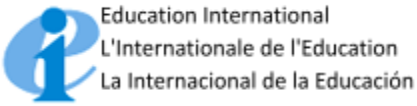
Integrating Health and Social Programs within the Core Mandates, Constraints, and Concerns of Education Systems

A global dialogue led by ASCD, Education International and the International School Health Network

A White Paper Identifying Realistic Policy & Program Directions, Alternatives and Examples



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Founded in 1943, ASCD is the global leader in developing and delivering innovative programs, products, and services that empower educators to support the success of each learner. Comprising more than 125,000 members—superintendents, principals, teachers, professors, and advocates from more than 138 countries—the ASCD community also includes 54 affiliate organizations. The nonprofit's diverse, nonpartisan membership is its greatest strength, projecting a powerful, unified voice to decision makers around the world. The association provides expert and innovative solutions in professional development, capacity building, and educational leadership essential to the way educators learn, teach, and lead.

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Education International represents organizations of teachers and other education employees across the globe. It is the world's largest federation of unions, representing thirty million education employees in about four hundred organizations in one hundred and seventy countries and territories, across the globe. Education International unites all teachers and education employees. .

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The International School Health Network (ISHN) comprises practitioners, researchers, and government officials, as well as regional and other networks, international agencies, and organizations concerned with health, safety, development, equity, social development, sustainability, and other forms of human development. The network is recognized by the World Health Organization as well as other UN agencies and works in cooperation with several international organizations, professions, and networks as well as several regional cross-sector networks.

This white paper is a joint effort between ASCD, EI and the ISHN to promote and disseminate examples of health and social programs that have been successfully integrated within the core mandates, constraints, and concerns of education systems across the world.

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Recommendation 1: The health, social and other sectors need to seek, establish, and maintain new partnership models based on integration within the education system.

1.1 Consider different models of partnership and ways of organizing/monitoring their cooperation.

1.1.1 Strategic, stable, negotiated, formal and operational inter-ministry/ agreements.

1.1.2 Joint budgeting, service plans, hiring/assignment of school health or multisector coordinators.

1.1.3 Fit within organizational routines at the ministry, agency and school levels.

1.1.4 Align within various multi-component approaches developed by educators

1.1.5 Align within the multi-component approaches used by other sectors to promote health, safety, inclusion, equity, student rights and other forms of human development

1.1.6 Work through one designated team/person when dealing with education ministries, authorities or schools.

1.1.7 Establish, support inter-sectorial long-term policies/programs that align with the priorities of education systems as well as achieve other sector goals. These could include:

1.1.7.1 integrated student services, especially for vulnerable students

1.1.7.2 diverting troubled students from suspensions and conflicts with the law,

1.1.7.3 combining various hygiene/ sanitation (WASH), feeding and other interventions in low resource countries or in countries recovering from emergencies or conflicts to ensure access and participation in schooling,

1.1.7.4 combining various services, inter-sectorial coordination, interventions and focusing on alternative schools, vocational programs and alternative academic tracks to reduce the number of students dropping out of school,

1.1.7.5 using school meal and school feeding programs as a vehicle for strengthening inter-sectorial partnerships

Recommendation 2: Health system officials, decision makers, and researchers should examine and better understand, via dialogue led or facilitated by educators, the core mandates, constraints, attributes, processes, and characteristics of educational systems in order to better integrate within them. This includes a thorough understanding of the work lives, social backgrounds, and professional identities of teachers and other educators as well as developing different, more effective, longer-term work force development strategies for teacher education and development.

2.1 Recognize and understand the implications of the core functions of school systems, their values and norms and ideologies, the socio-political constraints and the current trends and demands being placed on schools.

2.1.1 Anticipate competition among the five core mandates that schools perform for society

2.1.2 Recognize how the core values/ideologies within education and other systems may clash.

2.1.3 Understand how community norms, parental privacy, professional norms/ taboos among educators will hinder or help health or social programs.

2.1.4 Understand the limitst to which school systems and educators can moderate/modify their strong, traditional and necessary concern for orderly learning environments, social control and school discipline.

