical dilemmas set for discussion are necessarily simplified and usually lack the detailed information that, in real life, is essential in balancing the various issues involved when a problem is being considered. Make whatever detailed assumptions seem reasonable and observe how these, rather than the major principles involved are often decisive in determining what should be done.)
A health charity wishes to campaign for the closure of a factory, pollutants from which are demonstrably causing ill health. What do you say to a member of the committee who points out that the charity's charter specify that its resources should be used solely for the purpose of promoting the health of people in the area, and objects that the proposed campaign would be political?
Would your attitude to the campaign be affected if:
The factory were the main employer in the area and malnutrition were also a major cause of ill-health.
Closure would cause workers to seek employment in a neighbouring mine which, though not causing pollution, experienced frequent injuries and deaths among its miners?
How would you respond to the argument that the above considerations were not matters of health promotion at all, and that resources set aside for that purpose should be entirely devoted to treating and caring for the victims of illness and accident, whether resulting from the supposed effects of the factory's pollutants, malnutrition, or mining accidents, as and when they arose?

Please read the following materials.

Does social and political context of health promotion make a difference?

In an attempt to widen the concept of health promotion beyond the medical model of curing and preventing diseases and dysfunctions, some health promoters attempt to define their activity in terms of more general values and principles and a more radical political agenda. Adams and Armstrong, for example, propose a model of health 'integral to and a result of social justice' (op.cit. p. 116.). They characterise health promotion as an activity which aims to 'empower' citizens: to 'strive for conditions which enable citizens to control their own lives through the equitable distribution of power and resources, so that none are oppressed, disadvantaged or discriminated against'. Practice in health promotion must therefore be 'anti-oppressive', 'inclusive and democratic'.

There is, of course, evidence to show that the incidence of all sorts of maladies and dysfunctions may be greater where there is social injustice, oppression, and economic exploitation. It can therefore be argued that even the narrower and more traditional goals of health promotion are more effectively achieved by promoting social justice than by providing medication and therapy. But for Adams and Armstrong social justice, autonomy and empowerment are not simply the means of promoting health but are part of the definition. For them, measures to reduce physical and psychological distress and disorders must be 'integral to or the result of social justice' for them to be health promoting. If they do not have these qualities, they should not be approved and supported as health promoting activities.



By their nature, principles and values are necessarily general in form and run the risk of becoming vague and platitudinous. Of course, as Loughlin (2002) observes, few politicians declare themselves in favour of injustice, oppression or the disempowerment of citizens. However, the meaning of social injustice and oppression in the context of radical discourse is fairly well understood and everyone knows that the verbal agreement between radicals and conservatives

that justice and fairness are 'good things', does not amount to much in practice. If principles and values are to provide any kind of guide to action they need to be expressed as identifiable goals and intentions, sometimes called 'agendas' or 'targets'. Paradoxically, this practice is often condemned by those most critical of the vagueness of more general aspirations. If policies, roles, targets and agendas are specified, this will necessarily limit the scope of individuals for uncoordinated radical activity (Foster, 1996). This raises further questions, such as whether progressive improvement or 'piecemeal tinkering' (Popper, 1945) is desirable or whether we should go for more radical reforms or, in some people's opinion, 'wholesale upheaval'. Our preference must be determined by an assessment of the most likely outcome of each course of action. Here we need to look at the details of the present situation (an empirical matter) and our ethical evaluation (see above) of predicted outcomes.

Task 2.4.2

Discuss the following as before.

i. A number of childbirth related deaths are seen to be the result of ignorance and traditional practices but this matriarchal community believes that education in relation to such matters by outsiders would be contrary to their religion and would undermine their way of life. Certain experts are prepared to say that interference with the community's way of life would gravely damage the psychological, social and spiritual health of its members. Ought health promoters to tone down their educational activities in the area?

ii. A well known philanthropist has bequeathed money to a health charity indicating, in somewhat ambiguous terms, that he/she wishes the money to be spent on an institution named after him/her in the capital city for the treatment of diphtheria. Local health workers know that many more deaths from diphtheria would be prevented by educating people in the countryside about the importance of hygiene and care over their drinking water. This would clearly be contrary to

the philanthropist's wishes but legal authorities could be' persuaded', without too gravely infringing the law, to interpret the will flexibly.

A more radical group of health promoters, however, points out that diphtheria is a relatively minor health problem in the area and argue that all available efforts and resources should be spent in encouraging the local people to take control of their own lives and get rid of an exploitive foreign backed regime, as a result of whose favours the so-called philanthropist had made his fortune in the first place. What should one urge the charity to do?

Please read the following materials.

What about results that we did not intend?

If, after the careful analysis of meaning and the appropriate forms of validation (both empirical and ethical) something is clearly seen to be a good thing, this does not imply that it is necessarily to be pursued. The concept of side effects or unintended consequences is well recognised in medical practice. Someone might quite rightly consider it good to be rid of the pain caused by their rheumatism but decide not to take pain killers because of the nausea and vomiting they may cause. Many people would no doubt be healthier – and as we saw, health normally has to be considered a good thing by anyone using the term – for a regime of cold baths, early morning jogging, various commonly advocated forms of abstinence, and early bedtimes - but the cost in terms of the other goods things in life might be unacceptable. This does not mean that better health is not a good, merely that we have to choose between goods that are incompatible.

We come back to the question of whether the promotion of health, one's own or that of others, is necessarily a good thing if we accept, as most people do, that promoting the health of others is only acceptable if it involves empowering them to make their own health choices. We do not need to consider cases of people becoming involved in unnecessary medical investigations and treatment on the basis of partial information fed to them for such disreputable reasons as boosting a health authority's target performance (as cited by Foster), or increasing the sales of pharmaceutical products. These practices are not health promotion according to any acceptable interpretation of the term.

Some people worry that health promotion may play into the hands of those who may want to restrict the resources spent on the provision of medical treatment (ten Have, 1994). Health promotion may be cheaper than surgical operations but the fact that anti-smoking or healthy eating campaigns may save

the government money is scarcely an objection in itself. More serious is the possibility that linking health to lifestyle and suggesting that individuals may be empowered to take responsibility for their own health decisions could carry risks. The danger here is that it may lead to a culture of victim blaming. It is all too easy to slip from 'These people are responsible for their own lifestyle choices' to 'so why should society pay for their consequences?' (Of course, this issue only arises when health care is publicly provided rather than financed by private insurance.) Ten Have (rather clumsily) suggests that we should try to separate retrospective and prospective notions of responsibility. In essence, the answer to the problem may lie in this direction. We do indeed employ the notion of responsibility in more than one way; in fact, in at least three ways rather than the two suggested by ten Have. However, although these are connected, confusion arises if we fail to differentiate between them. We may be responsible for something in the sense that we are to blame for it and may even merit some form of punishment in consequence. We may also be responsible for something in the sense that it is our job to attend to it or pay for it, in the sense that the landlord is responsible for repairs to the roof. Or someone may be responsible in the sense that they at least take account of the possible consequences of what they do, whether they ultimately decide to do it or not.

Being a responsible person in our third sense, taking account of the possible consequences of our choices, is the mark of a rationally autonomous individual and may be the goal of much health promotion or health education. Such a person considers various actions and lifestyles, drinking alcohol, smoking, enjoying a varied sex life, climbing mountains, sailing round the world single handed, joining the armed forces or whatever, and weighs the risks against the goods to be achieved. If we make the wrong decision and things work out badly we may blamed, but this is only justifiable if we have been irresponsible in not properly considering the risks and taking reasonable precautions against them. But it does not follow that if things go wrong as a result of our choices, even if we have been a trifle irresponsible, we are always expected to bear the full cost unaided and without compassion. Our society is unstinting in its efforts to rescue amateur climbers or lone yachtspersons who get into difficulty as a result of the enterprises they have knowingly undertaken and few would deny sympathy or treatment to volunteer soldiers on the grounds that anyone who joins the army deserves whatever he or she gets.

However much we may morally disapprove of the use of alcohol, tobacco, sexual intercourse with a plurality of partners or engagement in foolhardy adventures, we would scarcely wish to see these activities punished by the

withdrawal of treatment for serious, long-term or life-threatening diseases. Such a penal regime would certainly be inconsistent with any conception of human rights. We do not even deny medical to enemy soldiers or to criminals injured in the commission of their crimes. If some politicians see mileage in playing on the prejudices of mean-minded or censorious electors, that is reprehensible but it would do nothing to detract from the value of health promotion conceived in terms of treating individuals as agents and empowering them to take responsibility for their own health and lifestyle choices.

Task 2.4.3

Identify and discuss the issues arising from the following situations.

Ethical Case study 1

Petrik Sándorné, Mental Health Promoter Postgraduate Diploma, Szeged, 1997

12 years old girl, who has diabetes for four years. She gives insulin to herself, and checks her blood sugar level several times a day. She and her family have to work out a very regulated way of life. (I would like to note, that the everyday life of the family is full of conflicts, the mother is depressed, the father blames the child's sicknesses on the mother, saying that the mother does not care for the girl properly, does not pay attention to the daily results of the girl. Though the mother had become sick much earlier, before the girl became sick. She was also pensioned off because of this.)

When the girl became an adolescent her hormonal activity became even more unstable than it was before and sometimes she had symptoms followed by a blackout.

The case has happened not long ago, I have latched on to the events as a classmaster and played the role of an observer only.

The girl went home after the classes to have lunch. She had a very low level of blood sugar. She had a blackout during the afternoon, the mother phoned her husband to ask him to come home by car because they have to go to the hospital. The father did not react to the first call. The girl did not regain consciousness even after getting some glucose. Then the husband was notified for the second time to come home, as a situation like this, that the girl did not become conscious, had never happened before. In the hospital the girl had a four hours long coma and several collapses before her state was stabilized.

The parents told their own opinions, when suddenly I noticed a new detail. The parents were taking the child to a non-medical doctor, without informing the physicians. The non-medical practitioner had promised the child that she would recover by Santa clause.

Analysis

Parents:

- The physicians told them that the girl would never recover, they should abandon the thought that the pancreas of the child would ever work properly (traditional medical ethics: Do not do harm!)
- The parent is hoping – turns to a non-medical practitioner, who raises hope, gives some chance to recovery (Bioethics: The principle of subsidiarity! Cooperate)
- The parent has every right to expect the girl to check herself precisely at school, as she has every technical and other prerequisites for it (she can check and eat during the lessons as well). (Principle of autonomy – bioethics)
- The parent trusts in the liability of the girl, as she was made to realize that she herself was responsible for her own life (at the age of 12), she has to learn to live with it if she can not be cured. (Helping professionals: respect of life, the sanctity of life)
- Hope that after the first menstruation there will be some positive changes in the hormonal activity of the child. (traditional medical ethics: Do not do harm!)

Physician:

- Has prepared the parent and the child for the coming hardships, problems. (traditional medical ethics: Do not do harm!)
- He tries to calm the parents who live under an increasing stress because of the child, and their marriage went on pointing at each other and shifting the responsibility. (traditional medical ethics: Help!)
- He tries to persuade the parents to ensure a relaxed family background for the girl, as the regular blackout might have psychological reasons as well, not only organic ones. (traditional medical ethics: Help! Do not do harm!)

Child:

- The child is fed up with her illness, she is weary of it, she rebels at her faith. The approaching adolescence age can also fade in this problem, the neglecting of her illness. (Helping professionals: the principle of autonomy)
- She sees the perpetual worry and quarrels of her parents and lives under an increasing stress, making her situation even more serious.

- Her peers (not the classmates) mock her with her illness (bioethics: the principle of do not do harm and help should prevail)
- He is embittered by the situation, that the doctors can not help her. She is bereft of hope.
- A new hope came with the promise by the non-medical practitioner: "You will recover by Santa clause!" She takes it seriously and believes in it, as in many cases hope is the one that can help. But as the proposed date is approaching, she neglects checking more and more, hence she will be recovered soon.

Non-medical practitioner

- Gives hope to the parents and to the child who have lost hope. (traditional medical ethics: Do not do harm! Help!)
- Trusts in the favourable nature of the hormonal change.
- He might be able to succeed, there might happen a positive change, but he can not know the date for sure. (Principle of autonomy – bioethics)
- Is he allowed to make wanton promises concerning the serious state of the child. (Bioethics: disregarding the principle of do not do harm and help)
- He can be regarded as responsible by all means, as what happened shows that he misused the trust of the child. He should have been more careful, discuss the importance, but not the omnipotence of trust with the parent and the child. (bioethics: Do not do harm! Help!)
- I feel – this is my own opinion – that the competency of a non-medical practitioner is in the expert application of herbs, and I do not feel the possibility of him entering the dysfunctional operation of the organism deeper. I do not know if the secrecy he had expected from the parent (the parent was not allowed to tell the doctors about this treatment) was not for covering his incompetence. But even if this is the case, does he have the right to prey on the trust of a defenceless child? Or should he have urged the child to pay more attention to herself, to the good effects of the treatment, when the recovery starts?

After all these I should add, that I know the story from the little girl and her parents, who did not talk about the person in question adversely, they do not blame him, what is more, they go on with the treatment. Still I feel this person has made a lot of mistakes and was not correct with the family, and hurt basic ethical principles. I think one of his main faults was to hurt the principle of autonomy, hence the obligation to be informed was not fulfilled.

Ethical Case study 2.

Suhajda Lajosné, Health sciences teacher, 3rd grade, 2004.

The indiscreet class master

Location: Secondary school, 9th grade

Story

One of the most popular girls in class has not been to school for the third week by now. Nobody knows what could happen to her. She has disappeared from the dormitory as well. Finally, at the beginning of one of the Hungarian lessons the class master said: "She became pregnant and dropped out of school". There was a startling silence in the class. Nobody paid attention during the class. In the recess the best friend of the girl called the class master a liar and dishonest, telling, even if what she said was true she did not have the right to tell it in front of everyone. The classmates all agreed that the teacher's procedure was dishonest. The relationship between the pupils and the class master has not been without difficulties so far as well. They became totally distrustful with her. Especially when in September "A" has returned and – though some were mocking her at the beginning – she became one of the most popular again.

Background to the story

The girl was really in trouble. She lives her state through as a serious convulsion. She has left the dormitory without telling her secret to anyone. She has decided together with her parents that she does not want to keep the baby. Because of the time that has passed until coming to this decision and making the intervention and because processing the events takes time, she has finished the term as a private students, and continued her studies on a normal, full time base from autumn. The class master and the headmaster were informed by the family in good faith.

Ethical judgement of the story

The class master is to be condemned for the most often committed ethical violation, the divulging. The parents of the girl trusted her with a private secret when they revealed the real reason of the dropping out honestly. This was no business of the class mates, as the class master was not given an authorization to tell. The case was a tragedy in the life of the 15 years old girl that she would have liked to keep in secret and in the solution of which she needed help. The unrevealing of the secret made it hard for her to return to her classmates.

Under the rules of point 3.4 of the Code of Ethics the educator should "make his or her decisions with keeping the interests of his or her pupils in mind". This time it did not happen. The interest of the girl pupil would have been to keep the secret. The decision of the class master, that is to reveal the secret in front of the class, was motivated by a misinterpreted honesty and educational aim. This however does not justify her deed.

Supposedly she could be put in the wrong for omitting point 3.8 as well that says, she should have: "provided help in solving the private problem." She is guilty also of violating point 7.3: "secrecy concerning private information acquired during the educational activity". She has violated the private rights of the pupils with the divulging.

Ethical case study

The girl is as popular in the class at the moment as she was before the tragedy. We do not have information on the circumstances of her becoming pregnant, anyhow she will remember it for ever. The relationship of the class master to her class became even worse, she has lost their and their parents' trust.

The girl was 15 at the time of the events, too young to be able to solve and process an important problem like this. She trusted her parents and teachers and was afraid of the consequences and of the reactions of her classmates. The bad relationship of the class master with her pupils reveals a lot. Without regard to her age or marital status we can state, that she does not understand, is not aware of the problems of the children. I am almost sure that she does not have a child, otherwise she could be aware of the despair of the parents and would not have broken her word. The parents play an important part in the situation, placing the safety and happiness of their daughter in the foreground. They are ready to help by all means and to protect her from the hurtful opinions. If they have – and they definitely have – religious or moral convictions, they consider the interests of their daughter the most important. (A further problem would be namely if the parents, due to a fanatic godliness, would oblige the girl to keep the baby.) As the girl lives in a dormitory we should emphasise the role of the dormitory teacher, whose responsibility is also to pay attention to his pupils and to help them if it is needed. It the relationship of the class master and her pupils would be *quite good*, she would have visited the dormitory teachers of the girl, and vice versa. Three weeks had passed since the disappearance of the girl – this is a very long time for people not to act.

But going back to the basic conflict, the deed of the class master can not be justified. Even without her promise to the parents she should not have revealed

the tragedy of the girl in front of the class (neither in front of the staff). She violated the code of ethics in professional and moral terms as well, she brought an unpleasant situation on the girl and the parents, what is more, she has put a halter round her own neck (her bad relationship with the class, the opinion of her colleagues about the case). Her action can be called self-determining, she has exercised autonomy, that had serious effects on everyone (including herself).

Suppose we are talking about a teacher who revealed the case in front of the pupils for the best, believing it can be of use for them and they can learn from it. She felt she serves the truth and everybody has the right to know it. Divulging does not mean lying – do not forget it!

In the medical profession as well the workers often get into a situation in which they have to decide about telling the patient or the relatives about the bad prognosis of the illness. Though the patient is generally entitled to the right of being properly informed, sometimes it is the interest of the patient to be deprived of this right – attentive to the principle of "do good and do not do harm".

But the pupils are not patients, and they do not have the right to know about the secret of their fellows. In case it is not possible to keep silent, that is one of our pupils asks for the reason of the girl's dropping out, we do have to lie. We have to lie on behalf of the poor girl and of the parents. Hence we all know the gracious lies, for example: "A" became ill for a longer period, so she can not finish this term with you, but she will come back next year.

Here a further problem could be the religious engagement of the class master that is if she sticks to keeping the commandment of "do not lie", which could be further aggravated by her personal opinion on abortion. We touch an ethical point with this: "The educator does not bring her private or civic problems among the pupils" – that is she can not act herself out at the school just because she can not do it at home. She can not present her extreme opinions as they could be harmful to the developing mind of the children. Furthermore, the teacher is bound to keep in mind the developing relationships of her class and can not induce conflict, can not participate in the exclusion of a pupil (the danger of it could happen in case of a less popular pupil).

The other justification for the "intervention" of the class master is her intention to educate. On the one hand, she still should have considered the circumstances and the consequences, on the other hand this can by no means be a way of education (it is clearly visible from the fact that she could not hold her Hungarian lesson well then). There are books, videos and other more effective methods referring to the topic that are less insulting and cruel.

The question is, what is to be done if the class master regrets her deed right after saying the "divulging" sentence and she would like to do something to redeem her fault. In this case it would be very hard to reverse the events, it would be hard to apologize and she might in vain explain herself. However she could help with her kindliness when the girl returns. Self-reflection could have an important role, if not in this case but in other cases for sure.

Certain basic ethical norms played part in the decision of the class master. Supposedly she has an own, matured system of norms, in which "truth", "learning" and "discipline" are more important than the protection and understanding of others, and providing help. It is not sure that the teacher is against abortion, but she can be angry with her pupil for not leaving school due to this incident. The teacher's personal relationship to the given pupil and her attitude to the whole case should be revealed. The teacher should separate her private life from her professional life, if necessary she should refine her private opinion because of her profession, and she should consider the moral norms of the other person as well. The educator deals with people, with men of feeling, the problems of whom she should help as much as she helps to solve a difficult mathematical task.

Ethical Case Study 3.

Faragó Andrea, Health Sciences Teacher, grade 1. 2004.

Protection without immunization?

The topic of my case study is the question of the exhibition of the immunization or the intentional omission of it. I will discuss on the basis of the following story the rights surrounding the compulsory immunization, who has the right to decide and who is responsible for the decision.

The teacher Z. József and his wife did not let the doctors exhibit the compulsory immunizations to their three and a half year-old daughter, as they think the side effects of the immunizations can cause serious illnesses. They did not let the doctors exhibit some of the compulsory ten immunizations. They planned to do the same in case of their two months old daughter as well. The married couple think, that the immunizations circulated in Hungary are obsolete and contain agents that have serious side effects. In times when the immunization was due they have given homeopathic products to the elder child to give her immunity against illnesses.

Because of all these the parents were prosecuted by the town's court of guardians for endangering a minor. With the participation of the Medical Office and the court of guardians, this strange case got before the Town Court where a hearing began.

During the proving process, evidence for the charge – three doctors, the representative of the court of guardians and two district nurses – emphasized, that the immunizations have side effects only very rarely, they are however very effective against the dangerous contagions. Evidence for the defence were the parents and the grandparents who were talking about cases when the Diperte injection caused grips, or they mentioned a case when due to the MMR injection a child has temporary lost his ability to speak. The married couple has told on the hearing that they had made a responsible and reasoned decision when they did not let the doctors exhibit some of the immunizations, and they think they did not endanger their child. They have used homeopathic products for the immunization of their children and they also used an immunization that was not registered in Hungary.

The Town Court found the couple guilty of endangering a minor and sentenced them for six-six months prison, pendent for two years. The court has ordered the guardian custody of the parents to have the children get the missing immunizations. The verdict was justified by the fact that the couple had endangered the health and physical development of their children with their behaviour, and they have deprived their child of the immunity provided by the immunizers, this way endangering other members of the community as well. The appeal court has inflicted a fine on Z. József and his wife, as it found them guilty.

In the centre of the above story then is an educator couple and their two daughters; one of them is 3,5 years old, the other is 2 months old. The value- and norm system of the married couple does not correspond with the norms accepted by the community, they violate a community norm by preventing the exhibition of the compulsory immunizations to their children. The couple's point is that the immunizers have harmful side effects and they are not willing to expose the children to it, and they take all responsibility for this decision, they acted on behalf of protecting the health of their children. Their behaviour is against the norms though, as we are talking about the omission of exhibiting the compulsory immunizers.

In this case it is also a problem, that even the doctors do not agree in the question of compulsory immunizers. It is also a question how responsible the decision of the parents was without having medical knowledge. I have mentioned, that there are arguments pro and contra the immunizers on the medical level as

well. An argument pro the immunizers is the fact that there are serious illnesses that have no antidote, that are incurable. There are illnesses that are expedient to immunize as they can often have serious consequences. It is also pro the immunizers that the protection they offer are long-term and has less risk than the illness. The immunizers are however not without risks. Their most feared complication is the brain damage that appears with grips and the deterioration of intelligence and can make the child seriously disabled. Though it is still a question for health care whether it is due to the injection or to an other cause. This is very hard to prove. Most of the doctors consider the immunizers safe.

I see a serious moral conflict in the question, when endangers the parent his or her child more – if all the compulsory immunizers are exhibited keeping the possible complications in mind, or when he or she exposes the child to incurable illnesses due to the omission of exhibiting the immunizers. If the child of the couple is infected later how will they salve their conscience, as the primary responsibility is theirs. There is an other question: how will the adult child later receive the fact that he or she is not immunized against the incurable diseases because his or her parents prevented the doctors from exhibiting the immunizers. And if the worst happens, that is he or she becomes ill, can he or she forgive the "irresponsible" parents and how can the married couple salve their conscience?

Immunizers belong to the competence of the medical profession and to epidemiology, it is defined by law and the question is whether it can be changed by voting or by a parental decision. We can think about it, what has the priority: the parental decision that the couple has made with respect to the interests of their children, or a legally regulated and accepted social norm and moral. On this basis the individual value system of the couple conflicts the value system of the community, hence the omission of compulsory immunizers is not a moral behaviour on the community level, but it is a moral deed in the value system of the couple in question.

The couple in the story were fully aware of the consequences of their actions, though I think they were not aware of the fact, that their behaviour counts as endangering in the society. They were totally sure about what they did was right. They have made their decision out of free will. They have considered the consequences of their actions, though I think if they were acting really responsibly they should have provided their children with the compulsory immunizers. The intention of the couple was right as they would have liked the best for their daughters, they acted on behalf of the right aim, for their health. The means they have chosen, the omission of compulsory immunizers is not accepted by the society, it is against the norms. The couple did not count for the consequences, or

with the possibility of doing harm to their children with their decision, or with the fact that their deed is a crime.

The compulsory immunizers can be exhibited only once, in a certain age and the child can not decide in it, the responsibility lies on parents. I agree with the court's decision as the couple did not have the medical knowledge that would have form the bases of their decision. They did not have the right to act against the legally regulated system of immunization and endanger the health of their children and the community this way. I accept the court's verdict as the fine was mild penalty. There is no absolute truth in this case, but a sentence to prison would have been too serious as the couple did not have bad intentions.

Cases like this could be avoided if there were a system of immunizations introduced completely different from the present one: there should be among the serums some that are compulsory to be exhibited and some that are optional. The responsibility for the decision should lie on the therapist and the parent together.

SUMMARY

It is true that we cannot simply label an activity 'health promotion' and then demand that it receive approval and support on that account alone. There are various notions of health and a variety of ways of promoting it, and each of these must be evaluated in both empirical and ethical terms. We have to ask: is it achieving the desired outcomes, and are the desired outcomes really desirable? The appropriateness of both methods and outcomes may vary according to social and political context. The essentially contested nature of the concept of health, always having positive connotations but subject to a variety of conflicting interpretations, ensures that theories of health promotion will always be political.

Health, whatever meaning we give it, is a good which must compete with other goods and can, therefore, only be achieved at a cost. In any morally defensible society, choices between goods and the lifestyles that embody them must, as far as possible, be made by the individuals involved and one form of health promotion is concerned to enable individuals to make just such choices. Suggestions that such a practice may be used to justify withholding medical treatment from some patients are, it has been suggested, justified neither in logic nor morality. A central contribution of Applied Philosophy to the creation of a better world is to examine such issues as those considered above so that they do not become, for practitioners, a source of hesitation, confusion and discouragement and see their aspirations, as Hamlet puts it, 'lose all colour of action'.

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KEY CONCEPTS

❖ Democracy ❖ Empowerment ❖ Health Promotion, definition ❖ Health Promotion, unintended results	❖ Political context ❖ Social context ❖ Values

TOPIC 3

”MAKING HEALTH PROMOTION HAPPEN”

GENERAL TOPIC:

3.1 "MAKING HEALTH PROMOTION HAPPEN"

Peter Paulus and Thomas Petzel

UNIQUE TOPICS:

3.2 CREATING SPECIAL EXPERIENCE- AND SETTING RELATED INVOLVEMENT

Peter Paulus and Thomas Petzel

3.3 SUBCULTURAL CONTEXT

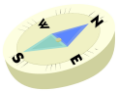
Helen Churchill

3.4 PROJECT MANAGEMENT

Zsuzsanna Benkő and László Lippai

3.1 "MAKING HEALTH PROMOTION HAPPEN"

OUTLINE



In the proceeding modules you have got to know different points of views and definitions concerning health and you have acquired knowledge about the basic aspects of the aims and the history of health promotion. This knowledge is the basis for any activity in the field of health promotion, but in addition the realization respectively the moderation of health promoting activities in a specific setting demands well-grounded competence in the field of project management. Therefore the present module deals with strategies of the introduction, support and management of health promoting activities.

OBJECTIVES

- Reflection of problems that may arise in the course of implementing health promotion acitivities and projects in a given setting
- Gaining knowledge about strategies of implementation and project management

CONTENT PART

Task 3.1.1

Please imagine the following situation (perhaps this is even applicable to the organisation you are actually working in): You are working in an organisation in which the daily routine is normally dealt with successfully. Although the situation is not the best from your point of view, the working conditions are not so bad that the working objective to be achieved seems to be endangered. During a meeting your superior informs you and your colleagues that from now on an external expert will attend to your organisation who will organise changes in the institution on different levels. Your personal work will probably be effected, too. During a first meeting with this expert you get to know that he wants to realize a pre-arranged concept which has been developed on the basis of scientific results:
Investigations have shown that on the average certain scopes of work in institutions seem to be problematic and should be reshaped. Just those fields of work are concerned in this concept which function relatively well according to your point of view, whereas no measures of alteration are planned for those fields where you would like to see changes. Furthermore, aims shall be reached by those measures you regard as irrelevant. The concept introduced by the expert has to be realized at once without any possibilities for you to influence the measures.

Please take some notes about your thoughts and ideas.
Some suggested questions: *What fears would be connected with the realization of the measures planned by the expert from your point of view? How sensible do you consider the exact realization to be, although the expert did not analyse the conditions which are actually existing in your organisation? Would you like to be asked for your opinion on this concept? How strong will your motivation be to help realizing the measures and - in addition to your daily workload - how much time and money would you like to spend for the realization of the concept? To what extent do you trust in the scientific results, which are the basis of this concept, that they will automatically lead to a success of the realization of the concept?*

Please read the following materials.

Problems going along with the implementation of health promoting activities and projects

The outlined situation can easily be transferred to the field of health promotion in an organisation. The difference for you is that you are less interested in the situation of those persons who are expected to carry out the measures they are possibly not interested in. Instead, you take the role of the external expert. Even if you plan health promoting measures and want to put them through in your own organisation, there are hardly any differences concerning the basic problems which are connected with assignment 1. The protagonists in the setting, too, which you want to support in carrying out the measures of health promotion ill have different attitudes towards health promoting activities. Although the definition of health has changed from the scientific and health political point of view in the last decades, you will certainly often be confronted with protagonists who have developed a more conventional understanding of health. In some cases these protagonists will not be convinced of the necessity of health promoting measures at all or they will consider such measures to be less im-

portant compared to other duties. But for a successful realization it is an absolutely essential condition that the health promoting measures are accepted by the protagonists in a setting. Suggestions about how to improve the acceptance are more closely explained in unit 3.1 (“Creating special experience- and setting-related involvement”). The improvement of acceptance goes along with the identification of sensible approaches for health promoting measures, which can be different in different settings. Here, too, it is valid that the development of own ideas and concepts for health promotion in a specific setting do not only lead to a greater effectiveness of activities, but above that to a higher acceptance and compliance among the participants or persons concerned. So-called "learning circles” offer the possibility to empower the personal involvement and individual engagement. This method is introduced and explained in unit 3.1.

A further unit (unit 3.2, “Subcultural context”) deals with a further basic factor, which influences the approach to health promoting activities considerably. Sub-cultural differences (for instance belonging to a certain social class or being of ethnic descent) among respectively within the target groups of health promotion demand the highest flexibility possible regarding the strategies as well as the contents.

Knowledge about project management is further elaborated on in unit 3.3 (“Project management”). After the mentioned identification of potentials in a specific setting and the accompanying propagation of modern concepts in health promotion definite plans for realization must follow, before measures can finally be realized in the phase of action. Especially if a long-term engagement of the institution in question in the sense of a permanent organisation development is aimed at, it is important while planning and carrying out the measures not to plan only towards aims which can only be reached after a long term. Short term success demonstrates the usefulness of carrying out

health promoting measures and improve the motivation for further motivation at the same time.

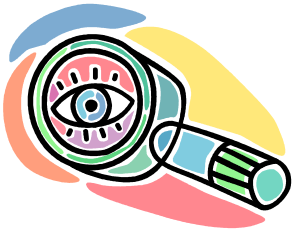
The putting into action of measures is not finished with the phase of acting: There has to be a proof of efficiency especially for activities which require a higher effort and/or which have to be institutionalized. Especially in the field of modern concepts in health promotion such a proof is often connected with special difficulties. Analogous to the pre-dominant traditional understanding of health there is often the expectation as far as health promoting measures are concerned that their effectiveness must be visible in concrete and measurable improvements of individual health indicators. Such an expectation is hardly realistic at least concerning the short-term effects.

Task 3.1.2

Please imagine the following situation at a school: within the scope of the assessment of the need for improvement a suggestion has been made to rearrange the schoolyard. In this way the pupils shall be offered more varied possibilities for exercise. Although teachers, pupils and parents have been very active by putting in their work during the actual rearranging activities there are expenses which an external sponsor volunteered to pay. After having finished the rearrangement you want to account for the success to the sponsor. How can you prove that there are actually positive effects in the sense of health promotion?

Please note at least three indicators which can be used for an evaluation of the rearrangement of the schoolyard. How would you gather data on these indicators?

Indicators:	How would you gather data?
1. ……	1. ……
2. ……	2. ……
3. ……	3. ……
4. ……	4. ……
5. ……	5. ……



Surely you have developed some ideas how to prove the health promoting effect of the rearrangement. Above all in the scope of such an evaluation it has to be considered from a scientific point of view that the assessment of the measures is made on a comprehensible and most objective possible database for outsid-

ers. The report of purely subjective impressions is not satisfying from that point of view. On the other hand an examination of the success of the project by the application of strict scientific criteria often cannot be realised because of the available resources. In unit 3.4 it will be explained in more detail which possibilities do exist for an adequate evaluation.

SUMMARY

There are quite some problems of implementing health promotion activities and projects. Some ideas were presented on how to overcome barriers. To get the support and acceptance of protagonists in the setting you are working in seems most essential. To be aware of sub-cultural differences in the target group concerning health promotion initiatives seems to be also very important. Above all a sound project management is important to carry out the project and its evaluation.

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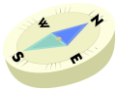
KEY CONCEPTS

- Implementation
- Project Management

3.2 CREATING SPECIAL EXPERIENCE- AND SETTING-RELATED INVOLVEMENT

OUTLINE



In the present unit strategies are discussed that may be helpful if health promotional activities are to be implemented in a given organisation. "Transparency", "participation" or "identification of needs" are some catchwords in this respect. As a method to facilitate an institution's work on topics such as health promotion, so-called "learning circles" are suggested.

OBJECTIVES

- Reflection of reasons for resistance against health promotion activities and of the importance of the participation of all actors in a given setting in decision making.
- Gaining knowledge about strategies how the implementation of health promotion activities may be facilitated.

CONTENT PART

Task 3.2.1

Before reading, please think for yourself which strategies could be used to minimise resistance against health promotion activities in a given organisation. Please note at least three such strategies.

1. ……...……
   ……..
2. ……..
   ……...……
3. ……..
   ……..

Please read the following materials.

Resistance and compliance of actors in a given setting

As has already been made clear in the introductory part of this unit, the first aim of health promoting activities besides the identification of specific starting points

is the promotion of the acceptance of measures among the persons affected. In the present part of the module suggestions are made how to achieve the highest acceptance possible. Securing the acceptance goes along with exploring and defining the needs in the field of health promotion in a specific organisation. Those needs are the starting points for specific health promoting measures.

At first it is advisable to empower the compliance among the persons concerned in a setting by a mutual decision to realize health promoting activities. This does not necessarily mean that all persons concerned are obliged to support the implementation of measures equally. Plans of health promotion can only be accepted if they are transparent. All persons concerned should be informed regularly before starting, but also while the measures come into force so that nobody is taken by surprise by new developments. The persons concerned should constantly be given the opportunity of taking part in finding decisions, of uttering their objections and making suggestions for optimizing. This possibility to utter criticism and fears is important because of two reasons:

The first reason is that all persons concerned will have the feeling of being taken seriously and do not get the feeling that decisions are made by a small privileged group and cannot be influenced. From the psychological point of view this is desirable, because it minimizes the probability of phenomena of reactance. Reactance can occur, if individuals get the feeling of restriction by external requirements. It is a behavioural reaction which aims at re-establishing the individual room for action. In the most unfavourable case this can lead to the so-called boomerang-effect, which means that a person acts contrarily to that what he is expected to do. Directly referred to the measures of the project it may be that persons do not support them only for the reason that they have not taken the chance of influencing the decisions. Secondly, such doubts reveal where possible resistances against planned measures can occur. Not all expressed objections can be taken into account, yet it will be useful to deal with them, because it may happen that measures can be altered such way, that the application will be made easier and that they will be accepted more easily. In other cases the resistance will be so strongly visible that the action will be abandoned.

The health promoters' duty at the beginning of the activities is to question traditional points of view concerning health, to make sure that the health promotion potential in a setting will be taken more advantage of. On the other hand it must not be understood in such a way that a new understanding of health and health promotion is or may be imposed on the people concerned: It will not be helpful for the acceptance of measures and projects, if the activity of health promoters is not understood as support, but as a lecture. Instead, the health promoters should perform the process of work with health promoting measures that way that the modern understanding of health serves as a guideline enabling the application of different measures. Those measures can be the ones which are covered by a traditional understanding of health (e.g. phases of physical exercise, respectively sportive actions, or the promotion of healthy nourishment), as well as those which take the broader term of health improvement into consideration (e.g. the promotion of "social skills").

A central aspect is the fact that a preconceived overall concept of health promotion does not make much sense. In single institutions there are different needs, so that there can be two complications when taking over a fixed, preconceived concept: On the one hand measures will be considered for which there is no need in this organisation at all, on the other hand there may perhaps be specific needs of the organisation which are not taken into consideration. The conclusion is that at first there has to be the identification of the specific needs of this organisation.

Task 3.2.2

Which strategies do you think may generally apply in order to foster compliance and participation of actors in a given setting?

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Please read the following materials.

“Learning Circles”: A method for fostering participation and compliance

The identification of an organisation’s specific needs in the field of health promotion activities has several positive effects: On the one hand measures can be planned that match with the specific needs, thus leading to a higher efficiency. On the other hand the consideration of specific interests and needs lead to a higher acceptance and compliance of the overall project by the persons acting. An essential condition for the success of project activities is the creation of an individual relationship of the persons acting in a setting to the aims and methods of the project. From the psychological point of view factors of motivation have to be considered as a central aspect for the planning and the realization of project activities. A success promising strategy for a better acceptance and a willingness to cooperate of the persons acting is to make clear to the persons concerned that the aim of the project activities is not the realization of abstract ideals and principles, but the specific improvement of a situation, which is considered unsatisfactory by the acting persons themselves. In other words: The activities must clearly refer to the really perceived needs in the corresponding setting. The idea of "action learning", which can be found in the future workplaces or so-called "learning circles", forms a frame for such an activity. Transferred to the field of health promotion "action learning" means that the protagonists of a setting are brought together in a group to identify topic related problems and challenges and collect and develop ideas how to deal with them. The knowledge and ideas of all persons involved are entered into this collection. In the most ideal case action learning leads to a cycle of identification of challenges, planning, action, evaluation and further development. According to this concept the health promoter has the duty to moderate the pro-

cesses of learning and development of the protagonists. He puts in expert knowledge in the sense of moderation competence and, if necessary, practical hints of whether there are any other sources of information available and how to use these for a field of topics. Concerning the contents he does not lead the process of discussion into in special direction but supports focussing on the topic (in this case health promotion) when it is in danger of getting lost.

"Action learning" processes

- reduce the dependence on external experts and empower the protagonists,
- improve the team spirit of the protagonists,
- ensure the problem orientation of the settings,
- aim towards action and change,
- use the complete experiences and competences of all protagonists,
- do not comply with a given time table but with the individual work speed,
- improve the readiness to further engagement through the individual experience that changes are possible, and
- lead to a permanent process of further development at best.

The process in a "learning circle" normally starts with a question chosen by the participants. It is advisable for the arrangement of the work process to start with a mutual resolution for the work on topics of health promotion to ensure the fundamental support of the protagonists. "Learning circles work on a regular basis, the exact frequency, number and duration of the meetings is fixed by the group itself. The protagonists with a basic interest in the problems in question should be involved, but one should also see to it that different opinions and experiences are contributed to the process.

Learning circles can easily be organised, because they need little more than a place to meet and the possibility to document the results of the meeting in any way. They offer the possibility to empower the protagonist's individual attitudes to the measures of health promotion. A "learning circle" wants to enable, to encourage and stimulate the engagement of its participants. The participants develop their *own* topics and *own* ideas. Such a "learning circle" is not based on the expertise of one or several experts, but on the individual experiences and

„Who will be his advocate?"

ideas of the participants. "Learning circles" proceed on the assumption that all participants contribute valuable knowledge and their own perceptions to the work.

In a "learning circle" the approach is made by questions contributed by the moderators. As the "learning circle" always deals with a paramount problem, the first questions should directly refer to it. In the case of health promoting "learning circles" it has to be considered that such questions do not cause a limitation of the subject matter and possible single working topics, but on the other hand are not too vagely put so that the actual topic is lost touch with. One approach for the work in "learning circles" can be to ask the participants to report on their personal experience, how they were confronted with a health relevant topic in the organisation for the first time. These personal experiences give valuable specific hints for possible approaches to the health promotion work thus leading to an individual involvement in the topic of the "learning circle". Furthermore it is ensured that the topics are not dealt with on an abstract and fundamental level which has nothing to do with the daily experiences.

For an ideally functioning "learning circle" the number of participants should be between 5 and 15, the number of 20 should not be exceeded.

To make the work of the "learning circles" easier, rules of conduct should be agreed upon with the participants. With help of these rules one wants to ensure a discussion among equal persons. These rules comprise:

- active participation,
- careful and active listening,
- open-mindedness for new ideas and the efforts towards an understanding points of view which differ from one' s own point of view,
- avoiding dominance and aggression in discussions,
- admitting of having difficulties in understanding, and
- avoiding deviations from the topic.

Task 3.2.3

Which of the following strategies should a health promoter use in the course of implementation of health promotion activities? Only one of the given alternatives applies.

a) One useful strategy would be simply to convince an organisation's members that the health promoter is an expert who knows best about scopes and methods of health promotion, e.g. by giving a lot of information about scientific knowledge about health and health promotion. Applying this strategy would strengthen the actors' compliance because they will be convinced that the scientific background will prove to be more useful than the expression of individual needs.

b) One useful strategy would be to point at the fact that the health promoter is an expert who was hired especially for designing health promotion activities for the given organisation from an outside view. Members of an organisation are often so involved in its structures that they simply lose an objective point of view. Thus, they are rarely able to identify their and their organisation's real needs.

c) One useful strategy would be to let the actors in a given setting participate in decision making about scopes and methods of health promotion activities. On the one hand, this strategy will make sure that the needs of the organisation and its members are taken into consideration, and on the other hand it will foster the members' compliance with health promotion activities.

d) One useful strategy would be to let the members of an organisation decide what to do and how to do it for themselves. Any way of moderation of the process of decision making would in fact mean to take influence from an external point of view. This taking of influence would severely harm the members' opportunities of participation and their motivation for further work on health promotion activities. An expert should simply observe this process and provide strategies and measures of evaluation in order to control the results of the activities when they are finished. So the organisation members will get to know if they were right or wrong and they can have a next try.

Please mark the correct alternative: **A** **B** **C** **D**

Task 3.2.4

To make the work of the "learning circles" easier, rules of conduct should be agreed upon with the participants. These rules comprise (please mark the correct answers):	
a) active participation	☐
b) immediate and honest criticism to others' ideas	☐
c) open-mindedness for new ideas and the efforts towards an understanding points of view which differ from one' s own point of view	☐
d) avoiding dominance and aggression in discussions	☐
e) open expression of anger and aggressiveness, so that reasons for such emotions can be discussed frankly	☐
f) careful and active listening	☐
g) clear restriction of time of speech so that every participant has the same opportunity to present his or her ideas	☐
h) admitting of having difficulties in understanding a topic	☐

SUMMARY

The concept of "Learning Circle" is presented as one of the more effective methods to implement health promotion in a setting. People from the target groups are involved in a participatory way. They feel empowered and show more compliance for the health promoting initiative.

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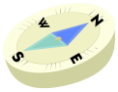
KEY CONCEPTS

❖ Identification of needs	❖ Participation
❖ Learning circle	❖ Transparency

3.3 THE SUBCULTURAL CONTEXT

OUTLINE



Health promotion is intimately linked to health education, and specifically to the impact and effectiveness of the educative process. Like any other educative activity, health education involves the cumulative building of knowledge and information, based on dialogue and exchange. This complex process, which may (and in the case of health education often does) involve a large number of social 'actors', influences, perceptions and activities, needs to be understood by the health promoter. He/she, in seeking to promote healthy lifestyles, will need to identify how best to inform and possibly change existing beliefs, attitudes and practices concerning health. To do this, the health promoter will need to understand the ways in which people 'construct' their personal understandings and behaviour about health matters. Many influences are at work here – for instance, the social networks which links people, ideas and values together, influences from wider socio-economic-political spheres, from the mass media and from different cultures and subcultures. Also important here are people's sense of control or otherwise over their own lives, and the extent to which they feel they play an active role in health choices and lifestyle.

OBJECTIVES

By the end of this module, therefore, it is intended that you will be able to

- Explore, with the chart groups with which you work, the role of social networks in shaping their attitudes, beliefs and values about health.
- Identify a range of possible social, cultural, economic, political and ideological influences which shape health behaviour.
- Consider the role of the mass media as a powerful set of messages to a mass population about health issues.
- Discuss the role of 'locus of control' in people's decision-making about health and lifestyle.

CONTENT PART

Please read the following materials.

How people build their understandings of health

In looking at the impact and effectiveness of health education, it is important to consider the ways in which people build up their ideas and beliefs about health. Previously, there was some discussion about what has influence on an individual's understanding of health. Within this section, you will be invited to explore:

- The networks within which individuals and groups build up perceptions of health and health education;
- Impacts on health perceptions – eg. the media;
- The approach of a health education campaign and how this effects response.

As we know, individuals may prioritise different aspects of health. An example of this would be where a person identifies physical health as the most important and perhaps the only element of health.

In presenting health education initiatives, it is important to consider how people build up their understandings of health. This provides a starting point and a frame of reference when addressing health issues. Common sense understandings of health are very powerful mechanisms and should be understood by the health educator and worked with.

Task 3.3.1

In working with a client group around general health issues, identify two ways in which you would find out their understandings of health.

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In doing the above exercise, you may have considered asking the group about their beliefs in an open discussion. Whilst a possibility, this approach can be difficult if individuals are unclear about what the parameters of such a discussion are. You may have considered a range of questions with regards to health

beliefs. In doing this, you present an element of structure and hence may need some idea of what kind of issues may arise. It is not the scope of this section to consider the best ways of collecting data. Rather it is vital here to think about what everyday occurrences influence understandings of Health.

Please read the following materials.

Influences on health beliefs

Social Networks

This relates to how family and friends conceptualise health through direct experience. Examples of this may be the development, affirmation and dismissal of ideas as to the cause of heart attacks. Through social exchange and the relating of experiences, people build theories around cause.

Prioritization

This idea has already been briefly considered. An example of this may be a family who believe that to take more physical exercise or encourage a better diet for the children would be good for their health. However, through prioritisation, these intentions are overtaken by a need to maintain a harmonious environment in the home, or by some other family obligation. In this way health care becomes an 'add on'.

Such prioritisation mechanisms point to a need for individuals to recognise health as an integral part of the individual.

Value Association

An example of value association would be to consider a child's interpretation of health. Her/his thoughts may be that some foods that are 'bad' for you, like those containing a large amount of sugar, fat or salt. It may be that the child considers eating these foods would lead her/him to be fat, lazy and ugly. These secondary things, in the child's eye may mean her/his social status is put at risk. As such, it may be that s/he fears s/he would have to take up a boring role in games, such as score keeper, or would be disregarded by her/his friends altogether. Therefore it is these assumed associated qualities that prevent the child eating 'bad' food.

Looking at influences of lay explanation to health illustrates a need to work in a bottom-up way. They equally show the need to work inclusively, both valuing and including individual representations. Such approaches are in line with empowerment and community development models as discussed in Module 4.

So far we have considered some of the ways in which individuals and groups build up their ideas about health. Social networks, prioritisation and value association all relate to social exchange and hence the social build up of lay beliefs. It is important to consider what other issues impact health belief systems.

Political Messages

An example of this was given by the Health Minister, Frank Dobson. In October 1997, he talked about halting the closure of the remaining 40 long stay psychiatric hospitals in this country. In January 1998, he went on to talk of a need to open 24 hour 'Nursing Homes' for the mentally ill.

Task 3.3.2

What messages do these actions send out to people?

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Some of the issues you may have considered are:

- Are long stay hospitals to exist as asylums in the true sense of the word, that is, as places of sanctuary and recuperation? Or do they become the new institutions?
- What does this say about the Governments' attitude to mental health problems?
- On what grounds would individuals be placed in nursing homes? Would this be when individuals are presumed a 'risk' to others, for example, on the prediction they may commit an offence? If this is the case, is this not a violation of human rights?
- What is the Government saying about holistic care?
- What about accommodation, support, accessible keyworkers, crisis service and proper aftercare?
- How does this address the need to integrate individuals back into society?

Media

In Western industrialised nations, we have access to a plethora of information about the world which we cannot, and do not experience first hand. We receive this information via the mass media. The mass media serves a number of useful functions in connection to health:

1. It draws the attention of the public to a health issue leading to it becoming a matter of public interest and debate, that is, it has an 'agenda setting' role with regards to health.
2. Once a topic has been put on the public agenda, the role of the mass media is to inform the public and stimulate debate on the issue. Good examples of this aspect of mass media function are:

    - Whooping cough vaccinations
    - Contamination of water supplies
    - Health service cuts
    - Child abuse
    - AIDS
    - Food 'scares'

3. The mass media may affect people's beliefs about health and illness, based on information presented.

The media is effective in that it creates an immediate emotional response that leads to swift action. For example the 'scare' regarding the whooping cough vaccine lead to an immediate response from parents who then refused to have their children vaccinated. Similarly the media coverage of 'mad cow disease' recently led to many people not buying beef.

Health programmes that offer facts about health issues elicit immediate responses. However, such responses are generally short-term. Once the media discussion dies down people tend to assume that the problem has been solved or gone away. They therefore go back to their usual behaviour. Thus it is questionable how much the media can actually affect beliefs about health in the long term.

As people's primary response to the mass media is emotional and not rational it is important for the media to not raise anxieties irresponsibly. Therefore publicity about, for example, rubella-damaged babies should always be accompanied by clear, simple, specific advice regarding the effects of rubella and how they can be avoided. This demonstrates the health promotion function of the media but depends upon the media acting responsibly!

Task 3.3.3

Think back to when you first heard about AIDS in the late 1970s/early 1980s (it is likely that your first information came from media coverage). What were the images/ messages portrayed at that time?

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Some of the terms you may have included are:

- Gay Plague
- Black Death
- Wrath of God
- In the Sun Newspaper, Gary Bushell announced that Heterosexuals are not at risk from AIDS 'it's official!'
- Government information leaflets sent to every home depicted a tombstone with the inscription 'Don't Die of Ignorance'.

AIDS was depicted as a 'gay plague', particularly in its early history, despite the risk of heterosexuals (victim blaming). AIDS is commonly depicted in the media in terms of stereotypical ideas of contagion, epidemics, the plague and the Black Death. Much media emphasis has been placed on the possibility of a 'miracle' cure, highlighting the search for a vaccine/cure.

The diversity of medical opinion regarding the possibility of coming up with a miracle cure threw the media into disarray. In 1987 the BMA said that anyone who had had more than one partner in the 4 years should not give blood. This was disputed by government medical advisors and led to the media reporting confusion among experts. The media eventually decided to follow the doctors' perspective that led to victim-blaming once more – if you were promiscuous you deserved it!

It is clear that health and medical programmes and articles in the media play a significant role in shaping the public debate and climate of opinion. But it must be remembered that the media is selective. It conducts 'symbolic crusades' and moral panics. It creates social problems, becomes obsessive and routinely omits certain issues and information. Therefore the media does not have an agenda-setting role.

Please read the following materials.

Locus of Control

The locus of control concerns how an individual perceives their ability to control aspects of their lives. In terms of Health Promotion, the theory is that people who feel that they have control over their lives are more likely to take on board Health Promotion messages and health-promoting behaviour. Health Promotion messages will be less successful with individuals who feel that they have little or no control over their lives and are more likely to see others (professionals for example) as responsible for their health. Broadly speaking, beliefs about health control can be divided into three categories:

- **Individual or self-control**
  The extend to which the individual feels in control of their life and responsible for their health.

  Powerful others
  The extent to which the individual feels that others (for example, Health Care professionals) are responsible for their health.

- **Chance**
  The extent to which the individual feels that health and illness are matters of fate or chance, over which they have little or no control (Wallstone and Wallstone, 1981).

Individuals who report having good health tend to score highly on measures of internal locus of control whereas those who describe their health as poor are more likely to see health as a matter of chance (Calnan, 1988).

Class 1, Culture and Education

Health beliefs are intrinsically linked to cultural norms, affected by many facets such as class and education (as well as gender, age, regional differences, race and religion). These beliefs are grounded in experience and tradition and based on a logic that makes perfect sense to members of those groups. For example, smoking may be a rational response for young mothers at home with two or three under-fives, living in poverty with no safe play areas for the children and no release from the stress of their domestic situation other than to smoke (Graham, 1985).

Class and education affect responses to health education messages. Calnan in a study of women aged between 21 and 55 found that health education had

more impact on women from socio-economic classes I and II than women from groupings VI and V. His explanation was:

- Working class women feel less in control of their lives.
- Working class women need to rationalise their behaviour (for example, smoking).
- The different socio-economic groups used different ways of reasoning: working class women gave reasons based on their own experiences whereas middle class women were able to reason based on statistics and theories of probability (Calnan, 1986).

Health promoters must recognise that their own health beliefs are steeped in culturally specific norms and that some values may not be appropriate for some groups. Health promotion initiatives, therefore, should be tailored to meet the needs of specific groups. Working with individuals from socio-economic classes IV and V, examples from individuals own experiences may be more effective, whereas the use of statistics and epidemiological evidence may appeal to individuals from social classes I and II.

SUMMARY

This module has identified a range of influences which shape people's personal knowledge about health. These influences come from individuals, groups and institutions at different levels of society. Their influences on individuals vary – some have a powerful influence, particularly when they are seen to be authoritative, personalised and credible. Their influence also varies according to the extent to which people feel in control of their own lives, and have a sense that they can bring about change in their lifestyles and to their health practices. The processes here are complete but need to be understood by the health promoter if health education and health promotion is to be effective. In planning any health-related changes, the health promoter must work from other people's 'starting positions' and seek to shape health behaviour towards healthier options.

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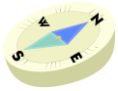
KEY CONCEPTS

❖ Locus of control	❖ Health belifes, influences on
❖ Understanding of health	❖ Mass media
❖ Social networks	

3.4 PROJECT MANAGEMENT

OUTLINE



In this chapter we will review the theoretical and practical basis of health promoting project management. First we would like to know why project method is needed in health promotion. Here we review primarily the social sub-systems defining the operation of modern societies and the health promotion related implications of organisations. In the second part of this chapter you can find the short description of project management. In the last part of the chapter independent student work is prepared with the help of presenting the case study of a concrete health promoting project.

OBJECTIVES

- To make you realise that health promotion is not to be considered the task of health care only, but in an optimal case it is an activity interfering society as a whole.
- To call your attention to the fact that we live our everyday life in the network of organisations that affect our health seriously.
- To enable you by the end of this chapter to give a precise definition on the characteristics of project method.
- To work out a short, concrete school health promoting project based on the knowledge you acquire on the characteristics of project method and on the supporting material and guidance provided.
- Finally, to provide you with the basis of evaluating health promoting projects.

CONTENT PART

Please read the following materials.

Why is project method needed in health promotion?

As you have seen in the previous chapters, health is a complex concept. You could also experience that the new bio-psycho-social-ecological health concept that forms the basis of the health promoting approach is not easy to understand. It is right then if you ask how the complex, often

controversial theoretical approach to health promotion containing many aspects can be fulfilled as a coherent practical activity.

One of the key statements of health promotion is exactly the fact that the successful practical use of its complex health concept requires the application of new, innovative methods. One of such successful innovations of health promotion was project management, the theoretical basis and practical applicability of which will be the topic of the present chapter.

The dynamics of modern societies

During the deeper analysis of bio-psycho-social-ecological health concept (see chapter 1.) it has clearly turned out that human health is strongly influenced by the social circumstances. Consequently we have to consider this factor during health promoting interventions as well. But what do we know about the social backgrounds of health promotion?

Luhmann tried to characterise the dynamics of modern societies by defining social sub-systems. According to his conception, the social sub-systems distribute among one another the problems and tasks that arise during the operation of the society. Each sub-system has its special and consequently narrow social task. This way no new tasks can be given to them, moreover they do not undertake new problems. Luhmann has identified the following social sub-systems: economy, politics, administration, science, education, health services and family (Luhmann, 1982).

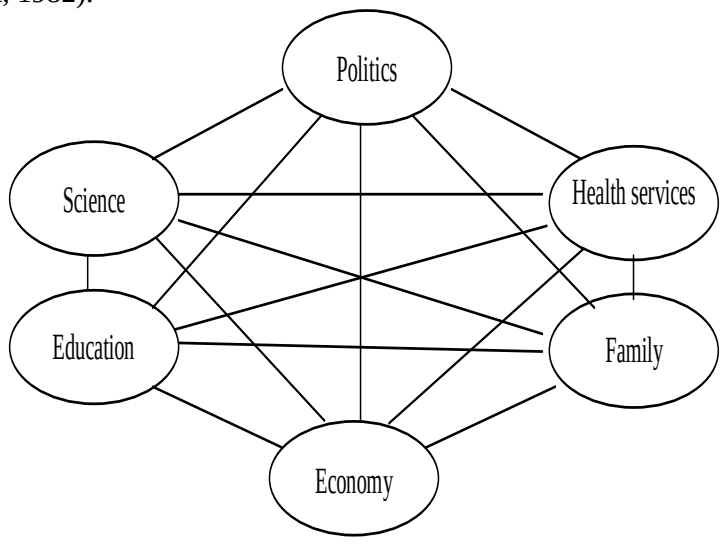


Figure 3.4.1 *Social sub-systems of modern societies* (Source: Luhmann, 1982)

Task 3.4.1

What do you think are the problems to be solved and tasks to be fulfilled by the following social sub-systems: a) education; b) family?

Social sub-system of health services

In most social sub-systems we find the complex network of institutes and organisations, furthermore we can identify professions and roles that are essential to the operation of the sub-system.

For example, according to public understanding we can list medical consulting rooms, hospitals, and medical laboratories under the social sub-system of health services, and we consider doctors and nurses as legitimate service providers. This simplified picture reveals already that the main task of health services is the effective diagnosis of and care for illnesses, ensuring the services of professionals as prepared as possible. Of course the tasks of the sub-system of health services are more complex than that, though its focus on illnesses is eye-catching.

Health however is influenced not only by the operation of the health services. According to research results in health sciences the role of life-style and social and natural environment is also considerable. The sub-system of health services can however not influence these factors effectively with the help of its own means. That is why modern health promotion can not be based solely on the sub-system of health services. So one of the main thesis of health promotion is that: “health is not the task and responsibility of one institute, one social sub-system, one given profession, but it is a comprehensive task embracing the whole institutional system of the society.” (Grossmann and Scala, 1994).

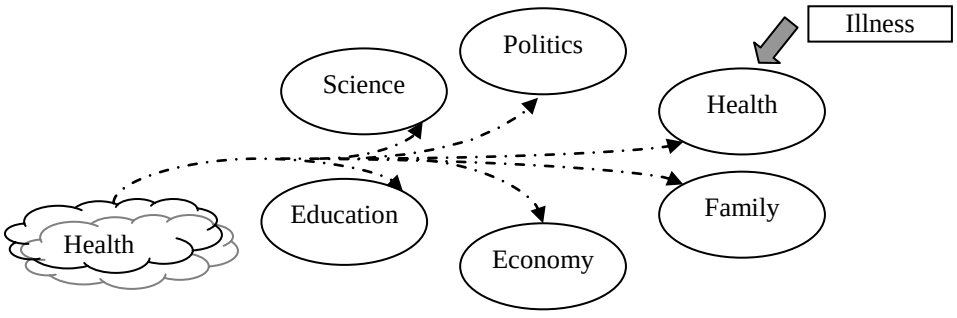


Figure 3.4.2 *Health does not have a separate social sub-system that is why it has to enter each social sub-system.* (Note: Figure 3.4.2 is a graphic version of Figure 3.4.1)

The connection of organisations and health

There are organisations in most social sub-systems. From an other point of view, we get in touch with different organisations several times during our everyday life. That is to say, organisations are the mediators of the social environment defining our life-style.

The organisation: A larger group of people built on more or less impersonal relationships, developed for the sake of fulfilling a concrete aim.

Organisations form our life-style and our health consequently, in several ways:

- The organisations we belong to influence our life-style and health directly. Some organisations strongly determine the physical and social environment we live our life in.
- Those organisations also affect our life-style and health which we get in contact with in some form. When we buy a product in the shop or when we make use of a service, etc., we get in contact with an organisation in a way that strongly influences our health or our health-related expectations.

The traditional way of health education tries to reach a positive change in people's health behaviour through extending their knowledge base. Some professionals say this approach has only less success.

Physical and social characteristics of human communities can be permanently changed through project management. The characteristics of human communities change during the effective health promoting project management in a way that healthier choice will be the easier choice (see WHO Ottawa Charter) for the members of the organisation, founding the positive change in their health behaviour this way (Benkő, 1995).

Task 3.4.2

Make a list for yourself containing the organisations you are the member of! How could these organisations influence your health? Draw up ten aspects!

Please read the following materials.

What is the project?

In the Health Promotion literature the project comes into existence either within an organisation or among the different social sub-systems. For us the project method meant the creation of a new – in sociological sense – autonomous organisation the aim of which is to ease cooperation and information exchange among the different existing social sub-systems. It is the new information and enlarging system of contact that makes the project the means of organisation innovation, here the means of health promotion.

This function can be fulfilled only if it can work autonomously on the one hand, and it can keep up and utilise its relationships with the mother institute on the other (Grossmann and Scala, 1994).

The health promoting project

Project method is very effective in health promotion. The reasons of it lie behind the characteristics of the project:

– *The project is a form of organisation to cope with complex, new, risky, intersectoral tasks within and between organisations, and an instrument of planned organisational change. Characteristically these new tasks require the reconsideration of cooperation within the mother institute or among the organisations.*

Health promotion can incorporate the formulation of new organisational aims and tasks also. New aims and tasks are however always though to be more risky than tasks already tried out and experienced.

The project method can reduce the risk of introducing new solutions.

– *Mobilizes and rearranges the resources of one or several systems for new tasks*

Financial and personal resources are equally needed for the fulfilment of new tasks. Health promoting projects provide possibilities for assessing existing resources and supply the missing ones (internal and external applications, etc.).

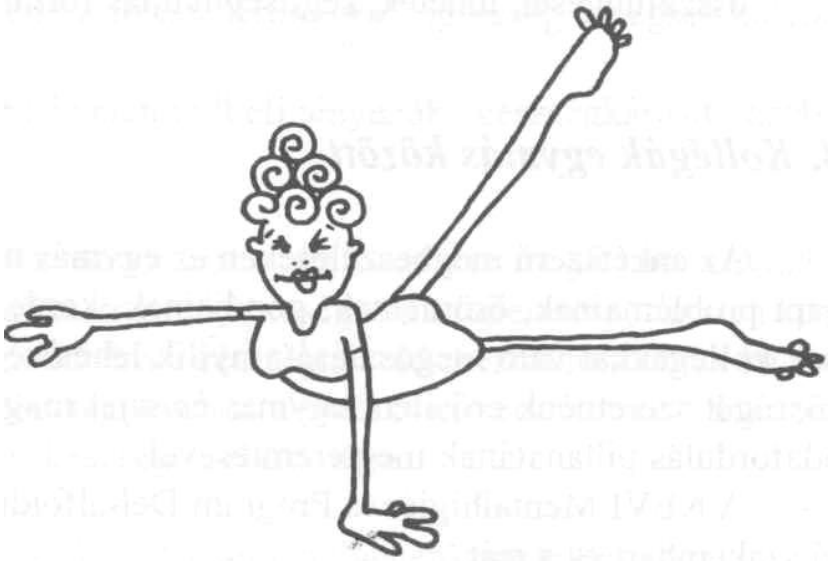
– *Offers a platform to evolve and test entirely new and surprising efforts to cooperate across boundaries of departments or organisations*

The final aim of health promoting projects is in every case to introduce the tried out experimental methods permanently to the mother insti-

tute. To this everything that happened during the project should be verified and communicated to the mother institute.

- *Allows clients and staff to acquire new experience and skills that they may incorporate into their day-to-day work*
- *Is important not just for handling its particular task but also in its impact on the overall organisation or other organisations involved* (Grossmann and Scala, 1994. pp. 56.).

The project is then an institutionalized laboratory that prepares future models for an organisation and begins to establish them.



As a summary we can state that health promotion requires a change in the social sub-systems. Important social changes in every case contain the change of organisations as well. One effective means of organisational change is the project method.

What is the structure of a health promoting project?