2.1.5 Overcome teacher concerns about monitoring and surveillance activities caused by inappropriate uses of high stake testing, school ranking and teacher evaluation schemes

2.1.6 Integrate health and social goals and programs within the appropriate, accountability and improvement systems used by educational systems.

2.1.7 Work within the prevailing management strategies/structures used in the education system

2.2 Recognize and respond to the latest and changing pedagogies and teaching/learning strategies being used in education systems as well as the resources available to schools in resource-challenged contexts

2.2.1 Recognize the dichotomy between the “behaviourist” learning theories underlying traditional health, personal and social development (HPSD) education curricula and programs which define specific knowledge, attitudes and behaviours to be taught and the movement in the education sector towards constructivist learning, which uses experiential, personalized and/or inter-disciplinary learning often across several subjects in the core curriculum

2.2.2 Adapt to the increased use of technology in the classroom to better assist teachers in their HPSD teaching

2.2.3 The health, social and other sectors and donor organizations need to recognize and adapt their educational programs to fit within the resources available in low resource and conflict/disaster-affected countries.

2.3 Truly understand the work lives, beliefs, professional identities, social background, professional norms and concerns of teachers to engage them over their teaching careers. Also address the organizational culture of the local health, social and educational authorities..

2.3.1 Address the beliefs/perceptions that educators have about the health and social issues

2.3.2 Help educators to understand the communities in which they teach and to reflect on how their own beliefs/values.

2.3.3 The work lives, professional identities and career paths of educators will affect their ability and willingness to engage in health & social programs.

2.3.3.1 Understand how the daily work routines of educators.

2.3.3.2 Recognize how the extremely accessible, visible, multiple roles of the school principal as the front-line manager will affect their starting, supporting, maintaining and succession planning of school programs.

2.3.3.3 The organizational culture of a school, health or social agency or ministry will affect the willingness of teachers, agency staff or government employees to adopt and implement programs.

2.3.3.4 The relatively high rates of teacher turnover, especially for new teachers and for health teachers, will affect the delivery of health & social programs. Health and social program staff need to plan for these turn-overs as part of their sustainability and succession planning.

2.3.3.5 Address the “adopter concerns” of teachers.

2.3.3.6 Alleviate and address teacher wellness, particularly stress.

2.3.3.7 Work with many types of educators as well as professionals from other sectors.

2.4 Use a long-term, life-long learning, work force development approach to teacher education/development

2.4.1 Work with educational authorities to develop a long-term and strategic plan to develop both the generic teaching competencies and knowledge to address the over 25

2.4.2 Address the normative beliefs, self-efficacy, personal beliefs, professional norms, professional identities and perceptions of teachers

2.4.3 Trust teachers in preparing, selecting and adapting educational materials and teaching strategies by creating and maintaining banks of lesson ideas and materials rather than preparing one set of lesson plans and expecting teachers to follow and use them for years.

2.4.4 Integrate a work force development plan for teachers within the existing stages and structures used by the education system to educate and develop teachers

2.4.5 The training activities and strategies should fit within the current models used in teacher education and development, including support for induction, coaching, mentoring, adult learning and developmental approaches

2.4.6 Invest more in the education and training of non-educational personnel that will work closely with educators so that they can maximize their effectiveness when working within schools.

Recommendation 3: Health and social sectors must join the education sector in focusing on the growth and development of the whole child rather than directing attention and resources only toward specific diseases, behaviors, or conditions as separate or siloed entities.

3.1 The health, social, development and other sectors should maintain a focus on the needs of the whole child, including educational access and attainment, while still responding to specific urgent problems.

3.2 The health, social, development and other sectors should develop contextually sensitive, long-term joint policies with education, including models and plans for work for which multiple sectors are responsible

3.3 The health, social and development sectors should support a well-rounded, whole child approach to education as well.

3.4 All sectors should work together and with education to define a minimum, common set of contextually sensitive set of student learning objectives that can be taught in a mandatory Health, Personal-Social Development (HPSD) Curriculum/life skills education program as well as across all subjects in an inter-disciplinary manner.