The following process chart summarises the structure of health promoting projects:

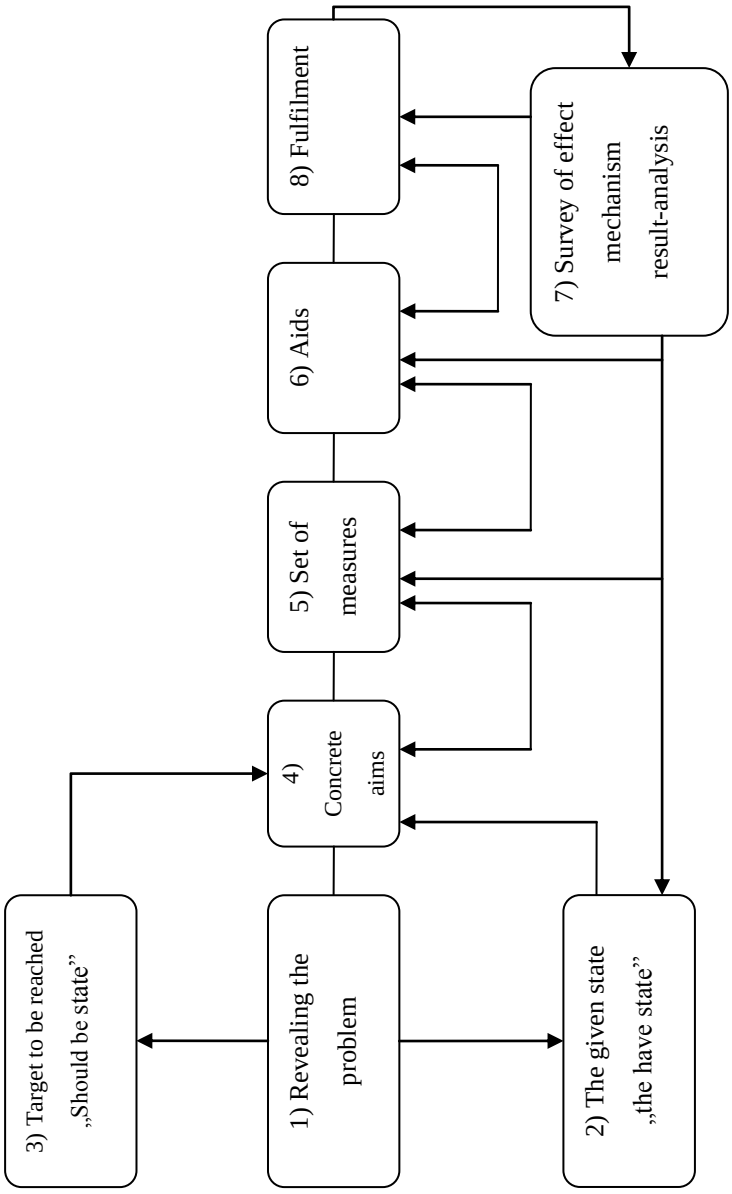


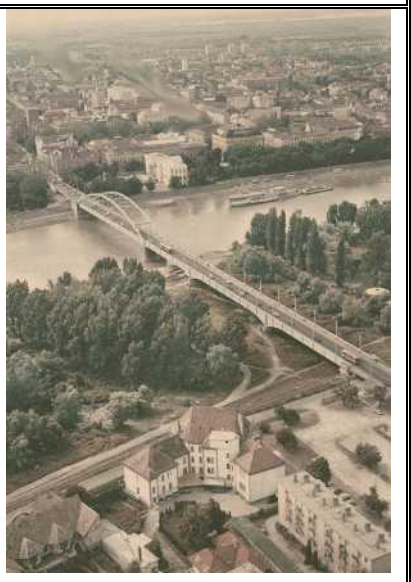
Figure 3.4.3 *The structure of health promoting projects*

To illustrate the above figure we will use a fulfilled Hungarian health promoting project. Please study carefully the 1st case study and compare it with Figure 3.4.3!

1st case study: Description of a city-level secondary school health promoting-mental health promoting programme

1) Revealing the problem: Professionals working in the health promotion programme office of a Hungarian city, Szeged, confronted with the need for supporting the educators of secondary schools in Szeged in the fulfilment of their health promotion programmes. Some educators have indicated to the office that the fulfilment of their plans is hindered by the lack of personal professional support mainly.

2) Revealing the given state, the „have state". Professionals of the health promotion programme office made a comprehensive state- and needs analysis with the educators of secondary schools in Szeged. This survey has propped up the importance of the lack of personal professional help.



3) Formulating the „Should state". Knowing the given state the professionals of the health promotion programme office worded the following aims:

- Compilation of a set of health promotion programme offers for the secondary schools of Szeged that enables educators to measure the possibilities lying in health promotion.
- The programme offer should provide schools with enough impetus for wording and fulfilling their unique health promotion targets.
- During the project the educator should be provided, if he or she requires it, with proper professional support in the following tasks:
    - Measuring the organisational characteristics and possibilities
    - Re/conceptualisation of health promotion needs
    - Development of appropriate health promotion projects that meet the needs
    - Getting in touch with the proper professionals
    - Fulfilment of the programmes
    - Evaluation of the programmes
    - Preparing the further course of the programmes

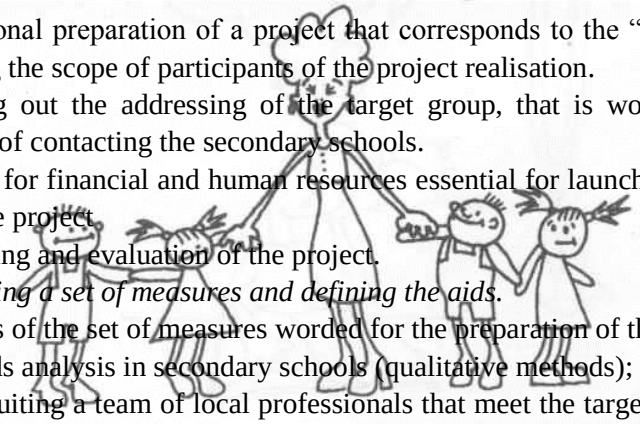
4) Concrete aims. The above general aims were broken down to the following concrete aims:

a) Professional preparation of a project that corresponds to the “should state”, defining the scope of participants of the project realisation.

b) Working out the addressing of the target group, that is working out the method of contacting the secondary schools.

c) Looking for financial and human resources essential for launching and operating the project.

d) Monitoring and evaluation of the project.



5-6) Formulating a set of measures and defining the aids.

a) Elements of the set of measures worded for the preparation of the project:

- Needs analysis in secondary schools (qualitative methods);
- Recruiting a team of local professionals that meet the targets of the project: doctor (public health, dermatologist and doctor of venereal disease, paediatrician, psychiatrist), psychologist, sociologist, social worker;
- Defining the target groups (pupils, educators, parents) and methods (parental meeting, lesson held by the class-master, extracurricular lessons);
- Working out the strategy for contacting the target group;
- Defining the scope of contact persons in the programme office and in the secondary schools as well;
- Compilation and working out of a health promotion programme offer for secondary schools and creating a handout;
- Application for providing the financial background of creating the handout, arranging the publishing and distribution;
- Working out the tool for quality management.

b) measures concerning contact to schools:

- Forwarding the handouts to the institutes.

c) measures concerning project operation:

- Support of educators in developing and fulfilling a programme that suits their schools;
- Carrying out quality management tasks.

d) measures concerning the closing of the project:

- Summary of project results (quality management, qualitative measures);
- Dissemination of project results.

7) Survey of effect-mechanism: this meant the fulfilment of quality management tasks in the present project.

8) Realisation: fulfilling the above set of measures.

Task 3.4.3

In the appendix (Annex 4) you will find the handout of the project presented in the 1st case study. Work out your own school project with the help of this programme offer for secondary schools! Take care of the followings:

- Formulate a concrete health promotion target that could be fulfilled in your own school as well (lesson by the class-master? Health-day? etc)
- Choose the target group of your project carefully (pupils? parents? educators?)
- Define the scope of participants essential for the realisation of the project (colleagues? professionals?)
- Please follow the example presented in Figure 3.4.3. while you introduce your own project!

SUMMARY

In this chapter we have reviewed the theoretical and practical basis of health promoting project management. We wanted to find answer to the question, why the project method is needed in health promotion. We have also reviewed the social sub-systems defining the operation of modern societies and the health promoting relevancies of organisations. In the second part of the chapter we have reviewed the main characteristics of project method.

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KEY CONCEPTS

❖ Social sub-system ❖ Organisation	❖ Project

TOPIC 4

SKILLS AND SKILLS DEVELOPMENT

GENERAL TOPIC:

4.1 SKILLS AND SKILLS DEVELOPMENT

Peter Paulus and Thomas Petzel

UNIQUE TOPICS:

4.2 COMMUNICATION SKILLS DEVELOPMENT

Marilyn Hackney and Helen Churchill

4.3 TEACHING AND TEACHING SKILLS

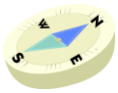
Peter Paulus and Thomas Petzel

4.4 GROUP DYNAMICS

Katalin Erdei and László Lippai

4.1 SKILLS AND SKILLS DEVELOPMENT

OUTLINE



In the following you will find a brief reflection of the effects of methods and scopes of traditional health education in contrast to methods and objectives of modern health promotion. So-called "life skills" play an especially important role in health promotion activities. On the one hand, the promotion of such skills represents one of the most important *aims* of health promotion, on the other hand professionals working in the field of health promotion need such skills, too: Communication skills are just one example. Teaching skills are also discussed because they effect the personality and skills development of students in direct as well as in indirect ways. One further part of this unit concentrates on groups and group dynamics. Groups play an important part in the life of all people. So-called social competencies significantly effect our abilities to perform in group contexts, e.g. concerning our cooperation with others. Thus, the promotion of such competencies is an important aspect of health promotion activities.

OBJECTIVES

- Reflection of methods and scopes of traditional health education in contrast to methods and objectives of modern health promotion
- Gaining knowledge about the role teaching methods and styles play for the promotion of life skills.
- Reflection of the meaning and the importance of various competencies such as communication skills, life skills or social competencies for modern conceptions of health and health promotion.

CONTENT PART

Task 4.1.1

Health promotion aims at changing health related attitudes and behaviours. Before reading which methods and objectives are prominent in modern conceptions of health promotion, please think about what you would suggest to do in order to change health related behaviours concerning the following cases:
1. You have a 13 years old girl pupil, who eats only fast food, mainly dishes containing a lot of catchup;

2. You have a 40 years old work-mate, a woman, who keeps on saying she should quit smoking, but gives no sign of actually doing it;
3. You have noticed, that your neighbour goes to the supermarket by car every time, though the shop is only 5 minutes walk. How could you persuade her to go on foot?
Choose one situation and please note at least three methods. What do you think how probable behavioural changes are as a result of the interventions you would suggest?

Please read the following materials.

Information, attitudes and behavioural changes: Traditional concepts of health education

Traditional concepts of health education often relied on the effect of supplying health relevant information. The aim was to increase the knowledge about health improving or health damaging behaviour patterns. Implicitly connected with it was the supposition that health relevant behaviour of individuals would change automatically with the better knowledge about health. This concept neglects the fact that has been known already from the social psychological research for a long time: Alteration of knowledge does not automatically lead to an alteration of attitude and an altered attitude does not automatically lead to an alteration of behaviour. Human beings have got for example efficient psychological mechanisms which influence the mental handling of information. Generally information is considered as threatening if they contradict the already existing attitudes. One mechanism which can reduce this feeling of being threatened is for example that the presented case studies are characterized as the "exception to the rule". The already existing knowledge is more or less immunized against changes. Even strategies which want to achieve a change of health relevant behaviour patterns by a confrontation with particularly frightening information about damaging consequences for health – one example would be the connection between the neglect of dental hygiene and its resulting damages to the teeth –, in all probability lead to an insignificant alteration of behaviour or none at all.

But even if the better knowledge is internalized, it does not automatically lead to a consideration concerning one's behaviour. It is known in the psychology of development for instance that teenagers create an unrealistic picture of their own vulnerability: They regard themselves as invulnerable, negative events only refer to "the others".

In addition the conviction that behaviour patterns can be directly influenced, neglects the fact that behaviour never results from a single cause. Varied factors play a role for the coming about of a specific pattern of behaviour. Attitudes belong to these factors as well as personality characteristics: Human beings differ in their ability of how willing they are to integrate information into their already existing world view. Situational variabilities are a further, very important aspect in this connection: behaviour is strongly influenced by specific situations. For example the presence of other relevant persons effects the behaviour of a single person. Especially factors like group pressure and conformity get importance in such situations. For adolescents this factor has a special relevance because just in this phase of life peer groups are especially important because the adolescents are gradually separating from their parents. Social recognition within these groups leads to an especially high pressure of adaptation and conformity. Even when individual health damaging patterns of behaviour are recognized, such consequences of one's behaviour have lower importance than the fear of losing the recognition within the peer group.

Actually in the past these factors have ever and again led to unsatisfactory results of health educating measures. The complex relations between knowledge, attitudes and behaviour were neglected, therefore the expectations of short-term success concerning health relevant behaviour of the target groups have not been fulfilled.

Methods and objectives of modern conceptions of health promotion

Yet, modern concepts of health promotion always have the work on specific and concrete attitudes and patterns of behaviour in mind: stimulation of exercise, healthy nourishment, resistance against drug taking are still up-to-date in health promotion. But such measures are not regarded as being sufficient to support health relevant behaviour. Additionally more and more factors have become important for health promotion which can rather become effective in the medium term or in the long term. So-called "life skills" play an important role in this connection. "Life skills" are abilities and competences which shall enable an individual to an altogether successful conduct of one's life. An understanding of health is developed, which exceeds the traditional point of view by far. The centre of interest is not explicitly and exclusively the physical health condition but the opinion that a high life competence enables individuals to lead a healthy life. Therefore modern concepts of health promotion highly aim at empowering the so-called "life skills", as they were formulated by the World Health Organisation

(WHO). These life skills are meant to promote a healthy life style and finally the health of the individual.

According to the WHO "life skills" are for instance general competences for solving problems, stress and fear management, self-attention, social integration, making decisions, interpersonal competences, "assertiveness", power of resistance against social pressure, critical thinking and competences of effective communication.

Referred to the above mentioned example of potential health damaging patterns of behaviour in fear of being refused by other relevant persons the promotion of life skills could for example be employed to enable individuals to resist group pressure better. They can develop a stronger resistance against social influences and in addition will be enabled by a higher communicative competence to make clear within a group why they do not show conformist behaviour. At best this will result in the experience that nonconformist behaviour does not necessarily lead to unconditional rejection in a group. Such an experience can also positively effect the self-efficacy of an individual. Such expectations of self-efficacy are very important for all fields of human life: If a person is convinced of always being able to solve general or specific problems successfully, it does not only effect the particular situations positively which have to be coped with, but the total conduct of one's life and consequently one’s overall health and well-being.

However, the high significance which the promotion of "life skills" has within the scope of modern health promotion concepts causes a further problem for the project management. As being already described in one of the previous modules, there is one problem in the moderation of health promoting processes in actual organisations: often the modern understanding of health and health promotion does not meet the expectations of the protagonists. Often these will still be characterized by a traditional understanding of health. Apart from the fact that those attitudes can be obstacles for the development of specific measures, there will be a problem for the evaluation of measures having already been carried out: Often specific changes in the condition of health of the target group are expected as a result. This expectation results from the assumption that measures have a short term effect. But this expectation, too, rather corresponds with the traditional under-

standing of health promotion: If for example a measure is to impart information about a specific health damaging pattern of behaviour one can really expect that possible effects – if at all – can best be observed directly after carrying out this measure. The possible effect may even decrease continually the more time passes between the measure and the evaluation. The promotion of "life skills" is not aimed at short-term effects.

Therefore concrete predictions about short-term changes of health conditions or health-related behaviour are hardly possible or hardly plausible. Long-term changes could only be proved by well-planned scientific longitudinal studies. The realization of such studies is generally not possible for individual institutions, because they exceed the existing resources and competences by far. This should already be made clear at the beginning of health promoting activities in an institution to avoid corresponding expectations – for these would almost certainly be disappointed. That does not mean, however, that one can do without the evaluation of the measures which have been carried out, but the modern understanding of health promotion has also to be considered in the evaluation. The success of the promotion of "life skills" can absolutely be verified for instance by a research in how far there are any differences before and after the measures referring to relevant variables.

The module at issue introduces the basic idea of "life skills", which are presented and analysed in detail in the first sub-module. A second sub-module deals with the conditions of teaching/learning processes which promote the development of "life skills". The question arises, which teaching/learning arrangements are especially suitable for the acquisition of such "life skills". In the third sub-module different aspects of group dynamics will be analysed in more detail.

Task 4.1.2

Please answer the following multiple choice questions. Please choose one of the given solutions. Only one solution is correct.

Attitudes can easily be changed by giving information which contradicts an individual's already existing knowledge.

A. Yes, because knowledge is the base of attitudes. Especially if instructors consequently insist on being right their influence on the change will be extraordinarily high.
B. No, because knowledge is completely irrelevant for the behavioural component of attitudes.
C. No, because an individual's system of attitudes is relatively immunized against changes resulting from new information.
D. Yes, because individuals have an inborn tendency for actualizing their attitudes permanently in order to adapt to their environment as good as possible.

YOUR ANSWER IS ……

Adolescents are especially susceptible to changes in health related attitudes promoted by experts and authorities.

A. No, because due to physiological changes during puberty their intellectual abilities are not sufficient to understand complex information about health-related behaviours.
B. Yes, because they usually submit to authorities unconditionally.
C. Yes, because their self-concept is so weak that they adapt to other points of view eagerly.
D. No, because factors such as group pressure prevent adolescents from adapting to deviating points of view.

YOUR ANSWER IS ….

Task 4.1.3.

Refer back to Task 4.1.1.! After reading the present chapter how would you change your answer to the task? How would you evaluate your method? Could you suggest a more successful method?

SUMMARY

Changing health related patterns of life isn't an easy task. There is a complex interaction between knowledge, personality characteristics like attitudes and situational influences which determine behaviour. Therefore traditional health education efforts expecting short term results in behaviour change have not been successful. The concept of "Life-Skills" which focuses on a more general and higher level of competence like stress management, problem solving etc., with a long term outcome expectation of interventions seems to be a more appropriate concept. But it has implications for acceptance of such interventions in practice by the target group and also for evaluation.

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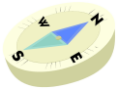
KEY CONCEPTS

❖ Behaviour change ❖ Health education	❖ Life Skills

4.2 COMMUNICATION SKILLS

OUTLINE



Health promotion is a social process which, like any other social process, is highly dependent upon good communication skills. These relate not only to the effective use of language but also to a number of other important ways of exchanging information, knowledge, emotions and values between human beings. In this first submodule, we are going to focus on the role of non-verbal communication. This is a vast field of investigation and involves many different ways in which people communicate and share meanings 'beyond words'. Indeed, it has been shown that non-verbal communication is itself an even more powerful medium than verbal communication, although it often is used to support verbal communication, rather than be a force in its own right.

OBJECTIVES

By the end of this module, therefore, we intend that you will be able to

- Identify a range of different aspect of non-verbal communication.
- Understand the cultural significance and interpretation of different types of non-verbal behaviour.
- Discuss the role which non-verbal communication plays in expressing emotions and meanings.
- Identify ways in which non-verbal communication can facilitate health promotion.

CONTENT PART

Please read the following materials.

Channels of non-verbal communication

If you watch people who speak a language that you do not understand you can often identify whether you are witnessing a social gathering, business meeting, argument or loving encounter. You can do this because you pick up on the intonations of speech and non-verbal cues. Non-verbal communication includes:

- facial expressions, gestures, movement and body language.

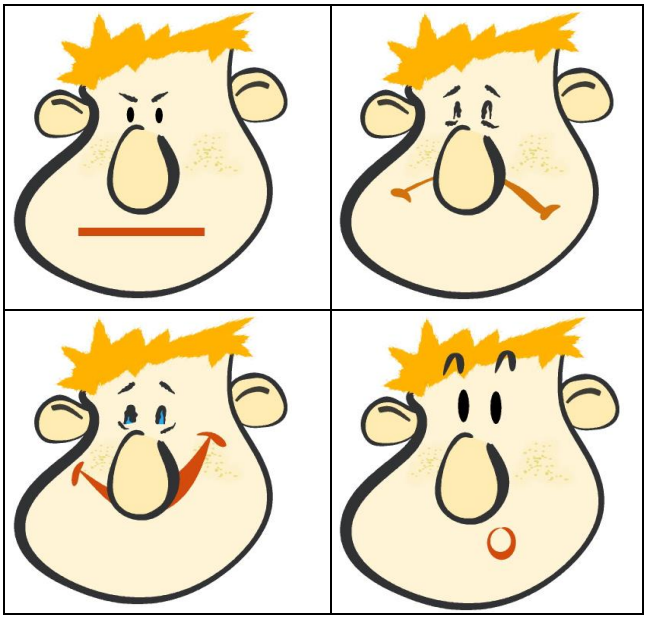
However, some aspects may not be so obvious. For example:

- physical characteristics – how individuals (and you) look
- touching behaviour – whether individuals make physical contact with one another during communication, such behaviour is often culturally-related, that is, more common or acceptable in some cultures than others
- para language – the way that something is said
- body language – communication occurs even when nothing is said or read

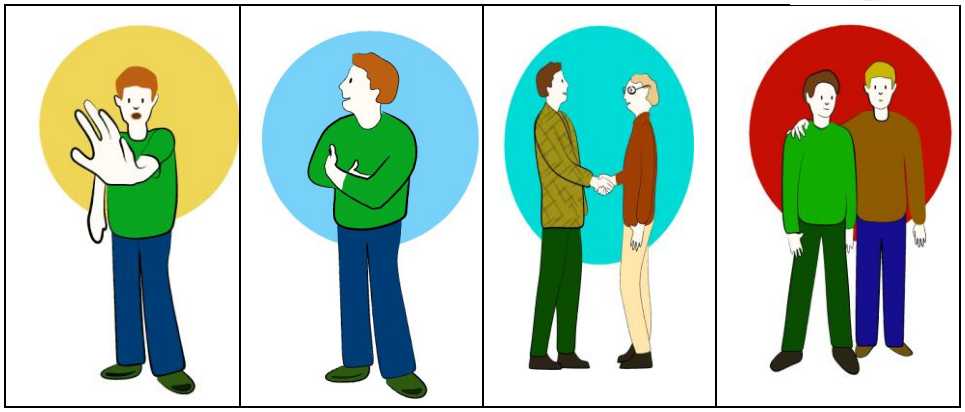
It is useful to think about how you come across to other people, to think about your own body language. Consider the following, as it should help you to identify your own style, positive or negative:

- *facial expression*
  it is pleasant, open, smiling?
- *posture, movement and distance* do you stand upright or slouched? Are you too near or too far from the other person? Are you higher or lower?

- *eyes*
  is your gaze relaxed and friendly? Do you maintain eye contact or avert your eyes?
- *mouth*
  do you hold your jaw tightly? Is your smile appropriate or misleading?
- *voice*
  watch the tone, inflection and volume. Notice if you whine or bellow, whether you convey sarcasm through the tone of your voice. Is it clear, gruff, high-pitched or audible?



- *gestures*
  watch for hands over your mouth or hands clutching at hair or jewellery or clasped behind your back. Are your feet shifting from one to the other? Are your arms folded?



- *attitude*
  are you perceived as friendly, dictatorial, spontaneous or patronising?

- *manner*
  do you present yourself as positive? Are you shy/withdrawn or calculating?
- *presentation*
  are you mumbling or speaking audibly? Do you swallow your words or come across as loud and clear?
- *appearance*
  what does your appearance say about the impression you wish to convey to other people? What about your clothes? Are they tidy, appropriate for the situation, loud, or an expression of your personality?
- *breathing*
  deepen your breath and calm yourself prior to an assertive confrontation. Noticing your breathing and learning how to relax your body reduces your anxiety and helps you feel poised and centred, even in a difficult situation.

Task 4.2.1

Imagine a group of people sitting in a room, a discussion is in progress. There is a pause in the conversation. A woman stands and then leaves the room. List as many explanations as you can think of for what the woman is saying non-verbally.

……
……
……
……
……

The woman in the hypothetical scene in exercise may have been saying very simply:
'I have to go now', 'I need to stretch my legs', 'this is a bit boring, I'll see what's happening in the kitchen' or 'I must go to the loo'.

Alternatively, she may be conveying a much stronger emotion:
'You have made me so cross I can't stay in this room'.
In this way you can see the impact of non-verbal communication, even when you say nothing at all, this in itself, often says something.

Some non-verbal communication is unintentional, for example, blushing or sweating. Sometimes it is difficult to interpret. Can you think of a time when

you have asked or heard the question 'why are you looking at me like that?' in a direct or non-direct way?

It is also important to remember that non-verbal communication is very culturally determined. Kissing hello or goodbye is acceptable in some cultures but not others, some do it twice, others only once. In some cultures shaking hands is not appropriate. In Mediterranean cultures it is not uncommon to see men hug each other or walk along the street with their arms around each other, not so in Britain. Some cultures infer different meanings from gestures, for example raising the eyebrows is a sign of surprise in England yet an expression of agreement in Greece, more worrying – to flash your car headlights in England usually means 'I'll wait while you pass', in Greece it has the complete opposite meaning: 'stay there I'm coming through!' The distance between people when communicating is also culturally specific. The British and Americans tend to feel comfortable with three or four feet between themselves and their colleagues in business conversations, other Europeans and Middle Eastern business people stand much closer.

- eye contact and gaze – the face is the most obvious place to view the meaning of communication but it is very difficult to analyse.

Facial expressions are so important for communication. This is why we tend to look at a person who is speaking to us (not just because it is polite). Many people have difficulty with telephone conversations, or find telephones impersonal; this is because they cannot see the face of the person they are communicating with. Automated, mechanical or robotic verbal communications can have the same effect for these reasons.

Yet the face is a complicated channel of expression. Ekman and Friesen (1975) have identified six emotions that facial expressions reflect:

- surprise
- fear
- anger
- disgust

- happiness
- sadness

However, it is possible to have 'affect blends', that is, a combination of two or more expressions showing different emotions.

Most of us are very competent at picking up messages from the faces of others, we learn this skill through the process of socialisation into the norms of our culture (unfortunately we can all think of individuals who do not appear to have picked up the skills of acknowledging verbal or non-verbal cues). Even when we have these skills it is important that we do not take them for granted and that we concentrate on our personal communication skills. Think about the way that you pick up messages from people's faces.

- watch people when they are not likely to be thinking of appearance (in a car at traffic lights for example), what are they thinking? What is their emotional state?
- sometimes you will see an expression flash across someone's face. What happens? How can you tell?
- contradictory expressions – when the mouth says one thing and the eyes say something completely different. How can this happen?

Which are basic facial expressions according to Ekman?

The eyes are a particularly valuable part of communication; 'catching someone's eye' is an important way to initiate communication with them. Avoiding eye contact or looking away means that there is no channel for communication. During conversations people look at each other intentionally for short periods, then look away. People look nearly twice as much when listening as they talking (Argyle, 1990).

People use visual and auditory signals as well as verbal and non-verbal behaviours. There is a whole process of interpreting and making sense of other people. This process is important for the health educator, because the way a person perceives and interprets events affects how they behave.

Task 4.2.2

Here are two (optional) exercises that you might like to try with a friend/partner, they are aimed at encouraging you to think about non-verbal behaviour viz: touch and eye contact.

A. *Touch*

This exercise is carried out in pairs, usually with someone that you know well and feel comfortable with. Discuss and summarize your experiences!

1. Keep your eyes closed while your partner touches your hand in the manner of a nurse/doctor, ii) a parent, and iii) lover.
2. See if you can discriminate between the different types of touch.
3. Reverse roles and think about the way that you would touch in these different situations.
4. Discuss the effects of being touched and the ability to discriminate between clinical and non-clinical encounters. Think about the implication of touch for the health educator working in one-to-one situations.

B. *Eye Contact*

Sustained eye contact may be threatening so it is important that you carry out this exercise with someone that you are relaxed and feel safe with. Discuss and summarize your experiences!

1. Hold a conversation with your partner on a theme of your choosing (use 'Doctors I have known' if you can't think of alternatives).
2. Both partners maintain eye contact throughout the conversation, then
3. One partner keeps theirs downcast throughout.
4. After each conversation, note how you both felt.

5. The importance of making eye contact when speaking can be stressed. Another aspect for discussion is the threatening nature of eye contact that is sustained longer than participants find comfortable.

Please read the following materials.

Interpersonal skills

Introduction

The previous module focussed on the important role of non-verbal communication as a powerful transmitter of ideas, perceptions, meanings and feelings between people. We also examined a range of issues relating to one-to-one communication and highlighted the importance of the need to be aware of factors such as non-verbal cues and prejudices if we are to be successful communicators. This module further examines interpersonal skills with reference to:

- influences on interpersonal relationships,
- listening skills,
- questioning,
- self-disclosure.

In so doing, we are drawing attention to some of the significant techniques of verbal communication, as well as the necessary conditions which the health promoter should seek to establish with his/her clients. Health promotion, whilst clearly dependent upon good verbal and non-verbal skills, also relies on an appropriately facilitating relationship. This involves the development of trust, self-esteem and a caring orientation towards the other person. The module seeks to identify how these conditions can be understood and put in place in ways which encourage clients to be active participants in their own health-related decision-making.

Influences on interpersonal relationships

It is important to be aware of certain issues that may need to be resolved before we become effective communicators.
According to Ewles and Simnet (1996), the effective health educator should:

- be accepting and non-judgemental
- encourage autonomy rather than dependency

- be open, trusting and encouraging rather than authoritarian or reserved
- value others, be empathic
- be able to make others feel good about themselves.

Implicit in this is a suggestion that the health educator's interpersonal style is perhaps partly dependent on personality and past experience. In our interactions we:

- make assumptions about ourselves, the person we are communicating with, the situation, what we expect and what is expected of us
- are concerned to collect and process as much information as we can about the other person and to present ourselves favourably
- may be conscious that the other person is putting on a 'front', we should try to see beyond this and work out what their underlying thoughts and feelings might be.

The art of listening

We usually assume that we listen to others when they speak to us. But do we? Listening is an active process, it is not the same as hearing. Physically hearing someone does not mean that we have really listened. It is important here to make the distinction between 'passive' and 'active' listening. Passive listening is non-responsive and superficial. Active listening is a skill we can learn and improve. To listen well we need to:

- observe the speaker
- concentrate on words and non-verbal behaviour
- think about what is being said
- be interested
- be open-minded

Listening is crucial for health promotion work. Health promoters need to listen for information, for reliability of what is said, for the client's feelings and perceptions of health and health related issues.

Listening Skills

For active listening *DO:*

- show interest
- be warm and supportive
- pay close attention to both verbal and non-verbal cues
- ask for clarification if you do not understand
- check out what you think you hear – reflect back
- allow the other person time to talk
- be silent when silence is needed
- try to put yourself in the other person's place – see things from the other person's point of view, even if you disagree
- encourage the other person to find their own solutions to problems

For active listening *DON'T:*

- argue
- interrupt
- give unsolicited psychological insights
- make value judgements
- give advice unless it is asked for
- give your solutions to any problems
- burden the other person with similar experiences you may have had
- give platitudes or moral tales to guide the other person
- talk all the time – filling in silences is unnecessary

Non-Verbal Behaviour and Listening

The role of non-verbal behaviour in listening is to show involvement and help the listener to read what is being said. This is achieved through:

- eye contact – sufficient to show involvement but not to stare
- facial expression – to show interest
- head movements – eg. a head nod will show encouragement, vigorous nodding suggest interruption
- posture and gesture – will give information about interest level

- paralanguage – the listener needs to cue into how people talk as much as what they say
- vocalisations – utterances such as 'oh' and 'mm' show interest, agreement and encouragement to continue
- silence – may be necessary for effective listening, together with body language and gestures, silence can convey empathy
- smiling – can reassure and keep channels of communication open.

It is important to remember that non-verbal behaviour can give negative feedback. For example, a raised eyebrow at the wrong time may convey surprise or disapproval.

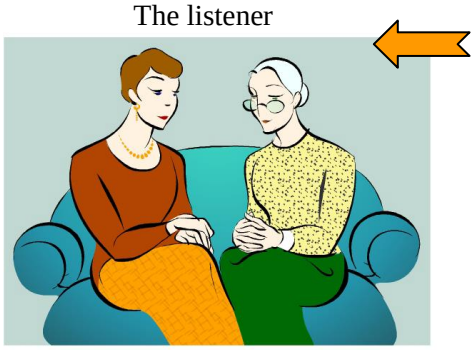
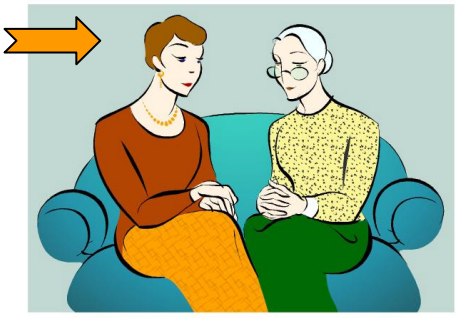
Levels of Listening

There are three levels of listening that can be identified, they may vary according to the situation or context, but are present to some extent in all encounters:

- facts
- feelings
- intentions.

As an illustration, take the example of the client who presents with respiratory problems and is overweight. The 'facts' level of listening is to gather the medical history. The listener may have to read between the lines of what is being said to gather the feelings or attitudes of the client towards the question of weight and health, whether the client has a positive attitude to health. Similarly, the listener will have to listen for the client's intentions with regard to future decisions about this issue, even if the client may not be consciously aware of her/his intentions. This will lead to effective listening.

According to Egan (1977) the possible reasons for failure to listen can be presented as follows:

‘Location’ of cause	Reason
The listener 	• self-consciousness • negative attitude to the material • impatience to speak oneself • fixed ideas on the subject • not understanding (difficult material) • stress/anxiety about understanding • selective attention (only hearing some parts of the communication) • not hearing due to a physical problem
The speaker 	• poor oral presentation • insensitivity to feedback • appearance
The learning environment	• noise • time of day • heat/cold

(from Egan, 1977)

Listening to Oneself

Listening to oneself is not about being preoccupied with ones own thoughts and feelings but the effect of being self-aware, being positively self-conscious can help identification of the need to listen (Egan, 1977. p. 120).

Helping Others to Talk

The role of the listener also includes encouraging the speaker to talk. It is important to think about how this is achieved. People can be prompted by:

- giving an invitation to talk, for example, by asking specifically: 'is there anything you would like to talk about?'
- encouraging by prompting, verbally or non-verbally, picking up on cues and suggesting ways in which the conversation can be moved forward;
- paraphrasing has a number of uses in conversation, it emphasises points, aids reflection and can help the speaker to come to their own conclusions;
- reflecting on what has been said is also important. This can be done by reflecting feelings: 'you seem pleased/upset about this' or reflecting meanings: 'you seem pleased about your weight loss', for example.

Questioning

Very often in health encounters questions are directed, that is, they are framed to elicit a response. Questioning can be done in various ways:

- initially *direct* questioning to assess the nature of a problem to establish needs
- *during interactions* to monitor progress and check upon objectives and needs being met;
- finally, *to evaluate* what has been achieved, to improve our own self-evaluation.

Questioning can also be divided into 'cognitive' and 'affective' forms:

- *Cognitive questioning*: to discover facts, opinions or ideas and to provide informative feedback;
- *Affective questioning:* to ascertain people's feelings, attitudes to problems and to help individuals discover their own feelings.

In health education work the majority of questions tend to be directed from the health educator to the client. However, it may be appropriate to encourage the client to generate her or his own questions. This may help the client in terms of:

- helping them to take a more active role in the encounter,
- generating confidence,
- generating independence,
- encouraging an open-minded attitude.

However, there are also a number of problems that may accompany questioning. Questions can be misused, they can be manipulative, or they may communicate negative attitudes. Some of the negative aspects of questioning are:

- leading questions – prompting a desired answer: 'I take it that you believe that ...';
- trick questions – may confuse or mislead: 'so you feel you are right in not reporting this problem?'
- biased questions: 'you are feeling better today aren't you?'
- multiple questions – will confuse when there are too many questions couched as one;
- marathon questions – again confusing when one question is surrounded by a mass of unnecessary detail;
- rhetorical questions – where the person asking the question supplies the answer.

Questions can also be 'open' or 'closed':

- closed questions – require a minimum response, they can be limiting but may be useful in establishing facts or information;
- open questions – have no expected answer, the respondent is free to make a variety of responses. Such questions can open up a flow of information and invite participation in the information-gathering process.

Self-disclosure

A degree of self-disclosure may be important in the communication process. By disclosing information about ourselves, we entrust the listener with confidential or sensitive information. This confidentiality may make us feel better about

ourselves and help us to decide who we are. It also helps to facilitate empathy between the speaker and the listener. Clearly this often feels risky, and could be a double-edged sword. Thus the extent to which we self-disclose will depend on the situation, the individuals involved in the communication and the confidence of the speaker. It is also important to remember at this point, one of the rules of good listening: to not take over the conversation with information about ourselves. We can all think of individuals who do not disclose much information about themselves. This can make us feel uncomfortable, particularly if we have disclosed sensitive information about ourselves. Equally, there are many people who are self-obsessed and who do not listen effectively because they are either talking about themselves or thinking of their next anecdote about themselves. The key is to achieve a balance.

There are a number of 'blocks' to self-disclosure:

- fear of intensity – individuals may not be used to such intensity;
- concern about confidentiality;
- fear of 'disorganisation' – what individuals learn about themselves may make them uncomfortable or cause cognitive dissonance;
- shame – may prevent disclosure;
- fear of change – the individual may have to alter previous comfortable patterns of behaviour in exchange for something else (Egan, 1977. p. 172).

„Why is self-disclosure important during confession?"

Task 4.2.3

The following exercise is aimed at helping you to identify issues sensitive to you, ones that you may think twice about in situations where self-disclosure may be appropriate.

Use a rating scale of 1 to 5, where 1 = very easy and 5 = very difficult, to decide how easily you could talk about these topics to:

A – a family member **B** – a colleague **C** – a class of pupils

Compute *means* from your answers! Which column got the highest and the lowest result? How would you explain the differences?

Task sheet 4.2.6

Identifying Your Secrets

Rating for each area

	A	B	C
Family relationships			
Things that make you happy			
Your body			
Feeling about death			
Social relationships			
Use of leisure time			
Sexual feelings and behaviour			
Feelings of depression			
Political preferences			
Intellectual capacity			
Homosexual tendencies			
Socio-economic background			
Your work			
Things that make you angry			
Fears and anxieties			
Religious beliefs			
Worries about health			
Your involvement in illegal activities			

SUMMARY

In this module, we have identified the importance of non-verbal communication both generally and in the context of health promotion. We have seen that non-verbal communication covers a varied repertoire of signals, often culturally determined, that communicate meanings and understandings between people in significant ways. We have also drawn attention to ways in which non-verbal communication can be developed as a skill in health promotion, bearing in mind that signals will be interpreted against a cultural or sub-cultural context which obviously needs to be understood and mutually recognised by health promoter and client group.

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FURTHER READING

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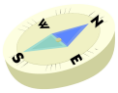
KEY CONCEPTS

❖ Communication , non-verbal ❖ Interpersonal Skills	❖ Listening ❖ Self-Disclosure

4.3 TEACHING AND TEACHING SKILLS

OUTLINE



Teaching skills are important in the health promoting school. Ways teachers interact with students and the psycho-social climate in the school and classroom have positive as well as negative effects on learning health and social behaviour outcomes. Concepts of health psychology and sociology like the concept of coherence from Aaron Antonovsky can be used to inform teachers about teaching styles that promote health and learning outcomes.

OBJECTIVES

- Understand the importance of teaching styles for learning, health and social behaviour outcomes.
- Know some empirical research results.
- Learn to relate concepts of health psychology and sociology to teaching in schools.

CONTENT PART

Please read the following materials.

Teaching and teaching skills

Teaching skills are important in the health promoting school. Students should learn facts about health at school but at the same time teaching about health should be performed in a health promoting way. The relevance of teaching styles and methods is not restricted to health education subjects but extends to every subject at school.

One might ask whether it is needed to talk with teachers about this matter. Are teachers not by their profession teaching in a health promoting way? Is it not one of their basics skills? The answer is “Yes, for sure”. But in reality it sometimes looks different, at least as far as German research on teaching behaviour is concerned. If students are asked how an ideal teacher should behave, they say that the teacher should:

- pay personal attention,
- have competence in subject matter,
- show respect,
- be accessible,
- be sincere.

As research shows, their expectations are rarely fulfilled. Asked to describe the real relation with their teachers students participating in another study (Freitag 1998) answered as follows (Percentage of agreement in brackets):

- My teachers are interested in me (49.6 %)
- My teachers take time for me (52.4 %)
- My teachers make me feel important (48.2 %)
- Our teachers make learning to be fun (34.4 %)
- My teachers encourage me to try harder (24.9 %)
- Our teachers treat us with respect (37.2 %)

These deficiencies in the relation of teachers and their students have consequences on both sides. For students, research shows the following results:

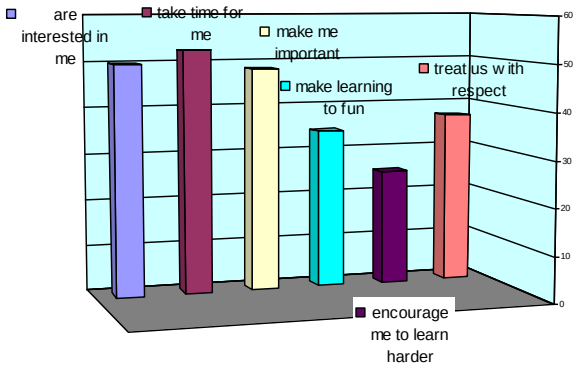


Figure 4.3.1 *Description of the real relation between teachers and students*

Lack or Deficiency in…	**Consequences as trends…**
Acceptance and esteem	School violence
Support from teachers and individual attention	Alcoholism
Accessibility for discussing problems	Psychosomatic Stress
Restrictive rule application	School violence
Discrimination and unfair treatment	Psychosomatic stress
Moral orientation and performance pressure	Competition and aggression

Research shows that deficiencies in the relation between teachers and students can cause severe psychological, psychosomatic or social problems for students. Especially in times of globalization processes social and communication skills become more and more important for an individuals ability to perform well in social contexts. Ethnically diverse classrooms are just one example for the consequences of globalization and will be found more and more often in the future. One example if these competencies are low, an individual's ability to cope with diversity (e.g. in the classroom) will be severely restricted.

The role of teachers play for the development of social skills (or life skills) becomes more and more important. Numerous studies have shown that teaching styles affect the students personality variables. Interestingly, the teachers" own perception of their teaching style seems less relevant for the students' development than the students' ratings of their teachers' behaviour. All in all, teaching styles have an impact on the personal relationship between teachers and students, and, again, the relationship between teachers and students affects the

students' social development: Students who report a positive relation to their teachers show better social competencies as well as better school achievement.

On the other hand some research results show how good relations look like, in particular relations that promote health and mental health. From the client-centered approach in clinical and educational settings we know what important attitudes for personal growth not only of students but also teachers are. Rogers (and after him many others have confirmed this) put forward three basic components of a helpful relationship:

- Empathetic understanding,
- Unconditional respect,
- Genuiness.

From research on family relations we know that the following attitudes of parents are important for a child to grow up healthy. In essence they look quite similar to Rogers' suggestions:

- Child-oriented,
- Cheerfulness / Sense of Community,
- Clarity,
- To be able to look from a child's point of view,
- Developmentally appropriate behaviour / patience,
- Recognizing emotions and feelings.

Some other results from research on parental child rearing practices show that a behaviour that is accepting the child and where parents are approachable but at the same time demanding and dominating seems to be the most favourable composition of parental behaviour. This style is called "authoritative" (Baumrind). In contrast, an authoritarian, a negligent and a permissive style of child upbringing show rather unfavourable results.

While this research was done in clinical and educational psychology another strand of research which is important for our discussion here emanates from health psychology and social medicine. Of utmost importance is the research of Aaron Antonovsky which relates to the so-called "sense of coherence". He defines it as: "..a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic, feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonable be expected.

This sense of coherence consists of three components:

1. The sense of comprehensibility: This component describes the expectation or the ability of the person to process both familiar and unfamiliar stimuli as ordered, consistent, structured information and not to be confronted with stimuli that bare chaotic, random, accidental and inexplicable. The term "comprehensible" is used in a sense of a "cognitive processing pattern".
2. The sense of manageability: This component describes a person's conviction that difficulties are soluble. Antonovsky has called this "instrumental confidence" and defined it as "the extent to which one perceives that resources are at one's disposal which are adequate to meet the demands posed by the stimuli that bombard us" (Antonovsky, 1979, p. 17.).
3. The sense of meaningfulness: This dimension describes "…the extent to which one feels that life makes sense emotionally, that at least some of the problems and demands posed by living are worth investing energy in, are worthy of commitment and engagement, are challenges that are "welcome" rather than burdens that one would much rather do without" (Antonovsky, 1987, p. 18.).

To promote a sense of coherence seems to be an important task of a teacher (not only) in a health promoting school. Is it possible to link certain behaviours of teachers, didactic or teaching methods with these dimensions mentioned above? The following list of activities which could be trained by teachers may be results of an in-service-teacher training.

Dimensions of the Sense of Coherence	**Promoting behaviours, didactics, methods etc.**
1. Sense of Comprehensibility 	• rules and regulations • relation to the life circumstances • transparency of planning of teaching activities • concrete goals, clear task orientation • wholeness • story telling, listening • plays, role-, group-, pantomime-, puppets-play • differentiation in the classroom • feelings of success • opportunities to talk to each other • drawing….

Dimensions of the Sense of Coherence	**Promoting behaviours, didactics, methods etc.**
2. Sense of Manageability 	• relation to life circumstances • achievement differentiation in the classroom • relaxation trials • opportunities to talk to each other • support / help / • experiences of success • plays, role-, group, puppets-play • accepting the person • wholeness • drawing • stories telling and listening • rules and regulations • exercise trials • clear goals and tasks • accept mistakes • coping with stress • conflict solution • develop own sensitiveness and expressiveness
3. Sense of meaningfulness 	• feelings of success • work in autonomy • participation • connectedness • relation to life circumstances • opportunities to talk to each other • acceptance of the person • story telling and listening • respectful relations • transparency of planning teaching activities • concrete goals, clear tasks

Task 4.3.1

Think your daily teaching practice through! On the basis of what you have learnt so far please identify five methods, aspects that you would change, and five that you would reinforce and use with more confidence. Explain your answer!

Task 4.3.2

Before going on to read materials about group dynamics, please think about the role group memberships play in your personal life.
(Please note that the term "groups" is defined in quite different ways. For the current purpose, it is not important whether you think of small groups with a lot of personal interaction between its members or larger social groups whose members are not personally acquainted with each other. Please think of "groups" as being of relevance for your social identity and as consisting of at least 3 members.)

Task sheet 4.3.2

- With which groups do you personally identify? Please write down at least 3 groups that are important in your life.

……
……

- What would change if you would no longer belong to these groups?

……
……

- Do these group identifications and memberships contribute to your personal well-being? If so, in which way?

……
……

- What happens if you get into conflict with ingroup norms and values?

……
……

- Which social competences do you need to perform well in the context of social groups?

……
……

SUMMARY

Research shows the importance of teaching styles in the classroom on learning, health and social behaviour outcomes. Aaron Antonovsky's concept of coherence is used to show how health psychology and sociology can inform teachers about teaching styles that have positive outcomes on various variables including health and learning.

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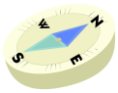
KEY CONCEPTS

❖ Client-centered approach	❖ Teaching styles
❖ Sense of Coherence	❖ Teacher, ideal

4.4 GROUP DYNAMICS

OUTLINE



Groups have an outstanding role in personality development. The class at school, as a unique group, can be characterised by determinable characteristics, the knowledge of which is indispensable for effective educational work. In this chapter first we review the dynamics of school groups, then we show the frames and methods of self-knowledge group work and school group work.

OBJECTIVES

- During studying the chapter you will be able to define the characteristics of a school class as a group.
- You will be able to identify the basic principles of group-work forming the basis of self-knowledge/mental health promoting work.
- You can create an overall picture on the psychological methods applicable during group-work at school.

CONTENT PART

Please read the following materials.

Theoretical introduction

Groups play an extremely important part in the life and development of people. During our life the first defining human community is the "small-group" called family, but we necessarily join to some smaller communities, where we live and act, in every period of life.

In the settings of educational work – school, dormitory – education and development is usually performed in group circumstances. There are several social formations in our life that can be categorised in various ways. One important categorisation possibility is the organisation of the given formation. There are communities that were institutionalised: social relationships are built around organised and regulated activities, and result in a so-called *formal community*. Within the frameworks of formal communities though – due to the sympathy – antipathy choices – spontaneous, voluntary associations: *informal groups* are formed, that make up the sphere of our most personal relationships (Csepeli, 1997).

The class as a group has several characteristics that partly distinguish them from groups that form spontaneously. Szatmáriné Balogh Mária and Járó Katalin highlights at six important features of class as a group that can also influence the conscious group-forming efforts of the educator (Szatmáriné and Járó, 1996).

Operation of school groups, group-dynamics is largely influenced by the fact that classes in the Hungarian education system are not spontaneously formed, but are artificially created formal units in most of the cases. So educators have relatively few possibilities to define the composition of the pupils, and vice versa, pupils have few words in choosing the composition of educators. So the members can not get to know and choose one another when entering the group.

School activity, the incidentally strongly achievement-centred atmosphere, individual assessment of achievement and dependence on the educators subserves the development of rivalry mainly. Several Hungarian researches refer to the fact that in achievement-centred classrooms the level of cohesion, the level of cooperation is often low (Szatmáriné and Járó, 1996).

Further specificity is the fact that the school as an organisation and institute defines the conditions of group dynamics and restricts its frames. As an effect the school-group has only relative autonomy. That is why each of the classes, sooner or later, develops a unique, dual operation. The formal level follows the aims and logic of the larger unit and develops its formal and official structure. Educators generally see the operation of this level only.

The informal, sovereign level of the class is formed by personal connections, value choices that can strengthen or even weaken the values and structures of the formal level. Among the two "micro-cultures" – formal and informal – there are hidden or open bargaining, or in extreme cases value-conflicts are going on, the "bumpers" of which can often be the educator him- or herself if he or she is not aware of the existence of these two micro-cultures (Szatmáriné and Járó, 1996).

An important task also is to reveal the role of reference groups and comparative reference groups. (Bagdy and Telkes, 1988). Class with its norm-system and structure forms pupils' personality in a direct form as well. Communities influence personality development too through their filtering, shaping and mediating functions. We can state then that the organisational frame of school personality development is provided by the class. That is why the various groups and communities provide a self-evident setting for self-knowledge and mental health promotion work.

At the same time, the size of a class is much higher in the Hungarian educational practice than the optimal size of groups, that is, 10-15 pupils. In a

large class of 30-40 pupils the possibility of direct, smooth communication can not be ensured. The relations, competing or cooperation of sub-groups that develop this way are of vital importance in terms of the climate and dynamics of the class (Szatmáriné and Járó, 1996).

An important factor is the age-homogeneity and definiteness of groups that exercises an effect on the permanence, content and form of the groups.

The above specialities define to a large extent the frames and conditions of group-work in the classroom communities. Correspondingly the effectiveness of group-work is largely defined by the success in developing an optimal environment at schools for small-group developmental work.

Frames

There are several possibilities to develop the different aspects of personality in a group form. There are certain aspects however, that are essential for the effective work of every self-knowledge and mental health promotion work.

"Self-knowledge work is looking for, getting to know and deliberating the background factors of behaviour revealed in the social mirror" (Bagdy, 1990. pp. 48.).

Self-knowledge and mental health promotion work is done in a unique setting, that is at the same time more and less than the social world we are living in. It provides a more intensive experience, but due to its artificial nature, it creates a world that models reality.

To create and operate such – "just like as" social sphere – requires a unique viewpoint and attitude. Without striving at completeness, the most important viewpoints are the following:

- Individuality: that means wording our experiences, feelings in "first person singular" and undertaking ourselves.
- Manifestation in concrete things: this means accepting the "here and now" nature of self-knowledge work.
- Honest, open attitude, accepting others.
- Emphatic – understanding attitude, that makes the transmission of feedbacks that deepen the self-knowledge of group members possible.
- Acceptance without classification, disapproval and judgement: this is the attitude that creates the safe, accepting atmosphere essential for deepening the self-knowledge process.

The above frames are indispensable for making the school application of the following methods effective.

Methods

Nowadays the aim of applying methods that need group-work at school is often in connection with the development of skills that are related to social competence. Social competence is the complex system of social motives and social abilities, habits, skills and knowledge. According to the definition of Argyle, when we are talking about social competence it means the possessing of an ability or skill that enables individuals to reach the desired effect in their social relationships (Argyle, 1983). There are several methods for the development of social competence; we will discuss some of these in the following section.

Offering models, recalling the model-following behaviour: in the majority of cases the fastest way of acquiring a skill is to observe someone (Bagdy, 1988). Modelling is an important learning method since early childhood already for the acquisition of adults' or peers' behaviour. The application of video-records is an effective method for the development of modelling behaviour and at the same time it is specifically suitable for enhancing children's interest Video-records have an important role mainly in the practicing of situations that require social problem-solving (Koncz, 1994). By using a video camera the self-presentation and communication culture of pupils' improves, the inventory of their self-expression forms enriches and it can also have a considerable self-knowledge effect and influence.

Applying reinforcement and forming, behaviour altering techniques: application of reinforcement techniques based on a rewarding and punishment, to influence behaviour towards the required behaviour. There are extensive psychological and pedagogical researches into the proper ways and proportions of rewarding and punishment. One of the most fundamental learning-theory laws, on the basis of the principle of reinforcement, is: if a person receives a reward for fulfilling a task or during this activity, the chance of repeating or keeping the rewarded activity up increases. In case of human learning, according to research results of social learning theory, the role of social reward – acknowledgement, praise, etc. – is extremely important (Carver and Scheier, 1998). The social rewarding by educators in the strengthening and forming of social problem-solving behaviour is a *critical factor* (Bagdy, 1988).

Role-play: Apart from keeping the level of activity and interest high, it provides possibilities for getting to know, repeating and practicing the ways of behaviour to be acquired. Role-plays are usually defined as impersonating,

animating, "dramatizing", activity-centred classroom activities (Bagdy, 1988). The role-play offers possibility for pupils to try themselves out in more roles, functions and situations. Role-play – resulting from its nature – often does not provide each group-member with a role. An advantage can be made from this disadvantage by making pupils who are not active players at the moment fulfil the active role of observers (Bagdy, 1988). Corresponding to the principles presented during defining the frames it is very important that the educator who directs the role-play should avoid the traditional evaluation, assessment of pupils' performance. Role-plays evoke interest from the pupils, the level of their classroom activity raises. At the same time this method provides possibility also for getting to know and practice creative behaviour forms during a social problem-solving process. (Bagdy, 1988).

Brainstorming technique: the special technique of brainstorming makes the expression of child creativity possible within group circumstances. Brainstorming techniques make the mobilization of creative ideas of the group possible in a way that they encourage pupils to explore and evaluate as many possible solutions to a problem or issue as possible. Brainstorming develops divergent thinking and aid the problem-solution-seeking, spontaneous activity of pupils by closing out the hasty critiques of creative alternatives (Bagdy, 1988). Early acquisition of the method enables pupils to realise the adequate application possibilities of the brainstorming technique later in the workplaces as well, and to apply these techniques according to the needs.

Task 4.4.1

Think of a class you have a regular weekly contact with: hold lessons, run sessions, etc. Please list some examples from your own practice of factors influencing the group dynamics of school classes. Use Task Sheet 4.4.1!

Task Sheet 4.4.1

Factor exercising an effect	**What effect does it exercise on the group dynamics of the class?**
The class is an artificially created formal unit	

School activity is achievement centred	
Classes have only a relative autonomy within the school	
Informal micro culture, formal micro culture, reference groups	
Class complement (number of pupils in the class)	
Age homogeneity	

SUMMARY

Groups have a highlighted role in personality development. School class as a unique group has definable features, the knowledge of which is indispensable for effective educational work. In this chapter first we have reviewed the dynamics of school groups, then we have shown the frames and methods of self-knowledge group work and school group work.

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KEY CONCEPTS

❖ "Empowerment"as a principle of health promotion ❖ Health ❖ Health Promotion ❖ Indicators of Health ❖ "Network ❖ Promotion" as a principle of health promotion	❖ Ottawa Charter ❖ "Participation" as a principle of health promotion ❖ Salutogenesis ❖ Sense of Coherence ❖ WHO (World Health Organisation)

TOPIC 5

HEALTH PROMOTING ENVIRONMENTS AND SETTINGS

GENERAL TOPIC:

5.1 HEALTH PROMOTING ENVIRONMENTS AND SETTINGS
Peter Paulus and Thomas Petzel

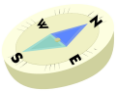
UNIQUE TOPICS:

5.2 DIVERSITY OF ENVIRONMENTS AND SETTINGS
Zsuzsanna Benkő and Erzsébet Gyimes

5.3 SCENARIOS: THE PRACTICE OF HEALTH PROMOTION IN SCHOOLS
Peter Paulus and Thomas Petzel

5.4 DEVELOPMENT OF OWN IDEAS AND PROJECTS
Mary Issitt

5.1 HEALTH PROMOTING ENVIRONMENTS AND SETTINGS



OUTLINE

In this unit, historical developments and principles of the setting approach in health promotion are introduced. The history of health promotion is illustrated by the citation of resolutions of various conferences dealing with health topics. The principles of health promotion and the conclusion that can be drawn from these principles are demonstrated by the example of health promoting schools.

OBJECTIVES

- Gaining knowledge about the historical development of health promotion.
- Reflection of scopes and methods of transferring health promotion principles to concrete settings.

CONTENT PART

Please read the following materials.

Historical developments leading to the current understanding of health promotion in settings

At first a definition of a setting will be given as a basis for the understanding of the current understanding of health promotion:
"A setting can be understood as a field comprising all relevant environmental influences, for instance towns, communities, firms, schools und hospitals. The important difference compared to all the programmes of prevention up to now is that now it is not a matter of a single intervention to reduce certain risk factors in a special system, but to introduce health as a principle of organisation. That means the intervention starts with the social system itself and changes the structures of communication, especially decisions and rules within the system. Insights and methods of organisation development have proved to be very useful."

The setting point in the health support

The Conference of Alma Ata (1978): Numerous developments concerning the concepts of health and medical care are based on the declaration which was passed at the conference in Alma Ata in 1978. Among the most important facts are:

- health is considered a basic human right, a principle that took certain aspects of medical care away from the physicians and made it a matter of politicians and professions of the legal system;
- as medical inequalities among the different sections of the population and the regions are not acceptable the strategy "Health for All" was developed;
- it was differentiated between health education and health promotion. Health education aims at individuals and groups on the base of the concepts of competence and justice of need, whereas health promotion aims at the *influences of the environment*, the physical as well as the social environment, considering the adaptation of the individual or groups to those environments.

The Ottawa Conference (1986): Above all there were two contributions of the agreed Charta, which left their marks on the future health support:

- to demonstrate the three main strategies of health promotion: (1) to stand actively for health and its representation of interests in all areas of politics *(advocating)*, (2) empowering and enabling communities and the individuals to realize their available health potentials *(enabling);* (3) mediating and networking among the different social areas and interests to promote health (mediating).
- the shifting of stressing the "medical problems of health" to *"persons with health problems in settings"*, broadening the activities from the limited medical system of health promotion to the bigger social system of the varied settings (family, school, firm, hospital).

According to the "Ottawa Charta" active health promotion requires the "development of health promoting overall politics", the "creation of health promoting environments", the "development of the competences of the individual to deal with health" as well as a corresponding "reorientation of the health services".

The Adelaide Conference (1988): The priority of the 2nd WHO conference for the promotion of health was the activation and specification of health promoting overall politics and issuing corresponding political recommendations. According to the Adelaide recommendations, health promoting overall politics "are characterized by an explicit worry about health and equal opportunities in all fields of politics, including the responsibility for its tolerability for health". The

main objective of these multisectoral politics is the supply of supporting physical and social environments in order to enable all people to lead a healthy life, respectively to enable them to choose healthier food or to make this easier. In this connection the following priority fields of action were suggested: the support of women's health; food and nutrition, tobacco and alcohol; creating a supporting environment; the development of new alliances for health and the obligation for a global responsibility for public health.

The Sundsvall Conference (1991): The main objective of the 3rd WHO conference for health promotion was the topic "supporting environments for health". The statement of the conference called upon all communities, towns, countries and governments to create such supporting environments. Other topics were "unequal health opportunities", "poverty" and "the access to a basic medical care. A further central topic was the achievement of a global obligation to account for the maintenance of health-supporting environments.

The Jakarta Conference (1997): The latest important international conference for health promotion in Jakarta led to the "Jakarta Declaration" with the title "New protagonists for a new era – health promotion for the 21st century" (WHO, 1997). Once again it acknowledged the main statements of health policy of the previous conferences and established the following priorities for health promotion for the 21st century:

- improvement of social responsibility for health,
- expanding the investments in the health development,
- establishing and expanding health co-operations,
- empowering the health-improving potentials of communities and the competences of the individual and,
- insuring an infrastructure for health promotion.

The Mexican Conference (2000): From ideas to measures

The health ministers taking part in the Fifth World Conference of Health Promotion in Mexico City and signing this declaration (1) appreciate the fact that the achievement of the highest possible standard of health effects life positively so that it can be enjoyed much more and that it is necessary for the social and economical development and equality; (2) acknowledge that the support of health and social development is a central obligation and task of the governments, participated by all sections of society; (3) take into consideration that within the last years important improvements in the field of health and the supply of health services through the constant efforts of the governments and the joint companies

have been made in many countries in the world; (4) acknowledge the fact that in spite of this progress there are still many health problems which hinder the social and economical development and which therefore have to be solved urgently to improve equality in achieving health and wellness; (5) take into consideration that at the same time new and re-appearing illnesses threaten the progress in health which has already been achieved; (6) realize that it is urgent to deal with the main social, economical and environmental facts for health and that for gaining this aim increased measures of cooperation are needed to improve health in all sectors and levels of society. (7) come to the conclusion that the promotion of health has to be a basic element of public policies and better health for all; (8) realize that there is enough proof that good strategies for health promotion are effective for the improvement of health.

Bearing in mind the above mentioned we sign the following:

Measures

A. Lay down the promotion of health as a basic priority in local, regional, national and international politics and programmes.
B. Take the leading part to ensure the active participation of all sections of society in carrying out measures of health promotion which empower and broaden the partnerships for health.
C. Support the drawing up of nationwide action plans for health improvement, if necessary by consulting the expert knowledge of the WHO and its partners in this field. These plans will be different according to the national situation, but they will comply with the basic rules, which will be agreed upon during the Fifth World Conference for Health Promotion und which may contain the following:
    - Defining health priorities and establishing health improving public politics and programmes to get started.
    - Supporting scientific research which speeds up the knowledge of selected priority fields.
    - Mobilizing financial and operational resources to build up the personal and institutional capacity for development, carrying out, supervision and evaluation of nationwide action plans.

Logo of the World Health Organisation

D. To build up or to strengthen national and international networks for the promotion of health.
E. To stand up for the fact that the authorities of the United Nations are accountable for the health effects of their development agenda.
F. To inform the president of the World Health Organisation for the purpose of the report at the 107th board meeting about the progress which was achieved by carrying out the measures mentioned above.

Task 5.1.1

Collect materials on the National Public Health Programme of your country and introduce it briefly to a delegation of foreign educator!

Please read the following materials.

The setting approach in health promotion: Conclusions for the practice

The environment people live in, work and play, includes the physical as well as the social environment. According to the definition mentioned above settings are organisations with specific structures (including the structures of power), which have specific tasks and are of different importance. Within these setting there usually are different partners with specific languages, cultures and interests (stakeholder, executives, employees and customers). These new partners often have their own agendas which include activities which only refer to health but can also be led by health. Activities led by health can take the form of health promotion in a setting or the form of "health promoting settings". Instead of a paternalistic approach ("What shall health promotion do for you?") the real health promotion puts emphasis on the participatory approach ("What can you do for yourself and how can health promotion help you with it?"). The evaluation of a setting project requires an approach which goes beyond the traditional evaluation of specific measures and includes the concept of a general accountability. This broader point of view has some consequences. Among these are:

- Appreciation of the different approaches of health promotion and education as a means of enabling human beings to deal with the dangers for their own health; to mediate between the interests of consumers and producers of health supply and to support the rights of the consumer;
- Adapting the approaches to the new partners in the different settings considering their specific agendas, "languages" and mechanisms as part of a model of health promotion through development of organisation;
- Abandoning the idea that health promotion and education are exclusively the task of those professionals and the development of a multisectoral approach with the people in the different settings for carrying out health promoting activities as part of their normal tasks using their professional responsibility and expertise according to their specific status;
- Where it is appropriate, introduction of the concept of a "health promoting setting" with all its relevant implications;
- Extension of the concept of evaluation to the evaluation of settings (evaluation of its influences, evaluation of interventions, of quality, of processes and products and measuring the results using the consumers' improvement of their health as an indicator).