3.5 The health, social, development and other sectors should work together to develop a joint work force development plan for educators and non-education personnel

Recommendation 4: This realignment of health and other sector efforts should be founded on a systems-based, organizational development approach focused on investments in capacity-building and continuous improvement.

4.1 Fit within or seek to modify a variety of school structures, practices and organizational routines (e.g recess, parent meetings etc.)

4.2 Recognize and address the bureaucratic and other characteristics of education systems.

4.3 Align their strategies with current models being used by educators to guide educational change.

4.4 Make ongoing investments in capacity and capacity-building that go beyond the transfer of knowledge about effective programs to employees to define the human and financial resources that will be committed.

4.5 Health, social services, donors of humanitarian and relief aid, safety, law enforcement and other sectors need to establish and enforce over-arching policies on holistic approaches to child/youth health, development and protection. Health ministries need to have policies on health promotion, police services on community policing and youth diversion, and so on.

4.6 The health, social, development and other sectors should establish comprehensive policies to guide their partnerships with the education systems. They should:

4.6.1 define explicit goals for working with their respective education systems and them codify them in joint ministry statements, service agreements and protocols,

4.6.2 establish requirements for their local agency service delivery regarding their local partnerships with local education authorities,

4.6.3 identify and then provide the funding for the staffing and training for the front-line workers or local agency (e.g. school nurses, social workers, resource officers, youth workers, psychologists and others) that will work with teachers and within schools

4.6.4 designate how their respective core sections/mandates will function when working with school systems.

4.7 The health, social, development and other sectors should define minimum service delivery levels as part of their relationship building with education systems.

4.8 The ministries and agencies in health, social, development and other sectors should review the structures within which school-related programs and services are delivered. Optimal structures, derived from the needs of children, youth and educators, should be considered as alternatives to the traditional, often ad-hoc structures which reflect the low status of school programming in other sectors, ministries and agencies.

4.9 All sectors should develop, implement and maintain “no-blame”, incremental, long-term strategies for working with the education sector that emphasize shared responsibility and leadership.

4.10 The health, social, safety, welfare, development, education and other sectors should jointly develop and maintain a joint monitoring and reporting system for assessing the reach and status of relevant policies, programs, practices and qualifications of personnel, agencies and ministries in several sectors that work with schools.

E. Signatory Organizations

Preface

It is time for a new paradigm. It is time to place children at the center of our systems and to array the necessary resources and services around them in order to ensure they reach their full potential. We must focus on ensuring children's success on all levels, developing the health, social, education and other sectors as vehicles and tools to enable that success.

For too long, key sectors such as health, welfare, development, humanitarian aid, safety/security and education have acted within siloes—achieving success in isolation, and too often working to cross-purposes. Yet they serve the same children, often in the same locations.

Schools are a perfect setting for this collaboration. Schools, working with other agencies and professionals from other sectors, become the most effective and efficient systems for reaching children and youth to provide equitable access and success in schooling, safe and healthy spaces, health and other services and a supportive social environment that engages students, involves parents and serves communities. Because almost all children and youth attend school. Integrating health, social and other programs more deeply into the daily routines of schools and students represents an untapped tool for improving learning.

The United Nations, in adopting the 2030 Sustainable Development Goals, has underlined the importance of education and schooling as being central to achieving all of the 17 goals. At the 2015 Oslo Summit on Education for Development UN Secretary-General Ban Ki-moon declared that this is a chance to reaffirm the human right to education, an opportunity to mobilize political commitment, and "our moment" to galvanize international support for education, as he met with several global partnerships, initiatives and organizations concerned with education.

> *"We are here to secure commitments to deliver on the promises of the sustainable development agenda. Education is essential to its vision of a life of dignity for all*," stated Secretary-General Ban Ki-moon.

The World Health Organization ongoing call for the inclusion of the Health in All Policies (HiAP) initiative has added to this opportunity for inter-sectorial dialogue. Margaret Chan, director-general of the WHO, has captured the sentiment underlying HiAP:

> *Collaboration among multiple sectors is imperative.... In the 1980s, when we talked about multi-sectoral collaboration for health, we meant working together with friendly sister sectors like education, housing, nutrition, and water supply and sanitation.*
>
> *—Margaret Chan, June 10, 2013 (Opening address,8th Global Conference on Health Promotion, Helsinki)*

Early in the HiAP process, health experts provided a strategic analysis that the health sector, as well as other sectors wishing to work within schools, need to take to heart.

> *"HiAP focuses on the role that governments play in achieving population health and equity." Working across government sectors is also difficult—'ownership', funding, reporting arrangements, departmental or agency culture, and language all present challenges for joined-up government. Government departments are often said to operate as 'silos', which need to be bridged to achieve joined-up government. In reality, government departments often work more like castles and keeps than silos, being actively defended to resist distraction from 'core business' and sectoral interests. In implementing HiAP, a number of questions are raised and need to be considered:*

- *It is one thing for the health sector to be interested in trying to solve its wicked problems, but why would other sectors want to work in a joined-up way with Health in an HiAP approach—what's in it for them?*
- *Health often makes up the greatest single expenditure of governments, so why should other agencies be asked to spend their funds on health outcomes? Again, what's in it for them?*
- *How should the power dynamics and relationships between health and other sectors be managed so that a fruitful relationship can be developed—who leads (and, therefore, who follows)? This is a vital question as relationship-building and partnerships are key aspects of successful across-sector work.*
- *How do you develop a common goal given the current institutional arrangements where each sector is striving to achieve its own goals? Without shared goals, at some level HiAP will fail.*
- *How do you develop a culture of cooperation given that sectors, and their leaders, are in competition for resources and 'their time in the sun'?*
- *What is Health's role in HiAP? How can it be inclusive and not dominant in partnerships given that health issues are generally seen as Health's responsibilities?*

Ilona Kickbusch, Kevin Buckett (2010) Implementing Health in All Policies: Adelaide 2010, Government of South Australia

In other words, if the HiAP initiative (and similar calls from other sectors for school involvement) are to be effective and sustainable, they first need to be based on a systems approach. If we are to expect that front-line workers in health and other sectors are to develop new ways of working with schools, then they will need to be supported by their respective ministries and local agencies.

Second, they need to truly understand, anchor and negotiate their way into the core functioning and concerns of education systems. It is not only about working "with" school systems, it is about working "within" their core mandates, constraints and concerns.

It is time for schools, health services, and communities to openly discuss potential battles for resources and instead negotiate the alignment those resources in support of the whole child while still ensuring that the specific priorities and problems are addressed. Policies, practices, and resources must be aligned to support not only academic learning for each child, but also the experiences that encourage the development of the whole child—one who is knowledgeable, healthy, motivated, and engaged.

We ask the health, social and other sectors as well as education to take a broader view of the child, one that views children as more than accumulators of academic content and more than health problems to be solved.

Yet integrating or even aligning these two sectors is not simple. Each sector has mandates, obligations, core audiences, and specific funding streams that require specific outcomes. In many countries, the alignment process requires participants to relinquish control and adapt policies that have served them for many years. If leaders are to adjust their approaches, they must first see and understand the value of change, and that value must outweigh any effort required for implementation.

The Rationale (Research, Data & Experience) for a Fundamentally New Partnership: Going Beyond "With" to "Within" Education, Schools to Systems, Health to All Sectors

There are several important reasons why the true integration of health & social programs within education systems is urgently required and why this integration needs to occur within a more holistic, contextualized, systems-based and incremental, explicitly negotiated, continuous improvement approach. These are based on research, data and reports on experiences as cited below.