Setting approach of health promotion – The health promoting school

In health promotion concepts for different settings have been developed (healthy cities, health promoting hospitals, workplace health promotion, etc.). The setting 'school' ("health promoting schools") shall be examined more closely:

"A health promoting school is a school which makes health its topic. It has introduced a process in school development with the aim to create a setting 'school', contributing to the empowering of the pupils' health relevant fitness for life and on the other hand improving the health which is related to the workplace and learning place 'school' of all taking part in school life. Paramount aim is to increase the quality of education at school".

The international experiences with this setting approach have led to systematizations so that today fields of actions and principles of this approach can be described consistently (see Table 5.1.1).

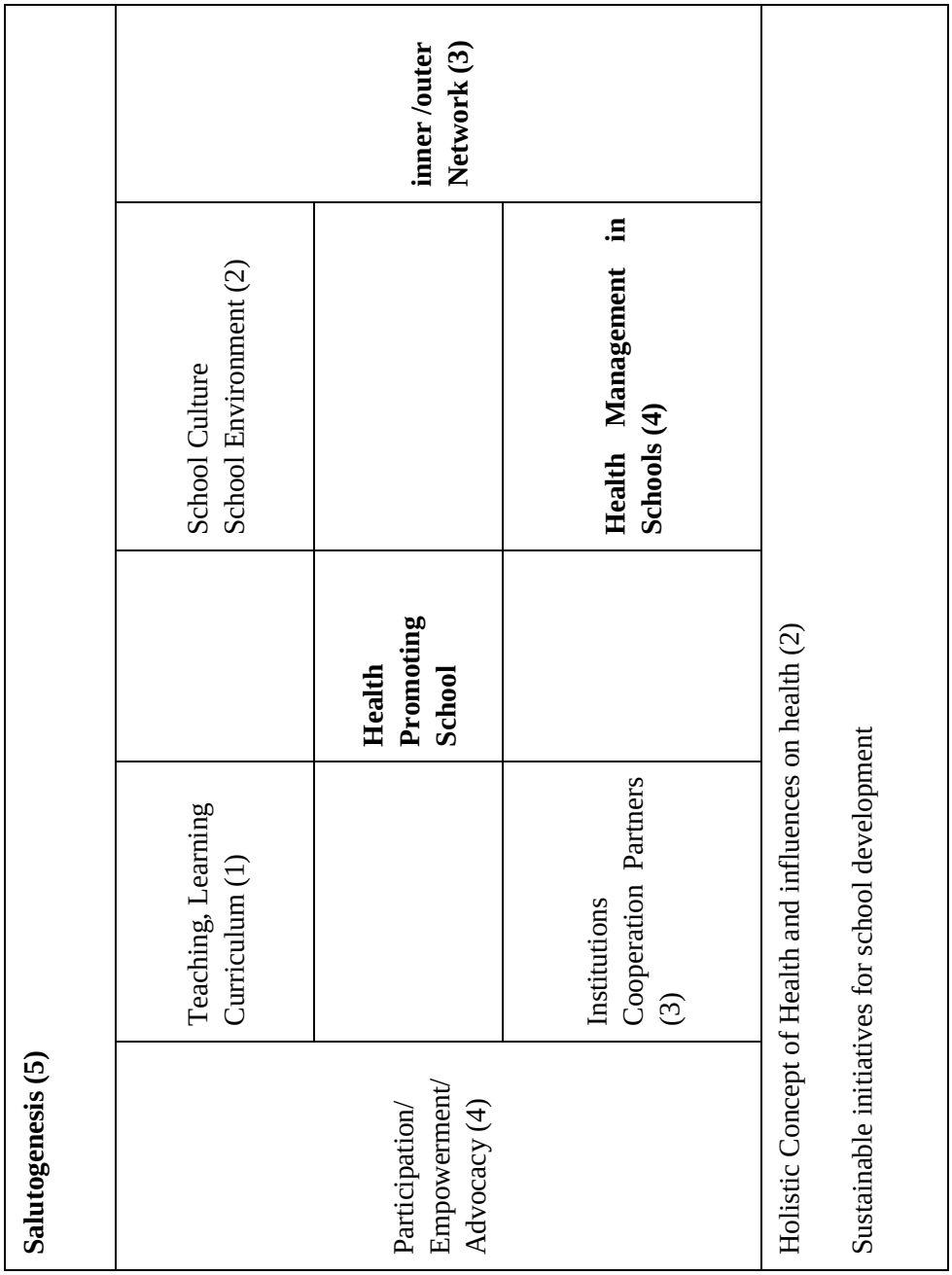


Table 5.1.1 Fields of action (inside) and principles (outside) of the health promoting school

The fields of action can be characterized as follows:

(1) *Teaching and learning*. It is not only a matter of health as a topic of teaching and learning but also a matter of health improving didactics and teaching methodology (for instance integrated learning, with all senses; exercise and learning; rhythm and teaching, significant learning).

(2) *School life and school environment*: This means health as a principle of school culture as well as a principle of building measures of schools (e.g. psycho-social climate; the schoolyard as an area for living and recreation; rooms of quietness and retreat; the classroom as a room for moving freely; light and colours as creative elements for the improvement of wellness).

(3) *Cooperation and services:* It means involving non-school partners as well as psycho-social services respectively medical services for empowering the health promotion at school (for instance school-psychological services, health departments, paediatricians, youth service, health insurance companies).

(4) Health Management at school: This means that the development as well as the use of principles and strategies is a topic at school. The school health management system is a management integrated in the school and working systematically containing different indicators of quality. It includes quality elements of quality of (a) leadership, (b) structure (c) process and (d) result (Bertelsmann-Foundation and Böckler-Foundation, 2000) which are related to one another by the perspective of "school as a working place". Important sectors are for instance styles of leadership, school culture and school atmosphere, attitude towards work, satisfaction with work and organisational learning.

The principles specified in the outer circle are briefly explained below:

(1) Sustainable development initiatives for the development of schools: Health promotion in schools is to be understood as a stimulus for the development of school. It shall be part of the school development and not only an initiating of single "events" which take place from time to time but which often remain without sustainable effect for the school.

(2) *Integral meaning of health:* In the health promoting school health is understood in a comprising way – as a further development of the definition of health of the WHO in 1948 – as a physical, psychological, social, ecological and spiritual balance of wellness. Putting emphasis on the subjective side of health and on *being* healthy shows how subjective humans are. Only the person concerned can decide about his or her well-being. One of the most important aims of health promotion is to involve her or him in measures of change and to put the experiencing person into the centre.

(3) *Variety of determinations of health:* Health is determined in many ways. It is not only influenced by the behaviour, but also by the genetic equipment, the socio-cultural facts (e.g. the educational system with the school) and last but not least the health system. And furthermore: These conditions are connected with each other and influence one another.

(4) *Self-determination, participation and empowerment:* The school decides which health problems are taken up and dealt with. It would be ideal if all different groups in the school could be involved with their wishes and expectations (pupils, teachers, parents, non-teaching staff).

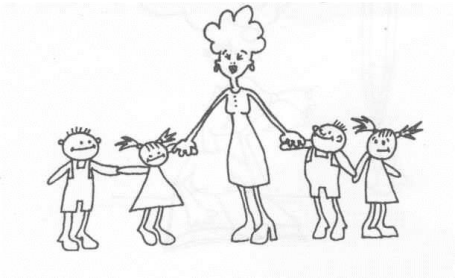
(5) *Salutogenesis:* The orientation towards the Salutogenesis as defined by Aaron Antonovsky (1997) is another central feature of the health promoting school: decisive principles are to empower human beings at school, to support them such way that they can develop and keep up confidence in themselves (feeling of feasibility), that their actions seem to have sense (again) and are valuable (feeling of making sense), that their life and what is going on around it becomes (again) understandable (feeling for comprehension).

Task 5.1.2

Choose one topic from the above mentioned! Look for materials on national webpages concerning the chosen topic and summarize your findings. Please look at websites that give a complex and professionally more valid approach to the topic.

A survey of international experiences shows that in spite of all the different preconditions the following five fields are important for a successful realisation of projects in health promoting schools (see Burgher et al., 1999):

1. *Improvement of the structural substance of the school and the school environment (action field 2):* Mending or installation of water pipes, installation or repair of toilets and washing facilities, building or conversion of schoolyards, renovation of school buildings or classrooms etc.
2. *Programmes to deal with various topics (action field 1):* food, environment & health, smoking, drugs and alcohol, multicultural society & health, sex education, AIDS-prevention etc.
3. *Building up democratic structures in schools (action field 2):* Being asked to take part actively in the projects, the pupils also learn to learn more independently, to utter their opinion more freely, to be more active concerning their relationship between teachers and mates, become more independent and free in their role as pupils. At the same time the relationship between teachers and pupils becomes more equal and the authority of the pupils' administration gains more influence.



4. *Further training for the teachers (action field 1):* The new demands through the implementation of the concept of the health promoting school had the effect on many schools that teachers were offered further training in the fields of health education and health promotion as well as in the field of communication, the activating teaching and learning methods and cooperation with the parents.

Task 5.1.3

Search your national database and look for 5 further education/in-service programmes for teachers that refer to the following values: democratic school structure, social sensitivity, increasing health competence, modern teaching methods, multiculturalism.

5. *Development of school organisation and school culture (field of action 2):* The changes caused for instance a change of break times at schools (to make sure that children get sufficient time to eat their breakfast) or that the problem of violence was discussed with the pupils and ways were mutually found how to deal with this problem.

Considerable contributions have already been yielded in the field "teaching, learning, curriculum", but there are still deficits in the field of development and implementation of effective school health-management-systems (SMS) and in the systematic planning and implementation of cooperation with external partners and services.

To put the concept of a health promoting school into practice, schools in the networks have time and again successfully cooperated with other schools partly even from other national networks as well as with external partners (e.g. police, fire brigade, communal authorities, universities, local institutions concerned with health or the environment, the public health services). The technical secretary's office of the European Network of Health Promoting Schools has time and again given valuable support to these local, national and international activities (see for instance the Transnational Network of the German Speaking Networks).

SUMMARY

Health promotion is in its essence a setting approach. To help people to change the life situations they are in a more health promoting way is the key element of all strategies. The resolutions of the international conferences on health promotion initiated by WHO reiterate it every time. They also stress that it is important to form alliances with partners from outside the setting to make health promotion an intersectoral and transdisciplinary action. The setting approach of school health promotion which evolved over the last 15 years in Europe gives a good example of this approach.

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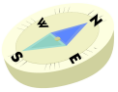
KEY CONCEPTS

❖ Health Promoting School	❖ Principles of health promotion
❖ Health Promotion Conferences	❖ Setting

5.2 DIVERSITY OF ENVIRONMENTS AND SETTINGS

OUTLINE



Health – as we have described it in the earlier chapters – covers all domains of life. Modern school health promotion / health education does not finish at the door of the class, or at the gate of the school, or at the staff room mobilizing educators or in the parental meetings motivating parents. What could be a better possibility than dealing with children in the nature, during camping. One of the fundamental requirements of modern health education is the child who is integrated into the natural – social environment. They step out of the school environment, leaving behind the usual achievement requirements schools make, but they bring their habits, examples, values, desires, characteristics and everyday culture with themselves. This is the treasury that is at the disposal of educators and their assistants prepared for the modern methods of health promotion (BSc students from the domain of health promotion or recreation, students studying social work, nursery or medical students). What children talk about during informal – but structured discussions is given on the basis of natural conditions, can be viewed, can be touched, smelled and experienced and there is also a possibility for experiencing and trying other elements of life-style out in practice, such as healthy nutrition, age specific hygiene, peer relationships, communication with adults, spending free-time in colourfully active ways.

OBJECTIVES

- In this chapter you can have an insight into the approach of modern health education. You can master those methodological principles on which you can build effective health promoting programmes.
- You can master methodological tricks that you can immediately insert into your everyday teaching practice. At the same time you also get support for the realization of longer educational activities, that need thorough preparations.
- You can get a feedback on how you can make the most of your knowledge, and approach acquired so far in the preparation of concrete practical activities!

CONTENT PART

Please read the following materials.

„Health is a dear treasure...“ – Treasure-seeking kids’ camp or A peek into the country of the treasure-seeker elves (2003)

As an integral part of our comprehensive health education programme, we present a complex topic week aiding the organisation of learning that steps out of usual school agenda and strives at making children acquire useful and experience-like knowledge through natural life situations.

This complexity refers of course to nature that is endless to almost all directions, as the topic of cognition, but not only to this; it refers also to the variety of activities induced by social time together and common experiences.

We emphasise nature and the natural environment as a setting, but it is not the usual ecological knowledge acquisition or study of the nature. Knowledge, human relationships and life-style examples scarcely or superficially known by children are emphasised, that can be of individual importance for them in their present life situations or in the future.

The programme can be fulfilled in various forms, e.g.:

Forrest school
Day-care camp
Summer play-house.

Its educational value – connecting to national and international developmental aspirations – is richer than the processing of the topic would seem at the first glance.

Given elements of the programme can be variously applied in lessons, extracurricular classes, children’s clubs and as free-time programmes, everywhere children’s playfulness, fantasy, empathy and creative activities can have a large scope: that is it can enrich everyday educational work with new perspectives, forming an organic part of new-type health education practice, effectively contributing to the innovative aspirations of schools.

The complex activity, life situations lived together, the “novel” living-space can bring such values (or **treasures** using the expression of fables) close to

the pupils that help to form their relationships, on individual and community level as well, into a basic moral principle defining their life quality.

These values – meaning the treasures of enrichment and accomplishment – develop from one another and with one another, as it is shown on the following scheme:

Values of the biological existence
(health or wholeness, physical and sensual pleasures)

↓

Values referring to the harmony of the self
(personal experiences, mental pleasures)

↓

values referring to social relations
(harmonious, consummating community relationships,
sharing the happy experience with others)

↓

values referring to social effectiveness
(active participation in creating the values of a sustainable society that lives in harmony with the environment, can be globally preserved and that is healthy)

↓

Values of the humanised society and world-concept
(experience that we can be part of natural and social wholeness as well)

We would like to contribute to this accomplishment with our programme, on the level of children.

Aims, tasks, forms of activities

Resulting from our basic concepts, (cf. Theoretical backgrounds) our main aim is to help children develop positive life skills, with a positive attitude to life. Authentic knowledge is essential to this, but applicable knowledge is more than this: the joint development of skills, expertise, competences (personal, social, cognitive) forms the basis of secure acting ability together.

On the basis of this we strive at involving each organs of sensing, providing rich experiences, processing information according to the age characteristics, providing own experiences, using the supporting force of positive and secure life-perspective.

The direction of development – if we can talk about any direction in this system-view approach – goes from sensitisation and sensibilisation together with the positive enforcing effect of emotions, through understanding and individual importance towards actual acting.

To sum up shortly: NOTICE!
GET AN INKLING OF!
UNDERSTAND!
DO FOR IT!

During working out this programme our main tasks were: to make the real charm in everyday „treasure seeking" along the health factors perceptible, liveable, and more conscious and attractive for children.

The following areas belong to the health factors:

- Protection, nursing, care (safety, like accident prevention as well)
- Environment
- Physical exercises (rhythming, concentrated work – relaxing, balance)
- Intellectual stimulation, individual performing ability, creativity
- Communication, cooperation.

According to this we have chosen life situations, "learning situations" where children can have the possibility to acquire this knowledge.

Other aspects of selection were:

Age- and developmental specificities (see later: forms of activities)
Season-specificity (here: Summer)
Features of organising learning (forest school, day-care, camp, dimension of being set or open)
Curricular programmes, developmental tasks.

Preferred forms of activities

Emphasis on methods that move children's fantasy and promote discovery seems to be evident within the more flexible and open educational frameworks.

To strengthen the playful nature of the programme, we have chosen several activities that are not customary. Our aim was to call attention.

(Children can further enlarge the set of activities during the time spent in the camp, using their own ideas.)

Task 5.2.1

Analyse the possibilities of a free-time health-project that is related to nature in your own school with the help of the system of aspects for planning a project presented in **Task Sheet 5.2.1**.! You can think in terms of the whole school, or in your own class as well.

The followings might help you in completing the task:

- If you go over the following chapters from the course material:
  1.1 Introduction to Health Promotion (modern approach to health)
  3.1 Making Health Promotion Happen topic and 3.4 topic (health promoting projects)
  4.1 Skills and Skills-Development topic and 4.4 topic **(**group-dynamics and communication skills development)
- If you use the annexes of the chapter
  Annex 5.: Health promoting sample project
  Annex 6.: Forms of activities used in the project and their possible experience and value contents

Task Sheet 5.2.1

– A SYSTEM OF ASPECTS FOR PLANNING THE PROJECT –

1) TARGET GROUP

ASPECT	**ANALYSIS OF THE ASPECT**
Who belongs to the target group?	
What is the age set-up of the target goup?	
Do they have experiences that could influence the planned project?	
What is by all means worth taking into account from the natural and social environment of the target group?	

2) SETTING THE OBJECTIVES

ASPECT	**ANALYSIS OF THE ASPECT**
What could be the short-term objective of the project?	
What could be the long-term objective of the project?	
Why could this project be important for me?	

3) RESOURCES

ASPECT	ANALYSIS OF THE ASPECT
Where could I realize my project?	
When could I realize my project?	
Who would I involve into the realisation of my project for sure?	

4) METHODS

ASPECT	ANALYSIS OF THE ASPECT
What methods could *I* use to meet the project objectives?	
What methods my *fellows* could use to meet the project objectives?	
What other methods are needed for the effective realization of the project?	

5) MISSING RESOURCES (financial and human)

ASPECT	ANALYSIS OF THE ASPECT
Are any other resources needed to be able to use all the listed methods?	
If yes, how could I ensure these resources?	

Task 5.2.2

With the help of your analysis prepared on **Task Sheet 5.2.1**. work out the plan of a free-time health project that is connected to nature!

SUMMARY

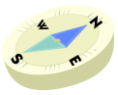
Modern school health promotion work can also be carried out outside of school. An educator who is methodologically well-prepared should be able to provide a child with developmental possibilities outside the school environment as well. That is why it is important to know those methods through which pupils can collect experiences on healthy life-style according to their age characteristics, by using their sense organs intensively and through own experiences. The communicational repertoire, the stronger peer relationships and the "hidden hints" provided for an active spending of free time contribute largely to the strengthening of mental and social aspects of health.

KEY CONCEPTS

❖ Health education ❖ Learning from experience	❖ Values related to health

5.3 SCENARIOS: THE PRACTICE OF HEALTH PROMOTION IN SCHOOLS

OUTLINE



The activities for health promotion in schools have different focuses. Each measure, with the hope of an increase in the well being of all school participants, can be considered as health promotion. Definite starting points for health promotion can be found on many different levels. In this part of the module we will present several specific examples of activities for the promotion of health in schools in order to acquire an impression from the existing possibilities. Of course, the goals and applicable measures suitable for each specific school depend on the given circumstances of that school. Expensive modifications to school buildings and rooms are really only possible for schools with strong social support. Nevertheless, health promoting measures can be implemented with relatively little financial support, which requires the corresponding commitment of those involved.

OBJECTIVES

- Experience the diversity of health promotion in the school setting.
- Experience the determination of health promotion by determinants of the specific setting of each school.

CONTENT PART

Please read the following materials.

Example activities for health promotion in schools

The school activities presented in this paper come from the following areas in health promotion in schools:

- Strengthening of physical well being (dealing with stress): relaxing, physical activity, experience with the senses at school
- Basis for health: nutrition at school
- Creating environmental requirements: buildings and school yards
- Supporting social life: conflict mediator program
- Strengthening of personality
- Prevention: danger of addiction
- Cooperation with partners from outside school

5.3.1 Gesamtschule Wanne-Eickel (Combined school): Conflict mediator program

Teachers' impression that they were being more and more often confronted with disputes and other disciplinary occurrences, rather than having to deal with academic difficulties, lead to the establishment of a conflict mediator program at this school. In 1996 a further education event was held on the topic "Violence in Schools", which was later followed by the establishment of the conflict mediator program. The school has stated, "This project is about strengthening the awareness of pupils, and also teachers and parents, for their responsibility for themselves and for others. Therefore, for us a 'healthy school' does not simply mean physical well being; but rather, we understand health in the widest possible definition as a unit, which includes psychological and communicative elements. Thus, it is also our goal, along with the measures for physical health promotion [...], to support pupils' abilities to treat themselves and others without violence."
(http://www.learn-line.nrw.de/angebote/gesundids/medio/praxis/sucht/zoff.html, 20.5.2003).

A so-called "body room" was set up for self-affirmation and relaxation training (as well as a reflection part with discussions on topics like relaxation, role-plays, etc., and also romping and playing space to release contained aggression. Furthermore, a conflict mediator project was established in the school. The program requires that all pupils in the fifth or sixth levels first take part in a "basic training program", which strives for better conflict and problem solving skills, more tolerance toward diversity, increased empathy, better self assertion and self control. These questions are then re-examined in different subjects later on in further levels. Pupils can act as conflict mediators beginning in the 8th level. They will learn how to guide mediation discussions. In specific mediation discussions they should make sure to follow the established rules of discussion. The persons in conflict are offered the possibility of presenting their view of the conflict and understanding the other's presentation. The persons in conflict should develop their own solution for their problem.

The school describes the activities and plans at present in the following: "So far, pupils from the 5th and 6th levels are being advised. The conflict solution basic training is an established one-week project with 2 hours daily, in which pupils also learn how a conflict medation discussion is carried out. During the lunch break the mediators are available for the 5th and 6th levels and are relieved of their usual lessons during that time. We have established a rotation system, so that the mediators do not miss too many classes. Since mediation requires two mediators, at least 16 pupils are needed to meet the demand. The training takes place in the second part of the 8th level in two mediation courses, each with 16-18

pupils who are taken out of lessons for one hour a week. [...] The actual mediation activity begins then in the 9th level."
(http://www.learn-line.nrw.de/angebote/gesundids/medio/praxis/sucht/zoff.html, 20.5.2003).

5.3.2 Konrad-Adenauer-Hauptschule (secondary modern) Wipperfürth: "Zoff dem Stoff" ("Fight the Stuff")

A project concerning addiction prevention was completed on the Konrad-Adenauer-Haupschule in Wipperfürth. On one hand, information about drug addiction was given to youth and parents in cooperation with the area police department; on the other hand, "party fun without drugs" was the goal of a pupil-disco. The cooperation with the responsible director of police was received positively, as was the work with other out-of-school partners, like other area Realschulen (secondary modern schools), the youth office, the state sports association and two addiction counseling organizations. The work between different classes and subjects on the topic of drugs was also seen as having a positive effect on the project. The project even became a fixed element of the school program and lessons. The many participants also judged the project in a positive way and indicated interest in a repeat of the project. It also received attention from local newspapers, which published articles about the project.
(http://www.learn-line.nrw.de/formulare/beitragview.php3?beitrag_id=210, 20.5.2003)

5.3.3 Pestalozzi-Förder (Support) School Brühl: "Fit Kids" – The Breakfast Company

On the Pestalozzi-Support School there are numerous activities with the goal of health promotion in mind, as on many other schools. An exceptional program has been underway since 2001/2002: a pupil company in which pupils, with the help of teachers and volunteer mothers, offer a healthy school breakfast to their classmates. The initial starting point for the project was the observation that many children came to school without having eaten breakfast. These same pupils seldom had snacks or sandwiches for the break. Then, in the course of the morning they would eat sweets instead of healthy nutritious foods. According to teachers, this leads to lower resilience and influences learning activities, while increasing susceptibility to sickness. Other effects also include overweight and limitation of movement. Therefore, this healthy breakfast has been offered since November 2000 once a week. In November 2001, the pupil company took over responsibility. In addition to the positive effect of a healthy breakfast, the pupils working in the company learn to take responsibility for activities in home

economics and business areas. This can help build and strengthen their personalities. Another positive aspect of this project lies in the opening up of the school through cooperation with out-of-school partners.

According to information provided by the school, the weekly breakfast is becoming very popular among the pupils. Teachers, other school staff and parents all agree that it is a positive project. An expansion to two days a week is in progress; so far it could not yet be realized due to lack of time resources.

(http://www.learn-line.nrw.de/formulare/beitragview.php3?beitrag_id=224, 20.5.2003)

5.3.4 Franz-Dinnendahl-Realschule Essen

Since 1993 measures toward health promotion have been a part of school life on the Franz-Dinnendahl-Realschule in Essen. Within the framework of a set of broadly established health promotion measures, a weekly two-hour back and spine training (10 weeks total), for example, was offered. Although this activity was offered outside of the normal lesson periods, pupils expressed satisfaction with the project. According to a school report on this activity, it is "important to note that despite a late lunch break and even having to wait after regular lessons the pupils gladly participated in this event. 85% responded that they had 'learned something new' in learning other movement and activity possibilities".

(http://www.learn-line.nrw.de/angebote/gesundids/medio/praxis/bew/rueck.html, 20.05.2003).

Obviously the teaching of these exercises has had a lasting effect: Three months after the back and spine training pupils still possessed deeper knowledge of the kinds of exercises that were presented and practiced and how to perform them. 85% of the pupils questioned responded that they had also used the exercises outside of the course. Furthermore, results from the back and spine training showed how corresponding measures could be integrated into the school's daily activities.

5.3.5 Neuenheerse Catholic Primary School: A great schoolyard for all

A long-term plan has been developed and put into action on the catholic primary school in Neuenheerse since the beginning of 2001 for remodeling and improving the school grounds. The school wishes "that the children open up to their environment. They should be able to observe, explore and experience"

(http://www.learn-line.nrw.de/formulare/beitragview.php3?beitrag_id=162, 20.5.2003).

The requirements, however, seem challenging: The school yard offers only "few incentive as a learning and feel-good place." Furthermore, potential places for playful activities for the children scarcely exist. The traditional "Town and Environment Day" held at the school provided an occasion to change this unsatisfactory situation. According to the school's statement, the grounds were to "become a comfortable and stimulating learning, playing and living space [...] through team planning and work. The school should become better connected with its close environment"
(http://www.learn-line.nrw.de/formulare/beitragview.php3?beitrag_id=162, 20.5.2003).

Since activity has begun, flowerbeds have been regularly created and tended, the schoolyard has been cleaned, walls painted, etc. Moreover, new playing apparatus has been put up. Not only have teachers and pupils assisted in these actions, but there has also been cooperation with out-of-school partners, for example with a forest warden, a garden centre, a local bank or a paint supply shop.

The completion of these activities has been very positively received in the school. Now the schoolyard is friendly and is tended to by both teachers and pupils. New elements in the schoolyard (such as sunflowers) offer occasion for new ideas and topics in lessons. Other town residents enjoy the schoolyard as well (afternoons it is widely used), fulfilling the hope that the schoolyard "become an integrated part of town life". A further result the school has observed is that it is possible to carry out extensive renovations on a rather small school. This has motivated the school to implement further projects in the future.

5.3.6 Realschule Jöllenbeck: School remodeling

Health promotion is an integral part of the school program on Realschule Jöllenbeck in Bielefeld. During participation on a pilot project to school health promotion (GimS), "Gesundheit in und mit Schule" (English: Health in and with schools) numerous renovation measurements were taken. The purpose was to create playing and physical activity opportunities, especially for younger pupils, and to establish a quite zone and "feel-good spaces", a healthy breakfast for the break, as well as strengthening the pupils' personalities. A rarely used schoolyard area was transformed into a green classroom; an exterior wall became a climbing wall. Furthermore, a cafeteria was built inside the school. At the start of the renovations, the schoolyard consisted of a huge asphalt surface, unused grass areas and a sports field in need of repairs. Like on many other schools, many Jöllenbeck pupils came to school without breakfast or a snack for the break and tried to satisfy their hunger with sweets. Therefore, the first project was to take on

the planning and establishment of a cafeteria. "With the enormous involvement of a work-group class, a number of GimS members, parents, the custodian and a small amount of money (1200 €), the unused dreary school hall was transformed into a colorful cafeteria, a place to feel good. The pupils often go there now" (http://www.learn-line.nrw.de/formulare/beitragview.php3?beitrag_id=134, 20.5.2003).

As on other schools, the success of the first project on the Jöllenbeck school motivated the participants to take on more renovating and remodeling projects. The next project was to renovate the schoolyard. Valuable planning was achieved by including out-of-school partners and experts (Landscape architects, park authorities, school administration offices and the district authority), who also considered the pupils' interests. Security requirements were kept by consulting with the fire department and with the responsible community accidence insurance association Westfalen-Lippe. Out-of-school partners and, of course, the hands-on assistance from pupils, teachers and parents, made the school renovations possible. An external evaluation by the Institute for School Development Research on the University of Dortmund (www.ifs.uni-dortmund.de) was able to confirm the success of the measures taken: The play and physical activity opportunities received good notes from the pupils, as did the cafeteria, which is used by two thirds of the pupils at least once a week.

Task 5.3.1

Make an Internet search! Which programme(s) of the WHO Health Promoting Schools Network can you find referring to your own country? Please collect these programmes!

SUMMARY

Several examples of school health promotion in the school setting were presented. It was obvious that the setting approach relies on the needs of the schools itself and that the health promoting activities are depended on the actual opportunities of the school.

REFERENCES

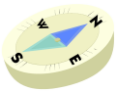
References are mentioned at the end of each model of practice

KEY CONCEPTS

❖ School health promotion	❖ Models of practice

5.4 DEVELOPMENT OF OWN IDEAS AND PROJECTS

OUTLINE



So far in this module you have been introduced to the very wide range of activity that is health promotion. This section of the module gives you the opportunity to work out how you want to put your learning into practice and test out some of the ideas that you have learned about in the earlier modules. This involves you in reviewing your learning so far in order to identify the kind of health promotion activity would be useful for your own setting. You will also have to complete an assessment that shows what you have done.

OBJECTIVES

- Summarise the key aspects of your learning,
- Think about your work setting,
- Work out what you can do best,
- Think about how this relates to your own learning needs and interests,
- Do a brief outline of what you propose to cover.

CONTENT PART

Please read the following materials.

Aims, tasks and activities:

Go through each chapter of the module
1. Summarise the key aspects of your learning in terms of

- Any theory that you want to try out in practice;
- Any resources that you felt were particularly useful;
- Any exercise that helped you in your learning or that you would like to try out yourself, adapting it to your own context;
- The information and resources that you have already collected, any reading you have done etc.

Task 5.4.1

See the above figure! What is he thinking about?

2. Think about your work setting. In Chapter 3.4. you were introduced to project management and the processes involved. In this chapter we have given some examples of the way health promotion can be developed in particular settings:

- List the kinds of health promotion activities that you would like to try out.
- Prioritise these in terms of :
  – What particularly interests you?
  – What you think would be most useful?
  – What it is possible for you to undertake?
- Is there any particular emphasis that you think the activity should take? For example are you interested in doing something that relates to skills? Do you want to do something that helps you develop a policy? Do you want to begin a new activity or exercise on a particular topic, for example, healthy eating? Do you want to undertake a small research project?

3. So that you can work out what you can best do you will need to discuss your initial ideas in your study group or with your tutor, and with the appropriate people in your setting. You will need to get their support. Also, they may have other ideas that would also interest you and in which they would like to be involved.

4. Think about how this relates to your own learning needs and interests in relation the review you completed in 1 above.

5. Once you have selected your idea. Do a brief outline of what you propose to cover:

- The nature of the activity;
- The timescale involved;
- Resources required;
- Identification of any issues concerning health and safety of anyone who may be involved in your project;
- Potential benefits to any target group or agency;
- Benefits for your own learning;
- The methods you envisage using to carry out your project;

- The support needed from your tutor, learning group and from your work setting;
- Your plans for documenting the work that you undertake;
- How you will evaluate your project;
- Any other important things that occur to you.