- Despite the compelling logic and promising evidence that multi-intervention programs on selected issues are effective, there are several studies and reports showing that full-scale, sustainable implementation and maintenance of comprehensive multi-component approaches are not being achieved and that multi-intervention programs are not being sustained. [1],[2],[3],[4]

[1] Marthe Deschesnes, Catherine Martin and Adèle Jomphe Hill (2003) Comprehensive approaches to school health promotion: how to achieve broader implementation? Health Promotion International (2003) 18 (4): 387-396. doi: 10.1093/heapro/dag410

[2] Junko Saito, Ngouay Keosada, Sachi Tomokawa, Takeshi Akiyama, Sethavudh Kaewviset, Daisuke Nonaka, Jitra Waikugul, Jun Kobayashi, Mithong Souvanvixay and Masamine Jimba (2015) Factors influencing the National School Health Policy implementation in Lao PDR: a multi-level case study, Health Promotion International (2015) 30 (4): 843-854. doi: 10.1093/heapro/dau016

[3] Michaela Adamowitsch, Lisa Gugglberger and Wolfgang Dür (2014) Implementation practices in school health promotion: findings from an Austrian multiple-case study, Health Promotion International, Advance Access 10.1093/heapro/dau018

[4] Behrouz Fathi, Hamid Allahverdipour, , Abdolreza Shaghaghi, Ahmad Kousha, and Ali Jannati (2014) Challenges in Developing Health Promoting Schools' Project: Application of Global Traits in Local Realm, Health Promotion Perspectives, 2014; 4(1): 9–17, Published online 2014 Jul 12. doi: 10.5681/hpp.2014.002

- Over-arching policy, basic funding and staffing as well as several system/organizational capacities must be built, maintained and monitored if comprehensive approaches are to be sustainable. [5], [6],[7]

[5] Sohyun Park, Eun Young Lee, Joel Gittelsohn, Denis Nkala and Bo Youl Choi (2014) Understanding school health environment through interviews with key stakeholders in Lao PDR, Mongolia, Nepal and Sri Lanka, Health Education Research, Volume 30, Issue 2, Pp. 285-297

[6] Heather A McKay, Heather M Macdonald, Lindsay Nettlefold, Louise C Masse, Meghan Day, Patti-Jean Naylor (2014) Action Schools! BC implementation: from efficacy to effectiveness to scale-up, Br J Sports Med 2015;49:210-218 doi:10.1136/bjsports-2013-093361

[7] Lisa Gugglberger and Jo Inchley (2014) Phases of health promotion implementation into the Scottish school system, Health Promotion International, Volume 29, Issue 2, pp. 256-266

- Despite the often-stated arguments and appeals for partnerships between the education, health and other systems, there are often tensions, misunderstandings, competitions and differing priorities among the sectors seeking access to schools that need to be addressed. Further, educators often view these programs as secondary to their core mandates. [8],[9],[10],[11],[12],[13] Indeed, better integration within education systems may be the key to successful implementation and maintenance of various health programs in schools[14].

- There are differing understandings and resulting confused actions about comprehensive approaches. These include differing views that the approaches are (a) a rigorous set of evidence-based interventions, (b) a set of principles and a process to understand what is already underway in the school, (c) that fixing or training educators to take on most of the responsibility for the approach is the best strategy rather than a shared responsibility of several sectors and levels, and (d) that the approach addresses a predetermined set of issues or that the approach results in a vaguely defined "healthier", "safer" or more "inclusive" school. [15],[16]

- The scarce resources within public health/health promotion ministries and similar sectors/agencies makes it difficult to maintain sustained funding of long-term programs such as health promoting schools[17] since so much of the activity and most initiatives are focused on urgent, emerging health or social problems, with demonstration projects, resource materials and small programs with immediate, visible results being funded. Unfortunately, this short term, project focus in the health sector aligns well with education systems, where individual schools are open, adaptive and responsive to small scale,

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[8] Venka Simovska, Lone Lindegaard Nordin and Katrine Dahl Madsen (2015) Health promotion in Danish schools: local priorities, policies and practices, Health Promotion International, (2015) doi: 10.1093/heapro/dav009

[9] Venka Simovska, Lone Lindegaard Nordin and Katrine Dahl Madsen (2015) Health promotion in Danish schools: local priorities, policies and practices, Health Promotion International, (2015) doi: 10.1093/heapro/dav009

[10] Nastaran Keshavarz Mohammadi, Louise Rowling, Don Nutbeam, (2010) Acknowledging educational perspectives on health promoting schools, Health Education, Vol. 110 Iss: 4, pp.240 - 25

[11] Deschesnes, M., Couturier, Y., Laberge, S. and Campeau, L. (2010), How divergent conceptions among health and education stakeholders influence the dissemination of healthy schools in Quebec, Health Promotion International, Vol. 25 No. 4, pp. 435-43

[12] Amanda Hargreaves (2012) The perceived value of Health Education in schools: New Zealand secondary teachers' perceptions, Journal of Curriculum Studies, Volume 45, Issue 4, 2013 pages 560-582

[13] Helena Melo, Ana P. de Moura, Luísa L. Aires and Luís M. Cunha (2013) Barriers and facilitators to the promotion of healthy eating lifestyles among adolescents at school: the views of school health coordinators, Health Education Research, Volume 28, Issue 6, pp. 979-992.

[14] Langford, R, Bonell, C, Jones, HE, Campbell, R & Langford, RM 2015, Obesity prevention and the Health Promoting Schools framework: Essential components and barriers to success. International Journal of Behavioral Nutrition and Physical Activity, vol 12.

[15] Couturier, Y., Deschesnes, M., Drouin, N. and Gagnon, M. (2009), L'appropriation par les acteurs locaux de la strategie globale de mise en oeuvre de l'approche E´cole en sante´ en lien avec la thematique des saines habitudes de vie chez les jeunes, Institut de recherche en sante´ du Canada, Quebec.

[16] Edith Flaschberger, Lisa Gugglberger and Christina Dietscher (2013) Learning in networks: individual teacher learning versus organizational learning in a regional health-promoting schools network, Health Education Research (2013) 28 (6): 993-1003. doi: 10.1093/her/cyt079

[17] Betty Bekemeier, Anthony L.-T. Chen, Nami Kawakyu, Youngran Yang (2013) Local Public Health Resource Allocation: Limited Choices and Strategic Decisions, American Journal of Preventive Medicine, December 2013Volume 45, Issue 6, Pages 769–775

external demands/innovations but resistant to large scale efforts to reform or change their fundamental core functions or priorities[18]. [xviii].

This paper seeks both to start a conversation around the need for change and to highlight specific policy examples globally in which such change has already occurred. Policy changes supporting this process have been showcased so that they can be reviewed, discussed, adjusted, and potentially replicated by others.

Consensus Statement

The following consensus statement was developed out of a symposium held in Thailand in 2013 involving more than 60 leading education, health, and school health experts from across 20 countries. Since its release in 2014, the statement and its implications have been presented and discussed at a series of regional summits calling for the integration of the health, social, and other programs within education at the systems level (USA, 2014; France, 2015; Canada, 2015; Brazil, 2016) as well as among UN agencies & global organizations. These regional events have been supported by a research/knowledge development agenda developed by an International Discussion Group and several webinars. Further, the challenge of integrating health and social programs within education systems in part of a global Delphi Consultation on current knowledge in school health & development with over 150 experts that will conclude at World Conference planned for December 2017 in Dubai.

The Integration of Health and Social Programs Within Education

Schools, working in partnership with communities, parents, and agencies, have always been an integral part of efforts to promote health, safety, and equity. These school-based and school-linked efforts have evolved into many distinct but overlapping multicomponent approaches. Yet despite significant progress and improved effectiveness, the implementation, maintenance, and sustainability of these multicomponent approaches has been problematic.

The inability to overcome the challenge of maintaining and sustaining these multifaceted approaches has led to this call for a dramatically different approach whereby health and social programs would be truly integrated within the core mandates, constraints, processes, and preoccupations of the education system. While there have been numerous studies, statements, and reports calling for greater alignment of these two key sectors, what is now clear is that we should not be seeking alignment of health and education, but rather integration of health and social development within education systems.

A deeper analysis of the goals, functions, and current operations of school systems is needed to determine the most practical, pedagogical, and political strategies whereby health and social priorities can be truly embedded within education. This should include dialogue in a variety of cultural, economic, and geographic settings to better understand the various school systems and their contexts. Health and social policies must be adapted, crafted, and integrated into the policies, processes, and practices of education systems. In short, health must find its cultural anchor within the education system.