6. You will now need to get the agreement for this activity from a senior person in your practice setting and from the module tutor. The feedback that they and other colleagues give may mean that you will need to modify your ideas. They may also want you to do a report on your project for your work setting in addition to the assignment you are completing for this programme of study.

7. The next stage is for you to:

- Work out exactly what you want to do;
- Ensure that you have evidence of any necessary permissions and compliance with any health and safety requirements;
- Decide on the timescale;
- Finalise the methods you will use;
- Put in place your evaluation strategy;
- Make the necessary arrangements to support your work and your learning.

  Summarise this in an agreement that can be signed by your tutor, a representative from your practice setting and yourself.

8. It is also important for you to negotiate at this stage what form your assessment will take. Will you produce a

- Report on your work?
- Portfolio that documents your activity?
- Combination of these?

  Perhaps you will try something different, but you need to negotiate this with your tutor. The agreement you have made will provide a useful means for you to check your progress with your project and help you structure any assignment that you do.

9. As you complete your project you will need to keep careful records of what you are doing as well as relevant documentation. This will include:

- Relevant information e.g. leaflets, articles, publicity for project;
- Records of meetings briefly describing the aims and objectives, process and evaluation of what the meeting achieved;
- Records of discussions with relevant people in your practice setting;
- Records of meetings with your tutor and learning group;

- Plans/programmes for activities undertaken, sample materials developed and used;
- Evidence of outcomes of the project;
- Any useful material including audio visual.

10. You will need to select the most relevant material from this when you come to complete your final assessment for your project, as agreed under 7 above.

SUMMARY

Now that you have read these guidelines you should be able to begin to develop your own ideas and projects using the health promotion materials that you have been working on throughout this programme. You now therefore need to:

- Review your learning to identify what interests you and what you want to focus on.
- Negotiate a project that you can carry out in your practice setting.
- Identify how you will record your work.
- Decide on the best form of assessment for you to undertake.

TOPIC 6

EVALUATING AND USING SOURCES OF INFORMATION

GENERAL TOPIC:

5.1 EVALUATING AND USING SOURCES OF INFORMATION

Peter Paulus and Thomas Petzel

UNIQUE TOPICS:

5.2 SOCIAL AND MEDIA INFLUENCES

Kl§ra Tark· and Zsuzsanna BenkŖ

5.3 HOW TO BE A CRITICAL USER

Mike Singleton

5.3 RESOURCE BANK

Peter Paulus and Thomas Petzel

members' sharing of perceptions and opinions, at the same time the individuals must take over norms and attitudes which are accepted by that society in order to behave successfully in it. Therefore social factors influence the individual perceptions of health relevant attitudes and corresponding behaviour. Growing up in a specific social environment leads to the adoption of already existing norms and structures.

Types of mass media

In a preceding sub-module (Unit 3.3) it has already been discussed to what extent subcultural differences have to be considered when planning health promoting measures and carrying them out; in the present module emphasis is laid on the consideration of overall social influences. Among the relevant factors in this connection are especially the media and mass communication. These have got an ever increasing importance in modern society. In the age of the information society it is above all television and the internet which have a strong influence on the knowledge, attitudes and patterns of behaviour of individuals. Many of these influences are not even noticed by the individuals, but develop without the control of a conscious reflection.

Mass media influences

With the influence of the mass media various anxieties are connected which refer for instance to a possibly growing readiness for violence. This anxiety is based on the widespread assumption that violent contents in the media serve consciously or unconsciously as behavioural models for individuals who are more or less voluntarily exposed to these contents. Apart from these often discussed effects of the media which refer to especially obvious problematic phenomena, there are various further influences which - as well as the phenomenon of an increased readiness for violence - are also important for health promotion.

Overview of content

This concluding module deals with such influences and with a critical treatment of the sources of information concerning health relevant topics. In the introductory part some selected insights of the media effects research will be presented and discussed in regard to their importance for the field of health promotion. This topic will be closely analysed in the following sub-module 1. Sub-module 2 deals with the question what conditions there should be for a positive, critical treatment of the contents of the media, respectively how the individual competences can be empowered for such a treatment. In sub-module 3

some sources of information will be introduced which deal with topics which are relevant for health and health promotion.

Relevant factors

Ideas concerning health and health promotion have changed very much in the course of time. One example of such changes are the changed ideas about ideal body measurements. Scientific research has presented numerous proofs that socio-environmental conditions have a strong influence on the individual attitudes and patterns of behaviour. In general, basic social influences have to be mentioned here:

Interculturalism and history

Health relevant knowledge and corresponding attitudes and patterns of behaviour are for instance interculturally different, but they also depend on historical developments within a society as well as on the particular socio-cultural environment.

Individual differences

There are individual differences as for example in dependence of belonging to a specific social class or the educational level.

Socialisation

Attitudes and behaviour which are regarded as norms in a specific environment are passed from one generation to the next by processes of socialisation respectively of enculturation. Parental preferences as far as the practises and aims of education are concerned have an influence on the health and health relevant behaviour of the children. If the social conditions change, consequently the ideas about health change as well. Scientific revelations contribute to such a change (for instance physiology, medicine and psychology) as well as fashion trends.

Fashion trends

An example for the fashion trends is the change of the image of an attractive appearance: ideals of beauty are spread by the mass media in the first place and can lead to a change of health relevant behaviour (for instance eating habits, the value of sportive activities). The ideal of beauty which is given by the mass media is regarded as one of several factors which contribute to the increasing frequency of eating disorders especially among young women, but also increasingly among young men. Especially in recent times commercial interests as well as informative intentions play an important role for such changes: The health respectively the

wellness sector has developed to an important economical factor. On the whole the change of life-styles goes along with the changes of health relevant behaviour but is in itself dependent on social e.g. economical conditions.

Peer group influences
In addition to the social influences there are especially the norms in peer groups for adolescents in which social pressure is applied to nonconformist behaviour of individuals. (cf. module 4c)

Leading influence of television and Internet
In the recent decades the mass media played an important role in the forming and change of ideas about health and health relevant behaviour. Today it is above all the television and the internet which strongly influence health attitudes and corresponding behaviour patterns. Such influences are being discussed on several levels: On the one hand one can assume that there is an unintended influence: specific presentations and topics which are spread by the media are absorbed by the individuals and integrated into the individual construction of reality. The "cultivation hypothesis" for example considers the individual differences referring to specific attitudes to be more or less uniformed by the enormous consumption of the offers by the media. Although it should be expected that individuals systematically develop different attitudes because of varying education and socialisation conditions, different family background, and individual life experiences, the "cultivation hypothesis" assumes that an intensive reception of identical media contents leads to an equalizing perception of reality. Presumably health relevant attitudes and behaviour patterns are also directly or indirectly concerned by this process. One has to assume that the already mentioned body ideals which affect the status and popularity of persons are perceived in the same way and are regarded as being worth striving for by actually very different recipients.

Life skills
The "life skills" mentioned in module 4 are affected as well: The perception of specific kinds of interpersonal behaviour and strategies of solving a problem goes hand in hand with an adjustment of one's own patterns of behaviour. An essential effect which would have to be expected according to the "cultivation hypothesis" is the limited range of individual repertoires of behavioural patterns.

Conscious media campaigns

Another aspect is to influence the recipients on purpose. Already since the 1930s mass-medial messages have been used to influence attitudes and patterns of behaviour of individuals specifically. Starting point of these attempts was the field of political propaganda, but in the following decades the possibilities were also discussed in other socially relevant areas to influence individuals by a specific presentation of information. The classical idea of health education is based on such a corresponding level: Media campaigns were developed and used against health damaging or for health improving patterns of behaviour to give health relevant attitudes and behaviour of individuals the direction wanted. However, such campaigns turned out to be effective on a restricted scale only.

The Agenda-Setting theory assumes that anchoring specific ideas in the individual conscience is achieved by covering these topics increasingly. According to this theory the subjectively perceived importance of topics is directly connected with the frequency of their coverage. Therefore the rating which individuals grant health topics depends on the extent to which these topics are covered by the media.

Passivity or activity?

The direct and indirect influences which have been described so far are essentially determined by contents which are offered by the media whereas the recipients are seen in a passive role: They are more or less exposed to the influences of the media to a more or less great extent, and according to the understanding of these theories and models their own experience and behaviour is directly or indirectly influenced in reciprocal action with their existing knowledge and their individual attitudes. In addition to these ideas a further group of theories concerning media effects focuses on the active role of individuals when consuming media contents. Such theories and models are subsumed under the title of the so-called "uses-and-gratifications"-approach. They assume that individuals choose and consume specific media contents actively. The choice of the contents is defined by the individual interests which are connected with the use of the media. Referred to health promotion this means that persons whose interest has been aroused for health relevant topics, will for example actively start looking for television programmes or internet pages offering such information.

Therefore it is quite sensible if media offers (television programmes or internet offers) are devised and offered without direct "educational" intentions. Especially for the internet it is valid from the start that the offers are not devised do attract uninterested people to a specific topic. Like for other offers it also applies for internet

homepages concerning health relevant topics that they are nearly exclusively visited by those people who have already developed an interest in that topic.

Be conscious about resources!

An overview of the resources and institutions which supply relevant information for the field of health promotion is offered in the concluding sub-module 3. In this sub-module some guidelines will also be discussed for the critical treatment of such offers.

Task 6.1.2

Please highlight at three things from the past 3 months that influenced your health concept the most through the media!

SUMMARY

This introductory chapter presented an overview on current knowledge concerning influences on individuals' perceptions and behaviour. Mass media, scientific knowledge, fashion, trends and norms in peer groups are mentioned. Some theoretical conceptions are introduced to explain these influences ("cultivation hypothesis";" agenda setting theory"; "uses-and-gratification"–hypothesis") Consequences for health promotion activities are discussed.

KEY CONCEPTS

- Mass Media
- Mass Communication
- Media, critical use

6.2 SOCIAL AND MEDIA INFLUENCES

OUTLINE

In health promotion there is sometimes a need for transmitting messages to the different strata of society. These messages, indirectly or directly, are related to health, healthy life-style. At the same time, messages transmitted by mass media are not always positive in terms of health promotion. Mass media thus interacts with the health promotion activity, can enforce or weaken the efficiency of interventions.

In this chapter first we process the general models of communication, then we touch upon the characteristics of mass communication. After defining the concept of mass and communication we will review the features and genres of mass media. Finally we will analyse the effect media exercises on the society and the relationship between the media market and health promotion.

OBJECTIVES

- In this chapter you can study some key elements of the manifold connections between mass media and modern society.
- You will be able to identify some aspects along which the efficiency of transmitting health-messages can be analysed.
- You will have a picture on the form health appears in the media market, in which You are also influenced.

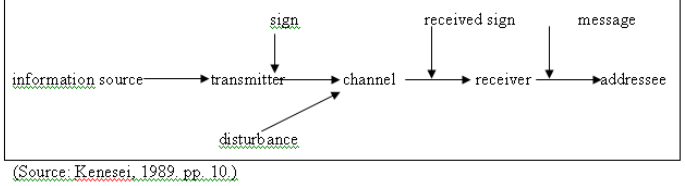
CONTENT PART

Please read the following materials.

Introduction

According to the classical notion, we can depict communication as the connection between different factors. According to W. Weaver we can plot the following model (Figure 1.):

Figure 1. *The elements of communication*



(Source: Kenesei, 1989. pp. 10.)

An other approach says, communication is like transfer, where instead of objects or goods, information is carried to the right places. Information always has a real, physically existing carrier.

The third notion examines it from the viewpoint of the addressee: An event is considered to be a message, communication if we suppose the experienced thing is standing in place of an other thing, refers to something else too apart from itself and it is the result of an intentional activity.

Components of communication

Summarised by Buda Béla (1994) the components of communication are the communicator or deliverer; the receiver; the content; the code; the communication situation; and the context. Communication happens in a social situation, in socially set conditions. Human behaviour follows social regulations, norms or rules mainly.

The role-theory

Actual effect and social function of norms is expressed by a special branch of the set of norms, the role-theory. The role is the complex of norms applying to a person in a situation or in the interaction. Each role is connected to a definite situation that the personality adopts in the system of social relations that is the social status. Communication is also defined in the roles – in given societies and in certain roles it is defined who can start the communication, what form it should take, which contents can not be included and what content should be presented. Socialisation in its sociological sense means learning the roles. Membership in the culture and in the subculture, the social stratum, belonging to a local community and to the reference-groups and the unique micro-milieu of the family-group define the norms and roles in a sociological sense and the context of direct communication through these. This so called normative model is supplemented by the interpretative paradigm or ethno-methodological model, according to which people entering into communication interpret and define the situation themselves.

Channels of communication

Communication channel we call every element of human behaviour that serves communication exclusively or primarily. Human communication can happen

through several channels. Each communication channel takes part in direct human communication. The taxonomic subdivision of communication channels are as follows:

A) Verbal channel
B) Non-verbal channels
    1) Mimic communication
    2) Communication by look
    3) Vocal communication
    4) Motional communication channels
        - Through gestures
        - Postural communication
        - Proxemics
        - Kinetic communication
    5) Emblems
    6) Cronemics

The present chapter does not intend to study the concept and scope of direct human communication further. A broader and more detailed theoretical overview can be found in Buda Béla (1994). Our aim is to summarise knowledge related to mass communication and to study its role in health promotion.

Mass communication

Our theoretical summary is based on the book of McQuail (2003) that is widely used in media education throughout the World. Mass communication can be considered as one of the communicational processes embracing the whole society. In the expression 'mass communication' mass refers to a huge amount or expansion; communication is providing and understanding a meaning, transmitting and receiving messages. Mass communication is not the synonym of mass media that is the technical realisation of information transfer. It is voluntary, and is shaped by the requirements of culture, life-style and the social environment. It is rather an idea than reality. It denotes such a condition and process that is possible in theory, but can only rarely be found in its pure form (similarly to Max Weber's concept of ideal type).

Features of mass communication

Characteristics of the process of mass communication are the large-scale circulation and receiving, the one-way flow, the asymmetric relationship to the receivers. Mass communication itself is impersonal and nameless, anonymous, politic, or builds on a market relationship and its content is standardised. Its

„reader" is the mass audience, which has a big complement, and is widely scattered. Members of the mass audience usually do not know one another, or rather the creator of the audience does not know them either. It is not interactive and it is nameless (anonymous), heterogeneous, every social stratum and demographic group is represented in it. It is not organised or an independent actor.

Mass culture

Mass culture in a broader sense is the taste, preferences, manners and style of the masses. It is often pejoratively understood, relating it to the presupposed preferences of undereducated, polyphagous, lower social classes. The expression is effete and the application of the expression 'popular culture' is more common, denoting what is preferred by many or by most of the people. It means what is popular among young people mainly.

Summing up the characteristics of mass culture: its beginning was at the '30s. It is predestined to reach many people, it is not traditional, not elite, it is a mass production, popular, commercial, homogenised and the different concepts of cultural value are strongly attached to social class differences. It is the big aggregation of more or less nameless consumers. The transmitter is often the organisation itself or a professional communicator with wide sphere, prestige or professional knowledge. Relationship between the transmitter and the receiver is mainly one-sided, impersonal, asymmetric, anticipatory and manipulative. The communicational content is not unique or creative; consumption goods. The reception is unique: the audience is the aggregation of scattered, passive viewers who do not have a possibility for real answer or participation. The viewer is part of a big group and has little contact to its fellow viewers.

Mass media

Mass media includes those wide-scope communication devices that reach and affect almost all members of the society to a lesser or greater extent (newspaper, magazine, film, radio, television, phonograph (recorded music), Internet). It is important because it has a universal scope, it is popular, public, it is important on the domain of politics, culture and economy and it is connected to the most fundamental questions of the society. Elements of the mass media institution are split by the type of technology, change in time, and are different by countries. The mass media institution is in the "public sphere" and has large-scale freedom. It does not have formal power and participation in it is voluntary.

Media depends on the society, though it has some independent scope. The relationship is dependent on time and place and is determined by the social

contexts – structural differences between social classes/stratums, economic and cultural differences, and the historical experiences, values, political-social conflicts. "Mass media" refers to those organisational means through which it is possible to communicate openly, afar, for many receivers, in a short time. It has gone under continuous technical development from the pictographs till the digital forms. Definite communicative aims, needs or applications are attached to it. It can have the following forms along the different technologies:

1. Printed media: the book and the library – The book as a medium is the technology of portable letters. It consists of pages bound together, it can be published in many copies and it has the form of a commodity. Its content is complex (profane content). It is characterised by individual utilization and the freedom of publishing. The library as the collection or storage place of printed books has an important informative function.

2. Printed media: the newspaper – The characteristic of the newspaper medium is the regular and frequent publishing. Similar to the book, it takes the form of a commodity also. Its content is informative, serves public functions and its main target is the urban, secular audience. It has a relative freedom. Its main types are: political paper, prestige paper, commercial paper.

3. Film as a mass medium – the film medium is based on audiovisual technology. Open performance that has a wide (universal) scope. It transmits narrative fiction mainly. It is of international nature and it is under strong social control.

4. Broadcasting ï radio and television – Television is the most multitudinous medium. It is characterised by many and manifold offer of products and by a wide scope. It plays a decisive role in modern politics. This can be considered the major news and information source that the audience considers to be reliable and creditable. It has an important benefit in education and the television is the largest advertisement channel. Its content is audiovisual, complex technology and organisation is in the background. Its nature is public, and it is under national and international overall regulation.

5. Recorded music ï Ăphonogramò – The bases of recorded music (phonogram) medium are the various recording and transmitting technologies. It is under low regulation and it is strongly international in nature. It is primarily for the younger audience. It has a huge upsetting potential, ability. It is characterised by organisational diversity and the variety of receiving possibilities.

6. New electronic media – They repose on two main innovations: satellite broadcast; utilisation of the computer (digitalisation). Computer-based techniques (for example Internet), with high interactive potential. They are equally suitable for serving private and public functions as well. They are under low regulation, and their important feature is being linked and the ability to be linked.

Early views on the media and the society

The basis of the belief in the power of mass media is the wide scope and visible effect of the media. The view that the propaganda which is directed at the masses is an important tool of forming opinions and behaviour, became accepted and established before the middle of the last century already.

There were huge changes throughout the World at the end of the 19th century and at the beginning of the 20th century. Slower, traditional, community way of life was replaced by the faster secular, urban way of life, and the scope of social activities was strongly enlarged. Crime, prostitution, being outcast and dependence were contributed to the increasing impersonality, isolation and uncertainty of modern life. It was stated, that the newspapers, the film and the other forms of popular culture has to do with crime, moral perdition, uprootedness, impersonality and with the lack of tie and community. At the same time it could also be imagined, that modern communication contributes to unity and community in a positive way. The mass media appeared as the indicators of a new kind of cohesion that could connect the scattered individuals in the mutual national, urban and local experiences. It has an important role in orienting the public through education, but at the same time its disturbing effect was apprehended.

The public tends to blame the media for the social problems, on the other hand they are expected to do more to remedy them. There is a moral panic about the media each time an inextricable or unexplainable problem occurs. The media depictions of crime, sexuality, violence are usually connected to the seeming increase of social disorder. New problems, such as increasing violent political protest and demonstration, international terrorism, the fall of democracy, political indifference and cynicism, are also often blamed on the media.

The concept of mass

In the beginning a negative meaning has accompanied the concept, with the connotation of the uneducated, ignorant, irrational, incontrollable, violent crowd.

In a positive sense, according to the socialist tradition, the mass expresses the strength and solidarity of simple workers who are organised for a collective aim or who turn against subjection. According to the Shorter Oxford English Dictionary the mass is an "aggregation where individuality gets lost". The above presented pejorative relevancies indicate the formless conglomeration of individuals, where individuality is missing.

Mass media genres and media texts

Genres are defined by the producers and readers of the media content in the same way. These can be identified according to form and content, these preserve their textual forms, and promote their development at the same time. The genre helps in the creation and reading of texts, it is characterised by a unique logic, format and language.

The media text in a general sense is the physical message itself (printed document, film, television programme, partition). The text is the meaningful result of the meeting of content and "reader" (Fiske). The text is created by its readers, and it is polisemic, that is, it has several possible meanings for its "readers". It attracts different social categories. Generally one preferred meaning is coded in the text, the meaning which the creator of the message wants the receiver to receive. The primary addressee of the message is called dedicated reader (e.g. the advertisement that is built on the model-consumer). There are gender-related media texts (e.g. soap opera – female; action series – male).

The media effect

The media can have its effect on the level of the individual, group, organisation, social institution, the whole society and the culture. Cognitive, affective and behavioural effects can be contributed to it. Klapper defines media types as follows:

- modification – the change of opinion or belief according to the intentions of the communicator;
- smaller scale modification – change in the form or intensity of thinking, belief or the form of behaviour;
- enforcement – enforcement of an existing belief, opinion or behaviour by the receiver;
- Change facilitation – the media has a mediating role in creating meanings and in the wider processes of social change;
- Preventing the change – they give one-sided or ideologically formed content deliberately, to prevent the change of the adapting audience.

Lang and Lang list further effect types:

- mutual – refers to those consequences when a person, or even an institute becomes the subject of a media report;
- boomerang – an effect that causes a reverse change than the planned result;
- outsider – it denotes the frequent belief, that they can influence everyone but us;
- sleeping effect – appear only later.

Persuasion

The tool of persuasion can be applied in every case when we want to develop opinions, attitudes, value judgements and probability judgements in people to which they would not have a practical standing-ground, or a competence that ensures proper support (Csepeli, 1997). Persuasion attempts can be very successful if they coincide with the desires, needs and expectations of the targeted audience. Persuasion is a message that is transmitted by a source to generate a deliberate effect.

The emitter of the persuasive message is the source, who has to be reliable from the point of view of the receiver. The purpose we attribute to the source and the extent to which the receiver feels the source similar to him- or herself is also important.

The communication itself can happen face-to-face or through vehicles. The face-to-face form can be more effective, hence the presentation of the transmitter and the conscious application of some metacommunicational codes become important.

The order of content in the message is a controversial issue. According to the "primary law" the important part in terms of persuasion is situated at the beginning of the message. According to the "remnant law" the end of the message is the ideal place, as after the final part there is no other information that could counteract with what was said. The way the message is delivered can be different also:

1. Spatial delivery: it organises its content in a spatial order.
2. Temporal delivery: it is based on a past – present – future breakdown. The efficiency of promise is connected to hope.
3. Deductive delivery: we make some general statement – that probably will evoke agreement – and then we deduce the statement the acceptance of which is a logical consequence of the previous ones.
4. Inductive delivery: The message contains some concrete examples and it either suggests or openly states the consequences that arise from those.
5. Psychological delivery: It is based on the fact that if certain needs are arisen in people, the tension evoked will turn into an inclination to act.
6. Problem-solving delivery: The message has to be worded as a dilemma and the decision should be confided to the receiver.
7. Causal delivery: First we have to reveal the consequences and have to point at the reasons behind afterwards.

Efficiency of the persuasive message is greatly influenced by the choice of words as well. Furthermore, messages using affective devices only are more effective than those applying pure cognitive influence.

Task 6.2.1

Collect everyday situations where you come across with persuasion!

The role of communication and mass communication in health promotion

The optimistic idea that media can cause deep changes in people's behaviour, life-style and attitudes was prevailing for a long period (Naidoo and Wills, 1999). The efficiency of media campaigns though are rather uncertain, or it is difficult to judge. It has to be considered who the media could address and what influence it is able to make; what role advertisements and publicity have; and how special further trainings and professional education appear in mass communication.

Media messages do not entrain immediate feedback. The media is more effective in spreading health related questions through certain type stories or

events than through others. Karf (1988) names four preferred domains (In. Naidoo and Wills, 1999. pp. 284.):

1. Overemphasis of medical dominance – for example, the display of extraordinary results, surgeries and interventions carried out by fine technique, in a hospital and in a way characteristic to doctors.
2. Consume-spirit (from the point of view of consumers): demonstration – for example „how shall we help ourselves" – stories telling who and how obtains certain health services.
3. „Care more about yourself" movement – for example the transmission of health education messages for the sake of choosing a healthy life-style.
4. Highlighting social, political and environmental questions – for example what effect can political changes exercise on health care, or how environment influences health.

Indirect messages

Media displays implicit signs and symbols that address health indirectly. The application of mass communication channels is socially determined, so a kind of unequal opportunities appear in transmitting health-related messages also. For example, the less educated readers of cheap tabloids get such messages about health that contain only minor value. The entertaining programmes often transmit hidden messages concerning life-style. For example, alcohol consumption appears in several television programmes as the means of social togetherness. Smoking, as the vast majority of the society refuses it, often appears as an accompaniment of minority existence.

Adverising

The advertising activities of the media can also have health related consequences, though the presentation of health related questions depends on the makings advertisements result in. Advertisements wish to parlay the typically existing dispositions, associating the advertised products with something people desire (e.g. drinking coffee and spending happy hours together with friends) and they hold out immediate benefit and pleasure. The health promoting messages though

are less funny and more imperative in nature, and often hold out the benefits of a distant future.

Efficiency

What is mass communication suitable for? It is able to raise people's interest in health-related questions; it is able to actualise the question of health; transmits information and it is able to accomplish a change in life-style. It can be really efficient if it operates as part of an integrated campaign, together with other elements, like personal counselling; if the transmitted information is of recent origin and it has affectivity too, and the information seems to be important for the average individual. Mass media devices are not suitable though for the transmission of complex information, for making people acquire skills and for changing people's attitudes or beliefs.

Health becomes a more and more marketable good, as winning looks, neat, healthy appearance and being arduous are becoming convertible capitals in the job market, and in social life.

Though on the one hand – in the wider population – health is still often connected to health care, cure and medicine supply. On the other hand, a wide range of products and services are marketed under the famed or real aegis of health. Those researches, advice, stories, lay experiences, accounts of professional advisers startling us for buying certain products or services and avoid others, cover several domains of our life from nutrition, dressing, and hygiene consumption till spending free-time. Knowing those time-scale researches that refer to our television watching, radio listening and newspaper reading habits within habits referring to spending free-time, it is proved that the role of these media must not be undervalued. While technical literature is published in a very low number of copies, the proportion of reading pictured magazines can go sometimes up to 30%. So those professionals – professions, like educators – should know what these magazines offer, what the wider audience meets.

Task 6.2.2

What do you think "health" is? Please write five concepts YOU THINK define health. (So we do NOT ask you to look up the definition of health in the literature.) Think through the concepts you would define health with!

1.) ……

2.) ……..……..……

3.) ……

4.) ……

5.) ……

Task 6.2.3

Search for some papers: daily newspaper, weekly newspaper or magazine. These can be journals, or periodicals from your own household, or papers from the athenaeum of the nearest library. The more newspapers you work with, the more interesting statements you can make!

Look for articles in these papers that address at least one from the five concepts in Your own health definition (see task 1.). It is enough if the topic of the article can be related to the concept. It is not necessary that the article contains the concept itself exactly.

Look for an article for each of the concepts! Please record the result of your search on **Task Sheet 6.2.3**!

Task Sheet 6.2.3

EXAMPLE OF HOW TO FILL IT IN

CONCEPT:	Representation of the concept in question
Data of the paper:	Author of the article (year of publishing): the title of the article. *Name of the newspaper*, volume, pages (from - till). e.g.: Newspaper Author (2061): From morning to evening. *Small paper for Big people*. Vol. XIII. pp. 11-12.
Review of the article	Overall, short review on the content of the article.
Connection between the article and the health-concept	Unfolding the relationship between the article content and the health concept in question in a few sentences.

1. CONCEPT:	
Data of the paper:	
Review of the article	
Connection between the article and the health-concept	

2. CONCEPT:	
Data of the paper:	
Review of the article	
Connection between the article and the health-concept	

3. CONCEPT:	
Data of the paper:	
Review of the article	
Connection between the article and the health-concept	

4. CONCEPT:	
Data of the paper:	
Review of the article	
Connection between the article and the health-concept	

5. CONCEPT:	
Data of the paper:	
Review of the article	
Connection between the article and the health-concept	

SUMMARY

In this chapter we have reviewed the relationship between mass media and society. First we have processed the general models of communication, then we have touched upon the features of mass communication. After an overview of mass media genres we analysed the effect media exercises on society. Finally we have shown the relationship between the media market and health promotion.

REFERENCES

Buda Béla (1994): *A k°zvetlen emberi kommunik§ci· szab§lyszerŤs®gei*. (Features of immediate human communication) Animula, Budapest.

Csepeli György (1997): *Szoci§lpszichol·gia*. (Social psychology) Osiris, Budapest

Kenesei István (1989, Ed.): *A nyelv ®s a nyelvek*. (Language and languages) Gondolat. Budapest.

McQuail, D. (2003): *A t°megkommunik§ci· elm®lete*. (The theory of mass communication) Osiris. Budapest.

Naidoo, J. and Wills, J. (1999): *Eg®szs®gmegŗrz®s*. (Health promotion) Medicina Kiadó, Budapest.

KEY CONCEPTS

❖ Communation	❖ Health concept
❖ Mass media	❖ Persuasion

6.3 HOW TO BE A CRITICAL USER

OUTLINE

This topic is presented in a rather different format from others you have studied in this course so far. This is because it has been written, intentionally, as a checklist of information which we hope you will use in your professional practice. To begin with, it sets out general questions about collecting information which will help you identify the focus of your search. It assumes you will therefore start with a question to which you want an answer. It also recognises that you will find this inquiry difficult to begin with and therefore offers a number of strategies to help you.

Once you have identified information relevant to answering your question, you will then need to make judgements about the quality and validity of this information. You therefore need to subject it to a careful process of scrutiny and evaluation. Once again, the module provides you with guidance on this, and offers a range of questions which will help you make informed decisions.

OBJECTIVES

By the end of this module, you will be able to

- Identify, in general terms, the nature and content of the information you need.
- Focus and make selections of the specific information which is relevant to the (research) question you are raising.
- Practise some initial research strategies.
- Make informed judgements about the quality, relevance and validity of the information.

CONTENT PART

Please read the following materials.

Conducting an enquiry: Retrieving and Evaluating Information

1. What information do you need?
   - What is your research question?
   - What subject area and/or academic discipline is most relevant to your research question?

- What sort of information is needed for the current stage of your inquiry?
  - ❖ Starting point? An introduction/summary
  - ❖ A detailed analysis? A specialist/academic discussion
  - ❖ Primary research? A critical analysis of research literature

❖ Data? Statistics/surveys

- What *type* of information do you need?

❖ Text books?

- ❖ Academic journals?
- ❖ Web sites?
- ❖ Policy statements?

- How *current* should the information be?

2. Difficulties in retrieving and using information.

Your assumptions and knowledge will affect:

- Key words/search terms employed
- Recognition of relevance of material
- Capacity to understand material
- How you use the information

3. Initial research strategies

- Reading strategies
  - ❖ Superficial "... skim, don't read every work, look at titles/contents pages/headings/indexes/prefaces." (Key Skills Online package, at http://keyskills.als.stu.mmu.ac.uk/skillsTLTP3/IS/gathusestart.html)
  - ❖ Refined "... read introductions/first/last paragraphs of chapters/ conclusions/summaries, look for key words/charts/diagrams ..." [Ibid]
  - ❖ Detailed thorough reading/note-taking
- Refining and extending your vocabulary
  - ❖ Use of specialist dictionaries/thesaurus
  - ❖ Specialist glossaries

4. Evaluating information on the Internet.

"... Information is everywhere on the Internet, existing in large quantities and continuously being created and revised. This information exists in a large variety of kinds (facts, opinions, stories, interpretations, statistics) and is created for many purposes (to


.:VirtualSalt

Evaluating Internet Research Sources

Robert Harris
Version Date: November 17, 1997

"The central work of life is interpretation." --Proverb

Introduction: The Diversity of Information

Information is a Commodity Available in Many Flavors

Think about the magazine section in your local grocery store. If you reach out with your eyes closed and grab the first magazine you touch, you are about as likely to get a supermarket tabloid as you are a respected journal (actually more likely, since many respected journals don't fare well in grocery stores). Now imagine that your grocer is so accommodating that he lets anyone in town print up a magazine and put it in the magazine section. Now if you reach out

inform, to persuade, to sell, to present a viewpoint, and to create or change an attitude or belief). For each of these various kinds and purposes, information exists on many levels of quality and reliability. It ranges from very good to very bade and includes every shade in between."