[18] Keshavarz N, Nutbeam D, Rowling L, Khavarpour F. (2010) Schools as social complex adaptive systems: a new way to understand the challenges of introducing the health promoting schools concept, Soc Sci Med. 2010 May;70 (10):1467-74. doi: 10.1016/j.socscimed.2010.01.034. Epub 2010 Feb 12.

Why Seek Integration within Education Systems?

Health and education are symbiotic: what affects one affects the other. The healthy child learns better, just as the educated child leads a healthier life. Similarly, a healthier environment—one that supports not just physical health, but social and emotional health—enables more effective teaching and learning.

Many jurisdictions have developed strong multifaceted school health programs, particularly when compact geography, unitary governance structures, or strong leadership is in place. However, many other health systems now face significant challenges just to maintain the resources available for overall health promotion, so their ability to support comprehensive approaches in schools is often reduced or narrowed to a select number of issues.

Yet such a narrow focus can be counterproductive: policies that focus only on one set of outcomes undermine the success and sustainability of interventions. Too often, we see health initiatives that compete with educational outcomes, as opposed to complementing them. Worse yet, schools frequently experience different health strategies competing with each other rather than collaborating with or complementing each other, let alone complementing educational goals. Initiatives focused on overall wellbeing often compete for resources with initiatives focused on drug education, nutrition, or even physical activity, even though together, they develop a healthy learner. As such, educators and policymakers often view health and other social programs as an “add-on” to their own core responsibilities, sustaining the tension between the health and education sectors rather than helping them come together as partners.

Why Now?

The WHO and the health sector have adopted a position favoring the HiAP initiative; the participants at a recent WHO health promotion conference (Helsinki 2013) issued a formal invitation to all sectors to take up that initiative. With this favorable environment, the time is right for educators and health professionals to come together to integrate their fields.

New research on ecological and systems-based approaches to school health promotion and social development offers fresh insights and opportunities for integrating the health and education sectors. This new understanding is congruent with current educational trends and research suggesting that school-based management and other forms of local leadership are ultimately more appropriate to the 21st century. Increasingly, education systems are being required to focus on the skills of social and emotional development, collaboration, and creativity. Safe, healthy, and supportive environments that promote the development of the whole child—socially, emotionally, mentally, and physically, as well as cognitively—are becoming the norm. A renewed partnership between health and education will help to take advantage of this new understanding of how to best support the whole child.

Recommendations

This consensus statement contains four recommendations:

1. The health sector needs to seek integration within the education system—not education’s adoption of health priorities. It must seek, establish, and maintain new partnership models based on integration.
2. Health system officials, decision makers, and researchers should examine and better understand, via dialogue led or facilitated by educators, the core mandates, constraints,

attributes, processes, and characteristics of educational systems in order to better integrate within them.
3. Health and social sectors must join the education sector in focusing on the growth and development of the whole child rather than directing attention and resources only toward specific diseases, behaviors, or conditions as separate or siloed entities.
4. This realignment of health and other sector efforts should be founded on a systems-based, organizational development approach focused on capacity building and continuous improvement.

Moving Forward

The Global Consensus Statement clearly articulated the need to integrate the health and education sectors in order to support the development of the whole child but it is not a totally new idea. Similar conversations have been taking place in various countries and among various sectors for a number of years. In the United States, such discussions have included groups like Health in Mind, the National Coordinating Committee on School Health and Safety, the U.S. Department of Education's Office of Safe and Healthy Students, and the CDC's Division of Adolescent and School Health, among others. In Canada, these dialogues have included Physical and Health Education Canada (PHE)'s Healthy School Communities, as well as detailed alignment at the provincial level, especially among the ministries of education and health in Quebec, Ontario, and British Columbia. Outside of North America, key players promoting sector alignment include the International School Health Network, UNESCO FRESH, Schools for Health in Europe, and the WHO's Health Promoting Schools framework, as well as many national ministries and country-specific organizations. Examples of successful integration and alignment can be seen across every continent, proving the global importance of promoting a concentration on the whole child.