Harris, R. "Evaluating Internet Research Sources",

http://virtualsalt.com/evalu8it.htm

- Authorship
  - ❖ Is the author a well-known/regarded or recognised name?
  - ❖ If not, have other authors mentioned the author positively?
  - ❖ Does the information source help you judge the credibility of the author?
    - – Biographical information eg "... education, training and/or experience in a field relevant to the information." (Harris, op.cit)
    - – Institution affiliation and address
    - – Contact information

- Publishing body
  - ❖ Is any organisation identified in terms of headers, footers etc?
  - ❖ Is there an identified Webmaster with whom contact can be made if there are problems/ queries?
  - ❖ If not, does the page/site have links to other pages where such information is available?
  - ❖ Where the organisation *is* identified:
    - – Can you judge whether it is recognised in the area of your research?
    - – Think how the organisation might be relevant to your research questions

- In what relationship do the author and the publishing body stand?
  "... Was the document that you are viewing prepared as part of the author's professional duties..? Or is the relationship of a casual or for-free nature, telling you nothing about the author's credentials within the institution?" (Kirk, Elizabeth E. "Evaluating information found on the Internet, at http://milton.mse.jhu.edu/research/education/net.html)
  "... Most scholarly journal articles pass through a peer review process, whereby several readers must examine and approve content before it is published. Statements issued in the name of an organisation have almost always been seen and approved by several people." (Harris, op.cit)

❖ Is the page/site a personal one rather than part of an official/ institutional web page/site?

- Point of view

  "... information is rarely neutral. Because data is used in selective ways to form information, it generally represents a point of view. Every writer wants to prove his point, and will use data and information that assists him in doing so. When evaluating information found on the Internet, it is important to examine who is providing the 'information' you are viewing, and what might be their point of view or bias ..... Because the structure of the Internet allows for easy self publication, the variety of points of view and bias will be the widest possible." (Kirk, op.cit)

❖ Does the organisation on whose page/site the document exists have a vested interest in the issue/topic addressed?
❖ If there are any advertisements etc on the page/site does that suggest a point of view?
❖ Is the material on the page/site endorsed or opposed?

- Connections between the material being viewed and other research

❖ Is there a bibliography?
❖ Does the author refer to related sources and correctly attribute these?
❖ Does the author exhibit knowledge pertinent to the research topic/ questions?
❖ Is the author propounding a new theory/ approach and, if so, is there discussion of its value/limitations?
❖ If the author makes controversial or contentious claims, are these acknowledged and defended?

- Accuracy/verifiability of data/information

❖ Is an account provided of how the data was identified, collected, and interpreted?
❖ Is a research methodology explicit?
❖ Are other sources of data appealed to, and are there links to these?
❖ Is any non-published data acknowledged?

"... In addition to an obvious tone or style that reveals a carelessness with detail or accuracy, there are several indicators that may mean the source is inaccurate, either in whole or in part:

– No date on the document
– Vague or sweeping generalisations
– Old date on information known to change rapidly
– Very one-sided view that does not acknowledge opposing views or respond to them."

(Harris, op.cit)

- Currency
  - ❖ Where data is referred to, is there an indication of the date of its collection?
  - ❖ If there are dates cited within the material, how current are they?
  - ❖ Is the data such that it would be reasonable to expect updates and, if so, are these provided?
  - ❖ What is the publication date of the document and when was the page/site last updated?

5. The CARS Checklist for Research Source Evaluation: A Summary

Credibility	Trustworthy source, author's credentials, evidence of quality control, known or respected authority, organisation support. Goal: an authoritative source, a source that supplies some good evidence that allows you to trust it.
Accuracy	Up-to-date, factual, detailed, exact, comprehensive, audience and purpose reflect intentions of completeness and accuracy. Goal: a source that is correct today (not yesterday), a source that gives you the whole truth.
Reasonableness	Fair, balanced, objective, reasoned, no conflict of interest, absence of fallacies or slanted tone. Goal: a source that engages the subject thoughtfully and reasonably, concerned with the truth.
Support	Listed sources, contact information, available corroboration, claims supported, documentation supplied. Goal: a source that provides convincing evidence for the claims made, a source you can triangulate (find at least two other sources that support it).

(Harris, op.cit)

Task 6.3.1

- Conduct an internet search into materials corresponding to the age of your pupils and look for 4-5 media messages concerning health!
- Find one source which, using relevant criteria from the above handout, you judge suitable to an academic discussion of your chosen topic.
- Indicate briefly how your source meets the criteria.

SUMMARY

This module has served two main purposes – it has given you clear guidance about how to obtain information relevant to your research question/inquiry, and it has given you guidance about evaluating that information. You now have a set of practical tools for both functions, and a valuable support for your health promotion inquiries (particularly in relation to the CARS checklist).

REFERENCES

http://www/vuw.ac.nz/~agsmith/evaln/evaln.htm

"Evaluation of Information Sources" from the Information Quality of the WWW Virtual Library. Provides links to a host of sites/pages which address issues concerning the evaluation of information.

http://virtualsalt.com/evalu8it.htm

"Evaluating Internet Research Sources" by Harris, Robert. Provides a thorough, reflective discussion of key issues and questions to be addressed in evaluating and using web-based information sources.

http://servercc.oakton.edu/~wittman/find/eval.htm

"Evaluating Websites" which includes in the last third a useful tabular presentation of 5 key criteria for evaluating websites.

http://info.lib.uh.edu/pr/v8/n3/smit8n3.htm

Smith, Alastair G. "Testing the Surf: Criteria for Evaluating Internet Information Resources". The Public-Access Compute Systems Review 8, no 3 (1997). (Refereed Article).

A quite scholarly discussion which reviews academic discussions and offers in Section 6 a composite set of criteria and procedures drawn from the preceding discussion.

KEY CONCEPTS

❖ Critical user ❖ Evaluation, research source ❖ Information, retrieving, evaluating	❖ Internet ❖ Research strategies

6.4 RESOURCE BANK

Here you will find a list of useful internet sources. They link you to a number of important European and worldwide institutions, organisations and projects in the field of health promotion. For your own country you have to find out yourself which are the most important links for your research interests or puposes in practicing health promotion.

Links related to health in English

www.who.ch World Health Organization, Headquarter, Geneva
www.ei-ie.org Education International is the federation of organisations representing over 29 million teachers and other education workers, through 343 member organisations in 165 countries and territories

www.who.dk World Health Organization, Regional Office for Europe, Danemark
www.phpartners.org/hpro.html Partners in Information access for the public health workforce. A collaboration of U.S. government agencies, public health organizations and health sciences libraries
http://directory.google.com/Top/Health/Public_Health_and_Safety/Organizations/ Google directory on health, public health and safty as well as organizations
www.eurohealthnet.org EuroHealthNet is an organisation that aims to contribute to a healthier Europe with greater equity in health between and within European countries. This is achieved by networking and cooperation among relevant and publicly accountable national, regional and local agencies in EU member states, in states seeking EU membership and in the European Economic Area. EuroHealthNet has no profit making aims and seeks funding from a range of surces and donors only to carry out its objectives. All partners and members are asked to be transparent concerning their interests.
www.who.dk/ENHPS The European Network of Health Promoting Schools is a development project in health education and health promotion supported by the World Health Organisation, the European Commission, and the Council of Europe. This WHO site provides links to health promoting schools information from around Europe.
http://www.wiredforhealth.gov.uk Wired for Health is a series of websites managed by the Health Development Agency on behalf of the Department of Health and the Department for Education and Skills. Health information is provided for a range of audiences that relates to the National Curriculum and the National Healthy School Standard.
http://wpro.who.int/hpr/docs/glossary.pdf Health Promotion Glossary of WHO
http://hpmult.net/pdf/introduction%pdf.PDF European multilingual thesaurus on health promotion in 12 languages

http://who.dk/document/e60706.pdf Health promotion evaluation: Recommendations to policy makers (1989)
http://europa.eu.int/comm/health/ph_programme/programme_en.htm Programme of Community action in the field of public health (2003-2008) The programme, which shall complement national policies, shall aim to protect human health and improve public health. The new programme is based on three general objectives: *health information*, rapid reaction to *health threats* and health promotion through addressing *health determinants*. Activities such as networks, co-ordinated responses, sharing of experience, training and dissemination of information and knowledge will be inter-linked and mutually reinforcing. The aim is to embody an integrated approach towards protecting and improving health. As part of this integrated approach, particular attention is paid to the creation of links with other Community programmes and actions. Health impact assessment of proposals under other Community policies and activities, such as research, internal market, agriculture or environment will be used as a tool to ensure the consistency of the *Community health strategy*.
http://www.hbsc.org/overview.html Health Behaviour in School-aged Children (HBSC) is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study aims to gain new insight into, and increase our understanding of young people's health and well-being, health behaviours and their social context. HBSC was initiated in 1982 by researchers from three countries and shortly afterwards the project was adopted by the World Health Organization as a WHO collaborative study. There are now 39 participating countries and regions.The first cross-national survey was conducted in 1983/84, the second in 1985/86 and since then data collection has been carried out every four years using a common research protocol. The most recent survey, the sixth in the series, was conducted in 2001/02. Since its inception, the study has been developed by a multi-disciplinary network of researchers from a growing number of countries in Europe and North America.
http://www.hp-source.net The comprehensive database of health promotion policies, infrastructures and practices.HP-Source.net is a voluntary, international collaboration of researchers, practitioners and policy makers, having the common goal to maximise the

efficiency and effectiveness of health promotion policy, infrastructures and practices by: Developing a uniform system for collecting information on health promotion policies, infrastructures and practices; Creating databases and an access strategy so that information can be accessed at inter-country, country and intra-country levels, by policy makers, international public health organisations and researchers; Analysing the databases to support the generation of models for optimum effectiveness and efficiency of health promotion policy, infrastructure and practice; Actively imparting this information and knowledge, and actively advocating the adoption of models of proven effectiveness and efficiency, by means of publications, seminars, conferences and briefings, among other means.
http://www.asph.org/ The Association of Schools of Public Health (ASPH) is the only national organization representing the deans, faculty and students of the accredited member schools of public health and other programs seeking accreditation as schools of public health. ASPH is governed by its membership and a board of directors. A number of standing committees and councils also recommend program directions and policies to both the board of directors and the members in general. Established in 1953 to facilitate communication among the leadership of schools, ASPH has gradually assumed a variety of functions.
http://www.wfmh.org/ The World Federation for Mental Health is the only international, multidisciplinary, grassroots advocacy and education organization concerned with all aspects of mental health! The WFMH was founded in 1948 to advance, among all peoples and nations, the prevention of mental and emotional disorders, the proper treatment and care of those with such disorders, and the promotion of mental health. The Federation, with members and contacts in 112 countries on six continents, has responded to the international mental health crisis through its role as the only worldwide grassroots advocacy and public education organization in the mental health field. The Federation's organizational and individual membership includes mental health workers of all disciplines, consumers/users of mental health services, family members and concerned citizens. The Organization's broad and diverse membership makes possible collaboration among governments and non-governmental organizations.

http://www.mhe-sme.org/en/home.htm
Mental Health Europe is a non governmental organisation committed to the promotion of positive mental health,. the prevention of mental distress, the improvement of care., advocacy., the protection of human rights of (ex-)users of mental health services, patients of psychiatric hospitals, their families, and carers.

http://cms.curriculum.edu.au/mindmatters/about/about.htm
MindMatters is a mental health promotion program for secondary schools. The program includes:

a *resource* for schools
a national professional development and training strategy
a dedicated website
an *evaluation* process
a quarterly *newsletter*.

MindMatters is a program to support Australian secondary schools in promoting and protecting the mental health of members of school communities. Each state and territory has a dedicated web page and publishes a schedule of free professional development activities. The 1996 audit of Mental Health Education in Australian Secondary Schools recommended schools as appropriate settings for the promotion of mental health among young people. Subsequent Commonwealth funding established a National Mental Health in Schools Project managed by a consortium from Melbourne, Sydney and Deakin Universities and the Australian Council of Health, Physical Education and Recreation. Mind Matters is the result of a successful national *pilot program* involving 24 schools in the government system, Catholic and independent sectors from 1997 to 1998. The MindMatters program is being conducted by the *Australian Principals Associations Professional Development Council* (APAPDC) www.apapdc.edu.au and *Curriculum Corporation* (CC) www.curriculum.edu.au and is funded by the *Commonwealth Department of Health and Ageing* www.mentalhealth.gov.au/
A German version of MindMatters is available under : www.mindmatters-schule.de

http://www.intercamhs.org/
Intercamhs is a new international alliance that aims to promote the mental health and wellbeing of children and young people. Already, INTERCAMHS has 294 members from 35 countries and membership is growing rapidly. Intercamhs brings together a wide range of professionals from all over the world, each with their own expertise and experience. Intercamhs is an international network of

agencies and individuals who believe that addressing mental health issues in schools is vitally important to the wellbeing of school community members. Intercamhs' vision is that mental health will be addressed through collaborative interdisciplinary whole school approaches for all school community members across nations. Intercamhs brings together experience and expertise from all over the world with the aim of enhancing the wellbeing of children and young people. It promotes the international exchange of ideas and experience and acts as a meeting place for a wide range of educationalists, mental health experts and other professionals interested in mental health. Intercamhs aims to raise awareness of the mental health needs of children and young people and the ways in which service providers can meet their needs. It also aims to support parents and teachers in their actions to strengthen the health and well being of those in their care.

Links related to health in Hungarian

http://efrirk.antsz.hu Állami Népegészségügyi és Tisztiorvosi szolgálat
http://www.eum.hu Egészségügyi, Szociális és Családügyi Minisztérium
http://www.eselyegyenloseg.hu/ Esélyegyenlőségi Kormányhivatal
http://www.gyism.hu/ Gyermek-, Ifjúsági és Sportminisztérium
http://www.kvvm.hu/ Környezetvédelmi és Vízügyi Minisztérium
http://portal.ksh.hu Központi Statisztikai Hivatal
http://www.om.hu/ Oktatási Minisztérium

http://www.oefi.hu/ Országos Egészségfejlesztési Intézet
http://www.eum.hu/eum/eum.head.page?pid=DA_11409 Rövid magyar nyelvű tájékoztatás az Egészségügyi Világszervezet (WHO) - Magyarországon is érdeklődésre számot tartó - híreiről és eseményeiről
http://egeszseg.lap.hu/ Rovatai: Problémák, betegségek; Gyógyászati segédeszközök; Kapcsolódó startlap oldalak; Orvosi műszer; Magánrendelők és -kórházak; Baba-mama, Fogorvoslás; Egészségügyi Oldalak; Baba-Mama magazinok; Kórházak, Szexológia; Természetgyógyászat; Egészséges életmód, fitness; Tanácsadás; Szervezetek; Gyógytorna, mozgásszervi rehabilitáció; Gyógyszerek, gyógyszerügy; Adatbázisok.
http://www.sulinet.hu/tart/kat/l Sulinet – egészség
Egyetemek, Főiskolák, ahol van Egészségtan-tanár; Egészségfejlesztő Mentálhigiénikus képzés: Szegedi Tudományegyetem http://www.u-szeged.hu/ Berzsenyi Dániel Főiskola http://www.bdtf.hu/ Széchenyi István Egyetem http://www.sze.hu/ Pécsi Tudományegyetem http://www.pte.hu/ Veszprémi Egyetem http://www.vein.hu/ Miskolci Egyetem http://www.uni-miskolc.hu/ Debreceni Egyetem http://www.dote.hu/ Nyíregyházi Főiskola http://www.nyf.hu/

APPENDIX

The focus-group records give a realistic reflection on the participants. We include only a structured, shortened version of these.

Annex 1: FOCUS-GROUP RECORD

Location: a middle-size Hungarian town (Kecskemét)
The parents of Gypsy primary school children took part in the focus-group.

In the record the chair of the focus-group is the interviewer, the others are the participants of the focus-group.

Interviewer: Please introduce your family!
Mr. R: I have a second-former son.
Mrs A: I have a 13 years old son, he attends the Gypsy school, I am not very satisfied with his results
Mrs. B: I have five children. Three of them goes to school, two goes to the kindergarten. Two are sixth-formers, one is a second-former. They study quite well.
Mr. Z: I have three children, the eldest goes to school, 7 years old, studies quite well.
Mr. L: I have two children, both go to school. One is a fifth-former, the other is a fourth-former.
Mr. T: I have a daughter, she is seven.
Interviewer: How do you feel yourself in the habitation where you live at present?
Mrs. B: I live in the garden suburb, I like living there, I work, I am away all day. My children live in the neighbourhood, I have grandchildren too. We have a bathroom too. My younger son has a room and kitchen. My other child lives opposite to me. I also have three grandchildren. My younger son has a son, the elder has two daughters. The girls are first-formers, they study well. My daughter will leave primary school on the 20th, she is 14. She was 4,4 at midterm, she gets a stipendium too. Workplace, work, is very good, succeeded. I was on a training. I would not change my workplace, everything is good at home too. Fortunately, I would like to bring my husband's health back only, he is on disability pension.
E: In a block of flats I bring my child up alone. I have good relationship with my neighbours. Only a few Gypsies live in the neighbourhood, it is not bad this way. My son is second-former. My flat is 33m^2, with all modern conveniences, I feel

well. My family life is balanced. I work until four o'clock, we go with my son to the playground, then we go home, and talk. Dealing with the child is important for me. We have a look at the homework. If he has problems we discuss them. I keep contact with the teachers twice a week. Last year I have managed to become a member of the local minority government. I work together with my parents. It is hard: I would like to change the flat to provide the child with an own room. My son would like me to come round with his father, he would like to live in a family. I exclude the neighbours from discussing my problems. Generally I discuss them with my mother and younger sister.

Mrs. A: I live in a Hungarian neighbourhood, in the downtown. In a flat with a room and a kitchen, no bathroom. One of the residents has bought all the flats, but mine. He wants to get it too, he acts at the local government on behalf of my leaving the flat. Gypsies were living there too, he was very skilful to get the flats. The local government was partner in it, and I have to go by all means. They have not told yet what flat I could get. Rightly I should have got one a long time ago, I like living there, I would have liked to enlarge it, but I have no choice now, either cave in or not. I will cave in, and go. Where, I do not know yet. I can be friendly. I get up at six o'clock, come to work. Or I settle my official businesses and then come here to work, direct things. This is an association. I have founded the association in 1997. We could do a lot of programmes. To help the Gypsies is in first place in my life.

The Gypsy people would like to integrate, would like to live next to Hungarian people, they feel they could reduce prejudice against themselves this way. 5-6000 Gypsy families live in Kecskemét, I know 150 of them, who should get a flat on the basis of individual consideration and needs, who wants to live in a village should get a flat there, who wants to live in a town, there should get a flat.

Interviewer: What would you change?

Learning: not only the attitude of parents, children should change, but the educator's as well, the relationship itself. Health: is neglected. They live in bad circumstances, they have disadvantages, they neglect going to the doctor, they are afraid of them, slush-fund. There are many ill people, 30 year-old people are disabled. Cardio-vascular, respiratory illnesses, inheritance, environment, malnutrition, lack of money, bad living circumstances.

Interviewer: What do you do at the weekend?

Mr. B: I live with my father, in "X" street. In three rooms. I get up at six, the children at school, kindergarten. My mother, my father, my two younger brothers and us. My wife is a housewife. My wife cooks, cooks well, we eat supper with the children. We live in a Gypsy environment. Here they live mainly in family

houses. My father is a pensioner, my mother works in the hospital. This house is a council flat, has gas heating too. We have been living here for 10 years, we did not have any problems. My neighbours are good. Most of the families have a workplace. I work here with a primary school degree.

Mr. Z: I live at my mother, in a 1,5 rooms flat. My mother has a house and we have built next to it. We live here my mother, my wife and the three children. I work during the weekdays, we make excursions at the weekend - zoo. The wife: washes, cooks, cleans. Money, house needed, the present one is too small. We also live in a Gypsy environment, though the neighbour is a Hungarian family. We do not experience difference.

Mr. L: I have 2 families (children), the four of us live in one room, in a shed building. The children go to school, my wife and me are working. A bigger flat is needed. My daughter is 13, my son is 14 years old. In the shed there are four rooms in a corridor. Medieval conditions, water in the court, there are rats, cockroaches. Even the one who tries to keep the surroundings tidy goes wrong. Very few people work from the yard. I started to work now on the 9th too.

Mr. R: at my father in downtown there is a 2 rooms flat. My wife works in a kitchen. Usually I go to the playground with the small girls. To have an own flat, I would like. Change it to a bigger one. The wives keep the house together.

Interviewer: How has your life changed in the past 10 years?

Mrs. B: I was working in many places, when I was a young wife I worked even with a bricklayer, in January 2000 a training started, I successfully finished it last year, since then I completed an other training as well, I got a social worker and nurse degree, I completed it with mark three. I got a certificate on health education as well, and now I had an advocator-discrimination training. For me things became better as I was learning. Earlier I did not have the possibility, with three children-. I would like to study further. I would like my children to be trained as well: my elder son is a bricklayer, but works as a trader, my other son has completed security guard training, he is a bricklayer at the moment, my third child goes to vocational secondary school.

My relationships do not change. I got along with Hungarians and Gypsies as well so far.

Mrs. E: I was playing with Gypsy and non-Gypsy children as well when I was a child. A change in my life is that I can work with Gypsy people. I am a Gypsy representative too. I help everybody. I started as an administrator, was working in three shifts as well. I have just found what I like doing.

Mrs. A: I was a housewife, I brought up my children. I was, I am a Minority Local Government representative since ‘94. I have started work there, continued it in the association too. A bigger turn: In 2000 I could create workplaces for myself

and for several other people. Since then I am working for the association. 8-10 people have permanent job in the office. This is made the best of. The project came, we could employ 15 people, sometimes 20 are working.
I am not satisfied, though the "S" foundation has supported 17 organisations and our work is by far outstanding compared to the others. It has turned out that we are doing unique programmes in the country every year. The possibility is open for everyone, we live with the possibility, we complete 5-6 programmes a year, these are permanent programmes, we have temporary programmes as well.
I am proud of many of our programmes. We have organised 10 camps, we take them for free or for a very minimal symbolic fee.
Mr. Z: There were no considerable changes in my life, it changed only when the children were born, because I have to work.
Mr. L: no change. What has changed, there was good and bad in it also.
Interviewer: When was better to be a Gypsy?
Mr. L: In the communist era, who wanted to work, could, it was possible to build flats, no workplace, no flat.
Mrs. E: it is much harder now. 0 chance for getting a flat. In the present regime those who have a big family can not build the flat. There was a bigger help from the state. More attention was paid to the families, to elderly. Who had a workplace could get a bank loan for a flat, now it is hard to arrange it.
Mr. R: discrimination at the workplaces, the registry office has sent me and the lady threw into my mouth that a Gypsy can not come to them. There are several such workplaces. She said they wouldn't hire me because many have worked with them and they left the workplace after one-two weeks. Because of a bad experience, this happens to the Hungarians too, but we have a brown skin.
Interviewer: Do they speak the Gypsy language in Kecskemét?
Mrs. A: No, only very minimally. Neither in childhood, nor the parents even. There are Romanians, around 5 %.
Interviewer: What do you expect from the future?
Mr. R: Better life, more work possibilities. To be able to earn more, to be able to live on the earned money.
Mr. L: Easy! Respect for my family, not to despise me in a club, to consider us human too.
Mr. Z: Financial, I would like better living conditions.
Mr. B: Flat, finances. I would try to study as well, a lot of sacrifice should be taken, but I would undertake it.
Mrs. A: I have already established my future, we can work together with my workmates, I would like to work less. On behalf of the Gypsies I would like the

opportunity – equal opportunities – and then the state of Gypsies would change, then the Gypsies could show too how much they worth. I would like to establish our future in a way, that the future of the children, our grandchildren is ensured through education.

Mrs. E: I expect a lot from joining the Union. The future of children, security in terms of studying, workplace, security in their family as well, including finances, family background, including everything.

Interviewer: School part: How much information do the men have about the school?

Mr. Z: Mainly the mothers have information. My wife does not complain, she arranges it herself.

Mr. B: I have little information about school life. The children do not complain, I attend the parental meetings only rarely.

Mr. L: Only if there is a problem. The teacher has beaten the child, he has no rights to it. Should tell. The teacher was given the sack. We are here for him to let us know. The child talked back, quarrelled with an other child. My wife was working, that is why I went in.

Mr. R: When my wife works in the afternoon, I go to the kindergarten with the little girl. The kindergarten teacher is very good. There are not any other Gypsy children in the group of the little girl.

Mrs. B: My daughter wants to study in a vocational secondary school training post office workers, but as instead of the fifth grade they teach computer sciences only now in the 8th grade, - it is an essential requirement there – now I will ask why do they teach it only now. The girl did not have problems with learning.

The focus-group records give a realistic reflection on the participants. We include only a structured, shortened version of these.

Annex 2: FOCUS-GROUP RECORD

Location: a Hungarian small town (Kiskunmajsa)
The parents of Gypsy primary school children took part in the focus-group.

In the record the chair of the focus-group is the interviewer, the others are the participants of the focus-group.

Interviewer: Ho do you feel in the environment you live in?
Ms. I: We live together with my mother, father. My neighbour is the Brigitta, we are sisters-in-law. My partner lives there too. Many, ten of us are living in this house. I start cleaning, washing, cooking in the morning, I toil with the children. This fills almost all my day. My husband is a day-labourer, my parents are at home, or they do a day-labour. My sister-in-law is retired too. There are Hungarians and Gypsies as well in the surroundings, I feel well. I would stay even if I could choose living elsewhere. It is good for me this way, the children, if I were 17-18 years old now. I would like to work, but here are the children. We speek Gypsy language in the family. This is our mother tongue. I have learnt Hungarian at school. I have not attended a kindergarten. The biggest from my children attended kindergarten for three years. We like mutton stew, beef. We are not choosy.
Ms. A: I am with the small girl, feed her, we eat breakfast, talk with my parents, with friends, we live together. Sometimes the atmosphere is tense, sometimes good. We eat everything as well. My partner is from Szeged, sometimes he comes to visit. We talk in Gypsy as well at home. Tension, clash of views is caused by the different opinion, the quirk. Since I gave birth I am depressed, I take everything to my heart. It is bad when someone hurts me. I can be hurt with personal things, but I would not change my home, I would not leave home. It is good with my parents, my sibling, my sister-in-law is there. The house is big, everyone has a separate room, in the meantime we are in the hall, or watch TV in the kitchen, share the bathroom. My relationship with my partner is changeable, we get on somehow.
Mrs. K: four of us live in one flat, my husband, the child and me. We make adobe in the meadow. I labour with the children. We do the shopping. There are many

Gypsies in the street. We are lucky, a flat with bank loan, we still pay it. My husband when we are not making the adobe goes to work. Cuts trees, works with a carpenter. I learnt Hungarian at schools. There are children who do not have to be taught, learn Hungarian by themselves. We speak in Gypsy in the family. My household is good, we cook, clean, wash. I would change: If we were richer, we are poor. I would like if our life could change. I would like to go to work. I would spend it on the house, the children, for lunch, for livestock. Now we do not have, but used to have horse, goat.

Mrs. B: I could tell the same. Coffee is first thing in the morning. I go to the shop, the children eat breakfast, I prepare the lunch, wash, clean, then we are talking in the hall in the afternoon, we deal a lot with the children, he does not understand Gypsy, I translate what we are talking about into Hungarian. My husband is in the Local Government. They eat everything what I cook. I would spend the more money on the children, clothes, I have two grandchildren, for the kitchen.

Mrs. K: For kitchen, children I would spend if I had more money. We buy meat, milk, bread a lot. Children like Chips. The children eat at school, I pay for that. They eat at home only during summer. They get breakfast from our money, lunch they have at school.

Interviewer: What has changed in your life?

Mrs. K: Gypsies did not live like this. They were poorer, they lived in the yard. 10-15 were living together, 4-5 slept in one bed. Some were eating, some were not. There were better days in my life. We were very poor when I was a child. We have changed. We ate better, earned. Our parents did not care for the children like this, they had different customs. The Gypsies in "M" were making adobe, now they do different work, they skin poultry.

Ms. I: picking paprika, hoeing, they work in tying. We were very poor in the days of long-ago. The pensioners also go to work. To skin. More money. What is put on the table shows more money. It is in vain to buy nice clothes when we die of hunger. We suffered a lot in our childhood.

Ms. A: I did not starve, I was an only child. I got everything. My mom said, that the doctor arrives fast now, it was not common in the old times. We progressed a lot. I finished primary school, gave birth, but I would like to apply for part time education from September. I have not yet experienced big things. My father would have liked if I attend a secondary school, I was admitted. I would like to make up for it. Young people are required to attend school. I would like to progress. Minimal wages, in harvest, they do not give it for day-labour. I wish to

have a house, a family, not to be in the same situation as in the old times. The elderly used to tell.

Interviewer: What is the relationship of the children with their peers, with their children?

Ms. A: The parents teach Hungarian children not to like the Gypsies. They make mock of Gypsies at school, I was despised, was called a slum resident, I was discriminated like a stranger. They talk nonsense, they do not know what they say, they do not understand, but say. It happened in the kindergarten, at school it didn't. We stood away with my girl friend in the break. I had a Hungarian girl friend as well who wanted to learn Gypsy from me. There are good ones.

Mrs. B: The Hungarian parents are different too. I did not recognise anyone hating me, we were all gypsies in the school in Kecel, no Hungarians. Only Hungarians attended the school next to us. It would be good if there were no racial differences, together would be good. Hungarian children should accept the Gypsies as well.

Ms. A: In the hospital, in the first room, only Gypsies were there. There were 4-5 other rooms, with only Hungarians. It was written: Gypsy room. The girls were happy about it, because when we were talking in Gypsy, we understood one another. Hungarians discriminate us, but we Gypsies accept it, we do not have other choice. In Szeged, in Halas this does not happen.

The focus-group records give a realistic reflection on the participants. We include only a structured, shortened version of these.

Annex 3: FOCUS-GROUP RECORD

Location: Hungarian shire-town (Békéscsaba)
One of the Hungarian national groups is Slovakian. They live in greater proportion in County Békés. The following discussion was made with them.

In the record the chair of the focus-group is the interviewer, the others are the participants of the focus-group.

Interviewer. What do you do? Where did you come from? How do you feel, how do you connect to this community?

Ms. K: I am from the primary school of a small village, I teach first-formers at present. I teach in full time, but my work in the Slovakian Local Government is just as important. Several settlements joined together, we have created a Slovakian association with the help of a cooperation agreement, and I hustle in this association also.
Ms. H: I am happy that I got into this area. Here work is not a necessitation, it is interesting. I like doing sports, I go for excursions with my children.
Mrs. E: My roots are tied to the Slovakians. I have spent (40) years in the education profession. I have 2 sons, 6 grandchildren and one great grandchild. I keep the traditions in the family as well, as far as possible, this covers keeping the Slovakian traditions. I try to maintain the family, not to forget the traditions.
Ms. A: My livelihood and my hobby are overlapping. I am a lucky person. I work in a bakery. I like travelling according to my own ideas, but I have little possibility for that.
Mr. A: Retired. I am member of a Slovakian organisation. I am from a Slovakian family. I have a 20 years old son.
Mrs. E: I work at …, in full time, I teach Slovakian language and about the Slovakian nation, I am responsible for the Slovakian relations. I pile pleasures, I work part-time in the Hungarian Slovakian research institute too, I am its director. My hobby is my work. I spend my free time with my family, sometimes I say it is enough, and I travel somewhere, to relax.

Ms. N: I work in the Slovakian primary school in Békéscsaba. I have second-formers. I have been working here for 10 years. My father was Slovakian, I have studied Slovakian in Szeged. I got back and I teach the small ones. My hobby is journalism. I had a TV programme in Slovakian for years here, but now I had a short break.

Interviewer: I would like to recline upon experiences, your anticipation. There is Slovakian origin, Slovakian tie. What does this Slovakian identity mean?

Ms. N: It has developed gradually. I became fully aware of it when I have finished college. When I came here to Békéscsaba – I have been teaching here for 10 years – I awake this consciousness in children from an early age. I am that type who becomes mature late. It is a huge responsibility to take it up, to teach it. A treasure.

Mrs. E: Identification with my family, with my roots, with the town, with my place of living, and with Slovakia too, though this relationship is the loosest.

Mr. A: I have lived all my life in it, more than now, I could not imagine my life other. I keep the traditions, my family too, we live in it now as well, we identify with it. I identify with Hungary too. I do not identify so much with Slovakia, my mother country is this. Have to live here, it is good for me here. Tradition in the family: in food, celebrations, customs.

We talk the same language. Children learn it at school as well. Clothing, celebrations, to wed the girls, farming, eating was different. We were living in a more intimate way. We saw our neighbours, we sticked together when someone had a problem. We protect one another's interests with the families.

Ms. A: I would cut myself adrift from identity. I deal only with minority identity. There are many kinds of ties, that we can be aware of. On the one hand, on the basis of history to understand ourselves, our own place, place of living, mentality, that develops by adulthood.

Thirdly, making others accept us. To make non-Slovakians accept "our kind", to insert our values, traditions to the Hungarian population. To cope with the phenomenon that the society often has a disdainful, neglecting attitude towards us, instead they should understand, discover the value we have in the group. Qualitative comparison between the two groups is not good, as they had different histories. This is where I see my own task.

Ms. H: I understand identity in a completely different way, I make distinction between identity consciousness and tie. I think the word identity consciousness is deeper. That child who was not born into a family where communication is for example in Slovakian. I think through getting to know the language, the traditions

he first just has a tie, then develops identity consciousness. It has many importance, but it is not the identity that comes first, it needs longer time.

Interviewer: Tell me concrete things that are different in your families, activities, relationships, environment than in the non-Slovakian families.

Ms. N: I can not list, as my whole family is Slovakian. I attended a Slovakian school all the time, I can not comment on this.

Mrs. E: It is not different in Békéscsaba, that my child goes to a Slovakian school, that my mom goes to a Slovakian club. My husband has also learnt some Slovakian words, he has accepted my family. Here in Békéscsaba we do not feel ourselves so different. Here are many people like us. We are together.

Mr. A: Different: maybe the eating habits. We cook stuffed cabbage in every second Saturday. Many things were taken over from us. (History) In the 50s the home made textile, most of the girls can weave, but our homespun are different.

We keep traditions to some extent and in other aspects our traditions have changed.

Ms. A: The biggest differences are in gastronomy, in eating habits. It has to be emphasised whether it is a holiday or an everyday eating, as folk traditions live during the holidays, but they are already in the background in everyday life. We are a quite young family, I do not keep the folk traditions to such a great extent. Difference, that we take the Slovakian journal, we have books that we read. The flat reflects not the national identity, but the social, financial, income and age differences are reflected. The ornamental home items come down, inherited, they are not only ornaments but have function, for example: jug. It has the same function as it had sometime back in the time of my mom, we keep jam in it. What are on the wall (pictures): the received, or artwork from a give painter, is for sure a Slovakian painter.

Mrs. E: There are many elements that are related to the Slovakians in my home. These are: those what my children also do, work, honest work, going to work in time, telling the truth, and everything else that is according to the law, I enforce these in the family too. It is important that these work well. The other, that I should enforce traditions, the forms of work at home. I do not think of the eating habits only, but of those things we have lived through in the family. My sons got married. My granddaughter wedded. There we kept to the Slovakian traditions. My granddaughter married a kraut boy, and they keep to their own traditions similarly in the Trans-Danubia. It was a good feeling how national cultures enrich events, traditions. There is a breakthrough in many things. A lot depends on the families, how long we require the traditions.

Ms. H: My daughter is a third-former, she goes to a Slovakian school. It is true that the teacher has asked us to do it, but we are speaking Slovakian for two months at home. As her father does not speak Slovakian, our family is bilingual, the usage of Slovakian language starts to become natural now in our home.
Ms. K: Cherishing traditions is conscious in our home, while effects by the Hungarians are always all natural. My son-in-law is 5 years old, they recite the rhymes in Slovakian also, I pay attention consciously to be able to ask whether he understands it or knows the meaning.
Interviewer: How do you feel, how has the Slovakian tie, the possibility changed, what do you expect from the future?
Mrs. E: As I become older the tie becomes stronger, and that is natural. Children, the teenagers are not very interested in it, for young people the question of being a Slovakian or a Hungarian is not a central question. This can I observe in my family as well, though assimilation is strong, this is a fact. The Slovakian community in Hungary belongs to those communities where assimilation is the most far-gone, together with this I see – a younger generation has grown up beside the activists that have been working for a long time. It is true that they will be small in numbers, but they will be able and ready to act for this community and the also want to act.
Mr. A: The Slovakians have changed during my life-time. I was born in the Horthy era, the Slovakians were strong at that time. It was impossible to live a nationality life, it was forbidden. The war came, the relocation, it has attenuated. We did not hear any other word than Slovakian. The Rákosy regime came. Spoiling, deterioration. Assimilation together with the modernisation. The Slovakians got help after the change of regime. We received help, there is a scientific institute too, that is financed by the state. There is help, because it is part of the Hungarian universal culture. I have very bad visions, I am pessimistic: County Békés is in the Southern-East corner of the country, there are no new factory investments, no highway, people leave. Those who have left will hardly come back. We cease to exist.
Ms. A: What was natural (like the air and the water) can sustain the community, the language and the culture only in a conscious form. This is the first stage of the survival of every culture. These are not the prerequisites of a normal survival.
Mrs. E: The Slovakians have settled 300 years ago. The Slovakians were decisive in this town. Our folk-writers and collectors of folk-songs have left and carried the culture with themselves. The intelligence has not stayed here to gather the nationalities together. As the number of nationalities decreases, the stronger the national identity becomes. The final fight for survival is very strong. This comes

now. To do everything for the nationalities. As the number of nationalities decrease, the force to belong to this community becomes more aggressively strong. The intelligence, young people have a huge task, importance in the survival of the Slovakian nationality.

Ms. H: About connecting the past and the future. I heard in my childhood the elderly speaking in Slovakian, but then it disappeared. We almost never use it. I took part in the population census, and I am attached to the Slovakians according to what was said there. Many young people chose his or her mother tongue and not English language to learn. Attachment reached its highest point, then decreased, now it will turn out what young people want.

Ms. K: Vision of the future: I have to live it, I consider it to be a tragedy. This happens in case of other things as well, that I feel, it will happen and this I have to watch. Have to be a dragon, to struggle consciously, to mobilize everyone that is possible. As a representative of the settlement I feel, from the local governments, from those people, who are heads of the community, they have expectations, they should go, in the meantime the essence dies away. I consider it to be a tragedy. It was good to listen to the others, they seemed to be encouraging, I feel a lot of truth in the words of Mr. A. and Mrs. E., I feel the same, that this thing will change in the future.

Annex 4: PROJECT HANDOUT

National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region

Healt promotion – mental health promotion
booklet for secondary schools

OPENING ADDRESS

Dear Director!
Dear Colleagues!

The National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region fulfils its health education, health promotion tasks in counties Csongrád, Bács-Kiskun and Békés since 1995.

We offer you our programmes on the basis of the integrative understanding of health (physical, mental, social).

Theories on health are basically about two health concepts: preserved health and health that is re-established through the cure of illness. The myths of Hygeia and Asclepios symbolises the two different viewpoints. For the followers of Hygeia health and preserving health is the natural course of things, and is something one is entitled to if he lives a wise life. That is why their main task is to discover and teach those laws and principles that ensure sound mind in a sound body.

The transmission of the perspective of *"health that smells like fruits*" and education is in the focus of the work of The National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region.

Our "Healthy school" workgroup that consists of teachers, mental health promoters, psychologists, psychiatrists, sociologists and social workers has decided to launch a health promotion programme in secondary schools (from September, 1999). Now you are holding the programme offer of this initiative.

We send the "Health promoting programme offer for secondary schools" to every secondary school of county Csongrád. Schools are offered the possibility to choose from the different topics (e.g. addictions, skin care, sexuality, conflict management) and methods (e.g. training, presentation, film processing) we offer for free. After the realisation of the programmes schools are asked to fill in a questionnaire.

The programmes are for pupils or/and for educators or/and for parents.

We use icons next to each item in the PROGRAMME OFFER to indicate for whom and in what form we offer the topic in question.

Apart from the Programme offer we also plan to publish a humorous "Mental health promotion booklet" for pupils.

If your school is interested in any element of the PROGRAMME OFFER or a PROGRAMME, or maybe you would like to choose from the IN-SERVICE TEACHER TRAININGS, please indicate your claims in writing and send a letter

to the address of The National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region (6721 Szeged, Sóhordó u. 5.).

The National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region can not satisfy the claims of every school, that is why we will consider the order of your claims, and we will volunteer to fulfil the required programmes in this order. You can ask for information concerning the programmes presented along the same points (aims, methods, themes) if you call the National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region's number (62/426-046).

For the sake of a healthy(ier) future generation strengthening the perspective of healthy life within the walls of the school is not too much and not too few to ask for. We would like to provide help to reach this aim and would like to ask schools help in it. We hope you will find among the offered topics those that satisfy the needs of your school the most.

dr. Benkő Zsuzsanna
Head of the region

CONTENTS

LEGEND

Who are the programmes for?
The target groups:

For pupils

For educators

For parents

Suggested form of presenting the programmes at school:

Parental meeting

Lesson held by the class-master

Extra-curricular activities

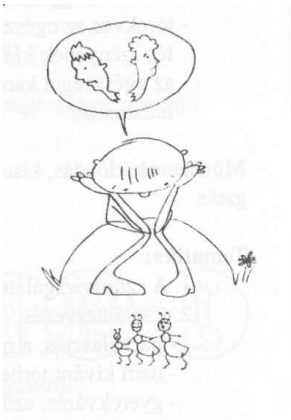
I. PROGRAMME OFFER

1. The world of teens

The aim of the programme:
To know and understand physical, mental and intellectual changes and processes accompanying adolescence; realisation and treatment of crisis situations in adolescence

Methods:
presentation, discussion, thematic large-group session

Themes:



1. The adolescent and the world
   – about adolescents in general
   (with special regard to social and mental relevance)
   – about crisis in adolescence in general
2. The adolescent – the school – the peers
   – about the possible problems of peer friendships
   – crisis situations of peer love
   – mental aspects of sexuality
   – pupil-teacher relationship
3. Adolescent in the family
   – state and problems of adolescents: in a complete family, in an incomplete family, in a family with alcohol problems
   – the effect of parents' divorce on adolescents
   – new marriage; relationship problems with the foster parent and his or her child
   – becoming detached from family
4. About some crisis situations of adolescence
   (the problem of suicide)
5. The role of hobby in mental development

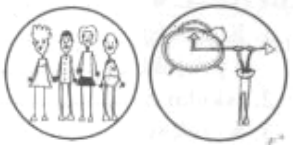
Number of lessons: 2 hours/session when required

The chair of the programme: … psychiatrist

2. For healthy teens

The aim of the programme:

– „preparation" for the role of parents
– transmission of a family- and child-centred perspective

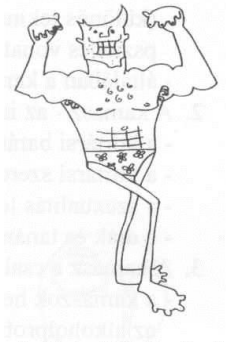


– strive at the creation of healthy nutrition habits and at the development of the need for healthy life conduct
– realisation of behaviour forms that damage health, making aware of the danger these mean

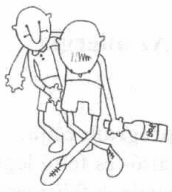
Methods: presentation, small group session, film processing, visit to institutes

Themes:

1. About the importance of screening
2. Family planning
   – choosing a partner, the advantages of monogamy in sexual life
   – unwanted pregnancy, abortion
   – expecting a child. Giving birth
3. Health of the family
   – illness in the family, care at home
   – infant care



4. Factors influencing health
   – nutrition: healthy nutrition, bad habits
   – physical exercise: dangers of the lack of and over excess physical exercise, the body building hormones
5. Addictions
   – smoking
   – alcohol
   – drug addiction
   – addiction to games



6. Visit to institutes
   – Medical University of Szeged, Female Clinic, Example setting Club
   – Child and youth gynaecology
   – family protection services, nurse consultants

Number of lessons: 2 hours/session when required

The chair of the programme: … doctor, public health advisor

3. Puberty – sexuality

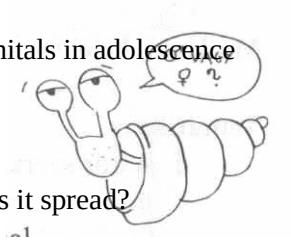
The aim of the programme:

Providing knowledge on love, sexuality, pleasure

Methods: presentation with slide projection

Themes:

1. Normal hormonal changes of the body and of the genitals in adolescence
   Genitals, libido – mental changes
2. Safe sex
   types of condoms, methods of using them
3. What is a venereal disease and what is not: How does it spread?
   Classical VD-diseases



Number of lessons: 45-60 minutes/session when required

The chair of the programme: … dermatologist and doctor of venereal disease

4. Allergy

The aim of the programme:

To realise the symptoms of lower and upper respiratory allergic diseases, cure and the possibilities of prevention.

Methods: presentation

Number of lessons: 45 minutes/session

The chair of the programme: … paediatrician

5. Neat appearance – good looks – self-assured impression – healthy self-confidence – half success

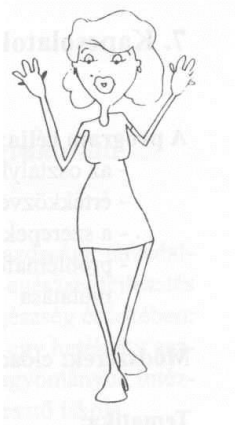
The aim of the programme:

Providing information on skin care and everyday hygiene

Methods: presentation with a slide show

Themes:

1. The structure and protective functions of the skin
   Is it good if you "over" disinfect yourself?
   Changes on the skin, inherent and acquired warts and birthmarks.
2. Sunlight – life – health, and something else ... does that cause cancer?
   Light protection: when? How much? In what way?
3. What does a nice, neat hair, skin, nail look like?
   Natural beauty, care
   The use of nail polish
4. About cosmetics, make-ups, protectors
   What?, Which?, For how much?
5. About acnes – is it a normal phenomenon or an illness?
   When do we have to turn to a doctor?
   Development of mental crises and inhibitions
   Disturbances of self-evaluation, depression
6. Those certain hard days!
   Sanitary pad or tampon?
   For how long is the unsystematic cycle normal?



Number of lessons: 45-60 minutes/session when required

The chair of the programme: … dermatologist and doctor of venereal disease

6. Effective communication

Independent training

The aim of the programme:

To enable young people to express themselves properly and to solve their problems successfully; to make them aware of the effects of their communicational actions to their environment

Methods: skills development training, learning by experience

Number of lessons: 20 hours

The chair of the training: … psychologist

7. In the net of relationships



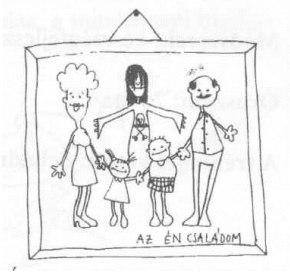
The aim of the programme:

- to strengthen classroom community in the unity of knowing oneself and the other
- value transfer,- looking for values
- enforcement of roles
- revealing problems; introduction of institutes that are competent in problem solving

Methods: presentation, informal discussions, self-knowledge games, film processing

Themes:

1. Family, or, "I am outside,
   I am inside,
   But still in the family."
   - The role of family in present societies
     Matching and comparison of the scale of values of the family and of the society
   - What is the problem with the adolescent?
     Principles of conflicts. Life cycles of the family
   - Family and ME in the future
     Imagined future, wording the desires
2. Our relationships, or "I am with you, but still alone"
   - Where do I belong?
     Attraction and repulsion by peer groups
   - „In a love-bath"



The importance, place and colourfulness of emotions in the life of an adolescent
- What is love then?

Number of lessons: 45 minutes/session (2 times)

The chair of the programme: … social worker

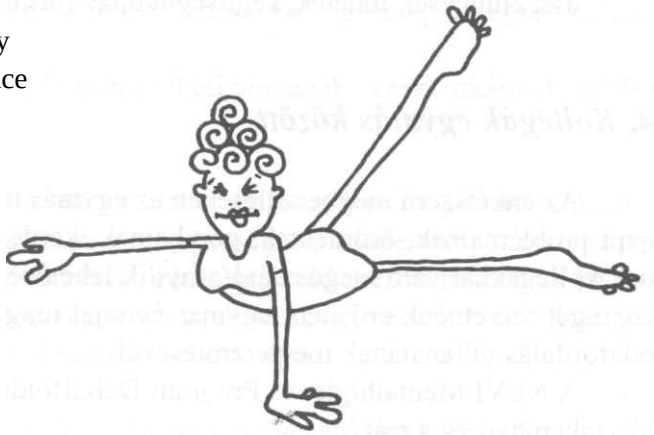
II. PROGRAMMES

1. Healthy life-style – theoretical and practical knowledge of project management

Political, economic, social, cultural, ecological, behavioural and biological factors can affect health positively or negatively. The aim of health promotion is to make all these prerequisites more favourable for the sake of health: individual and social skills should be developed. An effective means of this is the project, that operates as an autonomous organisation within the traditional institutes. One of the model-projects of WHO is the Health promoting school.

Form: 2 lessons of theory
3 lessons of practice

Chair: …sociologist



2. School health day

Compilation and fulfilment of the programme of a school health day, according to the needs and demands of schools.

Several topics offered in the previous section containing programme offers can be inserted into the framework of the health day. The useful and amusing health days complete the everyday continuous health promoting and-educating work. These provide possibilities for focusing on health, healthy life style, spending free time actively in a community in a more harsh form, addressing a wider scope of school setting.

Responsible for the programme: The National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region

3. Round table discussion

We would like to provide educators and directors of different educational institutes with the possibility to discuss professional and human questions with their colleagues in an informal manner. The National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region volunteers for

inviting professionals in the chosen topics. We are waiting for other topics as well than the list suggested below. We volunteer for taking part in organising the forum with pleasure:

a) conflict within the walls of the school (teacher-pupil, teacher-director, teacher-teacher)

– methods and possibilities of conflict management

b) problems of punishment and reward:

disciplinary punishment?, sending down?, effectiveness?

c) the role, responsibility and possibility of schools in public education, in culture

d) an asthmatic child at school – the connections between the disease and physical load, symptoms, forms of providing help

4. Colleagues among themselves

During these conference-like discussions educators working together can share their daily problems, joy, concerns, questions, doubts and success with their colleagues. We would like to make the educator community of the given school stronger by knowing one another and themselves better and by creating the moment of attention.

The National Health Promotion Institute (NEVI) Mental Health Promotion Southern-Great Plains Region provides the required professionals and tea.

III. IN-SERVICE TEACHER TRAININGS

Accreditated in-service teacher trainings of the Juhász Gyula Teachers' Training College in complete or in partial number of lessons. If educators decide on applying for the complete programme, the number of lessons attended here will count as part of the complete (30, 60, 90, 120 hours) in-service training.

1. Health education – mental health promotion

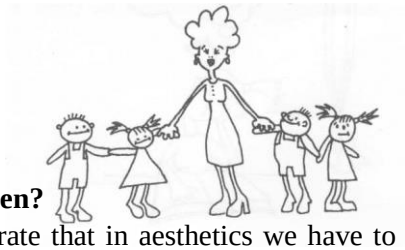
1. healthy life-style –
   differentiated understanding of health
2. conflict management training –
   consensus and cooperation, creative management of conflict situations resulting from the basic situations of power and rivalry.
3. mental health promotion –
   critical periods appearing during the course of life, borders of health and illness
4. healthy society –
   health damaging effect of natural, social and life-style factors.

The aim of the programme:

To provide proper professional knowledge for the preservation and promotion of physical – mental – social health; to develop the skills of knowing oneself and humans; to acquire knowledge and skills essential for the fulfilment of health promotion – mental health promotion tasks of every public education institute, and for the organisation and fulfilment of health education actions.

Number of lessons: 120 hours (four, 30 hours modules, that can be completed separately as well)

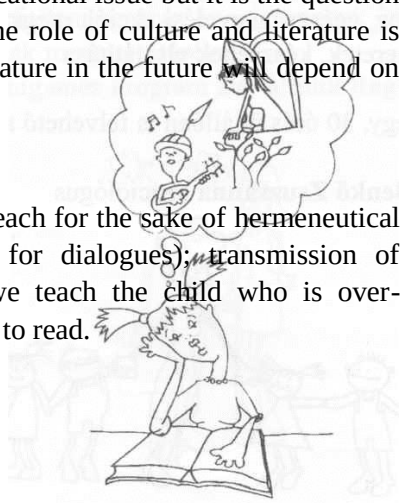
Head of the programme: …sociologist



2. Reading culture – Literature that shapes men?

In the approach of reading culture we demonstrate that in aesthetics we have to grasp the unique features we can not express but only through arts. If we make this sphere, this approach of human existence poor, we will make human existence itself poor. Only someone with a power of judgement can absorb the values of life and existence offered by literature. The growing amount of information results in selection in curriculum planning as well, the number of literary pieces increases and the school selects always backwards and the nature

and proportion of selection is not simply an educational issue but it is the question of educational policy and canonisation also. The role of culture and literature is less and less important lately. The place of literature in the future will depend on the elite intellectuals.



The aim of the programme:
What should we or what would be possible to teach for the sake of hermeneutical reading comprehension education (education for dialogues); transmission of reading comprehension strategies: how can we teach the child who is over-exposed to video-culture and computer sciences to read.

Number of lessons: 5 hours

Head of the programme: … literary historian

3. Music culture
Between the extremes of music as art and commercialised music there can be an attitude to music in which predisposition for music everybody has can operate. Undertaking the musical effect, experiencing it freely – without a scholarly attitude – can help to preserve mental integrity. By switching rationality and the force of conceptual thinking off it addresses us on a non-verbal level, makes us rest, dissolves and creates stress and contradiction, and arranges our internal-world.

The aim of the programme:
conscious application of listening to music individually and in a community as well, for the sake of everyday recreation and discovering the old-new source of pleasure.

Number of lessons: 5 hours (2 sessions)

The chair of the programme: … psychiatrist

4. Environment and health
I.
l. Historical antecedents of environmental protection and its relationship to the preservation of health.
2. Diseases that can be traced back to the damaging of nature and their prevention

3. Connections between healthy nutrition and bio-farming. Connections between organisms manipulated by gene-technology and food industry. Biodiversity.
4. The connection between sustainable development and health services. Conceptions for area development
5. Possibilities of educating for a healthy life-style at school.

II.
l. Understanding development. Characteristics of the consumer society. Effects of production and consumption on the environment.
2. Basic human needs. The way we feel in general. Factors influencing general feeling. The micro-environment. Home as a micro-environment
3. City – men - environment
4. Environmental procedures. Local, regional and global environmental problems.
5. Environmental and health relevance of traffic.

The aim of the programme:
To provide educators with knowledge essential for their environmental – mental health promotion work.

Number of lessons: 10 hours

Head of the programme: … biologist, … engineer

Annex 5: HEALTH PROMOTING SAMPLE PROJECT – SELECTION FROM THE PROGRAMME OFFER

Name of the project: „ Pages (days) from the life of Treasure-seeking Elves

Principles applied during working the project out:

The programme is a framework plan that can be flexibly altered according to the interest of children, the weather and haphazard unexpected events.

Furthermore, our important educational aim is to provide grounds for active contribution and independent activity in the creation of the programmes of all times, so the child-group has to play an outstanding role in the perfection of the programme, as this is the way through which we can reach our targets: to make the building in of the importance of individual contribution and "added value" experienceble.

The plan is tried out in the summer holiday, then comes evaluation and revisions if needed. This is the process through which the programme reaches its final shape.

Completed with valid documents we offer this programme warm-heartedly for others for an enriching treasure-hunt.

Participants: wonder-group of restless treasure-seeking elves
(Lower-primary school children, 6-8 year olds)

Location: Wonderland of Treasure-seeking Elves
(In the soft lap of nature, children's camp)

Date: when the sun rises early and sets late
(Summer holiday, 5 days)

Without joking, the "helpers" are:
radiating teachers who prefer fun
Dedicated teacher trainees
Kindergarten teachers, nurses (or trainees)
A doctor who is always available
Practical masters of the science and art of nutrition

Content (and spatial) structure of activities in the project:

THE COUNTRY OF TREASURE-SEEKING ELVES

Its most famous islands

Our secret maps
Rustle-map
Smell-map
Taste-map

ISLAND OF EXPLORERS
Trace-map
Sign-map

We sing and dance

ISLAND OF WIZARDS - CHARMERS
Role-plays
Drama-pedagogy
The forrest and the meddow comes to life …

Handcraft inspired by nature
A-ha!
Heureca!

ISLAND OF HANDYMEN – DEXTERITY
Art in nature
I have one (?) idea!

Do not panic!
Take care!

ISLAND OF GUARDS
Safety
First aid

Food-stock of forrests and medows
We have brewn what we are cooking

ELF WONDER-KITCHEN
Spread my table, spread!
Summer dainties
Let's drink, but what?

Temporal structure of activities in the project:

1. DAY

1.1 Opening address
1.2 Passport to the COUNTRY OF TREASURE-SEEKING ELVES
Cheerful discussion, getting to know each other
(Communication games)
the rules of treasure seeking
(Programme offer
programme of the week
daily agenda
requirements
wishes)
discovering the location
(Orientation points)
1.3 Playful elf-conferring
Something is always happening here ...
Emblem making flag
T-shirt
Hat
Satchel
Password, team-shout, elf march
Spells of treasure-seekers
Book with a clasp and a treasure chest
1.4. Creating the elf-nook

2. DAY

„Shine, Sun"
Sunlight is in the centre today.
Everything we know and we have to know about sunlight
There can be highlighted tasks and observation aspects as well:
Light – shadow
The life-giving force of the Sun
The damaging effect of the Sun (sunbathing, skin type, protection)
The Sun and the plants
The Sun and the animals, insects, butterflies
The Sun means this to me …

7-8 Greeting the Sun
Wake up, morning physical exercise by the forest, have a wash
Breakfast
9-12 ROAMING
BEING ALL EARS
12-14 Lunch
Silent rest „Have a rest and leave others rest as well"
14-18 DEXTERITY
STIRRING
SEARCHING
18-19 Dinner
19-21 Sitting by the camp-fire presenting the treasures found that day
HUMMING
BEING ALL EARS
21 „Retire for the night"

3. DAY

The tasty day of TASTES
Today we examine the topic of nutrition.
Our highlighted aspects: healthy eating at summertime
The amount of liquid we need
The food stock of the forests and the meadows
Dangers, they can be prevented!
Visiting our favourite people
We have brew what we are cooking

7-8 Fragrant, fresh wake up
The raspberry bush is calling. Cheerful morning physical exercise
Have a wash, eat breakfast
9-12 SEARCHING
TASTING
12-13 Special dainties: „We have brew what to cook today"
Present of the forest – the meadow
14-18 DEXTERITY
RUMMAGING
18-19 Light dinners, "creative dishes"
19-21 Walk, game, saying good bye to the Sun
Large poster (group-work): I liked this today

4. DAY

Today everything is in MOTION!

We explore the necessity and importance of physical and mental movements for being healthy.

Highlighted aspects: exercises in nature
To let do exercises
Changes and messages
Hidden happenings
Being safe (rules and violators)
It is good and exhilarating to move

7-8 The streamlet is calling Morning physical exercises, have a wash
Breakfast

8-12 STIRRING
ROAMING

12-14 Lunch, silent rest

14-18 Competition of Treasure-seekers
CHALLENGE day
Playful competitions
The cavalcade of islanders
„If the battery is starting to become dead...“

18-19 Dinner

19-21 TUNING
Observing the stars
Greeting the night

5. DAY

TOGETHER, WITH ONE ANOTHER, FOR EACH OTHER

The force of joint experiences is in focus.

Highlighted aspects: biocenosis on the meadow, field, in the forest and in the water
Men and nature
The strength of help
Together and for each other in good and bad
„We have found this all, we have been richer by these “
What is in the treasure chest?

7-8 Trilling call – morning physical exercise on the path, morning wash
breakfast (with a hidden message)
secret map, coded

call for an obstacle race

8-12 solving the coded message in groups:
obstacle race
aim: THE TREASURE OF TREASURES

COMPLEX BLOCK – all forms of activities appear as a stage in the competition
Being all ears
smelling
tasting
searching
tuning
humming
stirring
dexterity

Finally the big puzzle is solved, representing the whole added and compiled knowledge: the treasure chest is full!

12-14 Gala-Lunch, with guests
(Everybody can bring with him- or herself a "somebody", who he or she became fond of during the various events of the past days – it can be a plant or an animal …)

14- 18 Preparations for closing the camping
making surprises, rehearsal of the show

18- Closing discussion of treasure seekers by the camp-fire

Annex 6: FORMS OF ACTIVITIES USED IN THE PROJECT AND THEIR POSSIBLE EXPERIENCE AND VALUE CONTENTS:

The listed forms of activities can be altered, enlarged and revised according to the characteristics of the given child group.
Designations created on the basis of "speaking names" make children act and contribute in situations different from usual ones and they do all these with humour and merriment.
We find it important, that the child him- or herself chooses the forms of activities that are interesting and important for him or her at the moment.
These situations can be for him or her the developmental situations, the springs of development.
Some forms of activities were included with educational aims in mind, but we strive at grasping every situation in its complexity and make them experienceble for the child in its "Wholeness". (To experience it in the unity of head – heart - hand). The complete experience is provided by the

"glinting elf eyes
Warming elf-hearts, and
Busy elf-hands".

The whole personality takes part in the developmental process.

Forms of activities	Possible experience and value contents
BEING ALL EARS	rustle, noise, thud, Discovering and collecting "new sounds" "Hearing" the silence Wind, breeze, rainfall Changes according to parts of the day (being all ears in the morning and in the evening) "Hearing" the distance (close and distant noises, sounds and rustles) Attention and concentration exercises Meditative exercises Games (fantasy, guessing and fiction games …) (self-knowledge and communication games „I like it, it is pleasant ...") Search for onomatopoeias Creation of a "rustle map"

SMELLING	collecting fragrances, odours Smell of fresh grass and characteristic plants, Smell of moss-pillow Smell of mud "Message" of fragrances and odours (protection, prevention, possible dangers) Orientation by using smells (Elf kitchen alluring) Changes corresponding to the parts of the day (early morning, during the day, in the evening or at night) The changing smell-cloud Changes in the weather Games (fantasy, guessing and fiction games …) (self-knowledge and communication games Creating a "map of smells"
TASTING	experiencing original basic tastes Tastes of nature (spices, vegetables, fruits, berries, mushrooms) TAKE CARE!! Edible – non-edible – poisonous Taste compositions (eating habits ...) what is in the "elf-kitchen"? "We have brewed what we are cooking" games (If I was a goat …) Fantasy journey into the land of tastes Guessing with your eyes covered: Can you recognise it? (fruit, vegetable) TAKE CARE! Individual sensitivity to food Self-knowledge, knowing the partner Compiling the "collection of favourite tastes"
SEARCHING	life in the nature. Art in the nature Clouds, sunlight, wind, rainfall Evening, star constellations, shooting-stars Characteristic and unique plants, animals, butterflies Interesting stones, pebbles ... Reading traces. Trails, signs, messages The most … (motley, winding ...) games (island of explorers That could be … - stories from the traces)

TUNING	making tune and rhythm instruments out of willow and other materials found in nature games (Mood inspirations "Background music" Associational games) Self-knowledge, community building, situational exercises
HUMMING	Topic-specific songs (summer, sunlight ...) Animals, plants, insects, Camp-songs, excursion-songs, at the camp-fire With the prepared rhythm and tune instruments
STIRRING	Small and big movements: imitating games (e.g. characteristic movements of animals quivering of leaves, flights of birds, running of insects, the waving of water falling over the rocks motion and communication Safe motion, „traffic" (forest, meadow, water, bank of the river, mountain ... playground) means of transport - ship, boat, ferry-boat traffic rules proper clothes A sound mind in a sound body Cheerful exercising competitions (storks, sneaking foxes, Frisking little rabbits, toddling ducks, funny competition of frogy frogs) Morning elf stretching (morning physical exercises) Strength-collecting, "heave-ho!"
ROAMING – COMMPASS	Exploring nature, Connection of animals and plants Discovering changes orientation collection of experiences (for self-knowledge and for building a community as well) Together – for one-another – helping each other

	Safety, First aid Big book of discoveries „Guidebook to the Country of treasure-seeking elves”
DEXTERITY (HANDYMAN DRAGONFLY)	Bio painting (painting plants) Jewellery out of plant parts, twisting, spinning, weaving, using husks (grass, straw) felting (ancient handicrafts) bark-patterns, leaf-prints self-knowledge, knowing the other (hidden abilities) (creating balance) Elf gallery, art exhibition Creation of presents and surprises

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