Although this dialogue has become prominent in the past three years, it is by no means the first occasion for such discussion, nor the first time integration has occurred. The integrated approach has long been recognized as effective, and this publication is intended to offer insights into successful actions and improvements that have already occurred so that others may learn from them. Here, we outline the four main recommendations of the Global Consensus Statement along with key sub-points expanding upon each recommendation.

Where possible, we highlight successful examples of the alignment and integration of various sectors, particularly health and education. Through these examples, we illustrate the applicable recommendation or sub-point and offer insights into measures that have already been taken to enact positive change in the education and health sectors, ensuring the development of the whole child.

Much as our understanding of the integration of health and education continues to develop, this paper is an organic document, and as such, new examples will be added as they are submitted. We welcome you to send examples to wholechild@ascd.org.

Recommendations and Policy/Program Examples

Recommendation 1: The health, social and other sectors need to seek, establish, and maintain new partnership models based on integration within the education system.

1.1 The education, health, social service, safety, development and other sectors should consider different models of partnership and ways of organizing/monitoring their cooperation.

Thus far in this global dialogue, we have identified these different models for enhanced, integrative inter-ministry, inter-agency, inter-sectorial cooperation:

Model One: Governments and donor organizations can explicitly assign a leadership role to education systems (e.g., ministries, school boards, schools, education professionals) as the backbone of several multi-intervention approaches. School systems can then coordinate the various comprehensive and problem/behavior-specific strategies (e.g., healthy schools, safe schools, hygiene and sanitation programs, community schools, mental health, obesity, etc.) and develop flexible ways to report on progress.

Model Two: The role of the health sector, aid/relief donor organizations, and other sectors can be transformed to a facilitating rather than directing one that has traditionally involved selecting certain problems or behaviors as priorities. This model can provide more data for national, state, and local education authorities to assess their health/social needs, using surveys of students and policies/programs in combination with local data sets, so that educators can select the health issues of greatest concern to them. This model also requires the use of new methods for accountability and reporting on progress to avoid resulting in a series of projects rather than a more holistic approach to progress.

Model Three: This model emphasizes the inter-ministry approach across the whole of

Revised Quebec Inter-Ministry Inter-Sector Cooperation Process & Protocol

The government of Quebec, through its Institut nationale pour la sante publique (INSPQ), has been a leader in assessing the sustainability of its school health promotion model. Following a large international conference in 2011, the INSPQ and the Quebec health ministry re-assessed its approach to working with the education sector. The realization that the many, many topics emerging from the 2011 conference were overwhelming schools accompanied a similar development in the education sector that has led to a curriculum overhaul based more on generic student competencies rather than traditional subject-specific knowledge. Inter-ministry discussions as well as consultation with the two extensive sectorial networks led to the development of a Protocol on "Complementarity of Services" that was developed in the Montreal region.

The aim of the agreement is to support healthy development by providing continuous, accessible, and quality services to youths and their families as needed. A framework supports the implementation of the agreement at the local and regional levels. Read more >>

government by investing in relationships, joint assignments, coordination, creating incentives, and reorganizing budgeting and systems routines/procedures to ensure cooperation. In order to ensure that appropriate attention is paid to holistic development, a whole child, whole school approach must be built into the process so that no particular urgent issue hijacks the process and inter-ministry cooperation.

1.1.1 Examine new formats and processes for strategic, stable, negotiated, formal and operational inter-ministry and inter-agency agreements.

Formal inter-ministry agreements and protocols have been a long-standing strategy for implementing and maintaining multi-component strategies such as Health Promoting Schools. These agreements are seen as a vital part of a "whole of government" approach and as an essential element of the system/organizational capacities required to develop, implement, maintain and sustain such inter-sectorial approaches. The need for ministries and agencies to negotiate such agreements has been recognized by sectors wishing to strengthen their partnerships with the education sector.

Taiwan Inter-Ministry Agreement on Health Promoting Schools

Taiwan's Minister of Education and the Taiwanese Department of Health signed the "Joint Declaration on Health-Promoting Schools" in 2002; since then, these agencies have continued to collaborate with local governments, teachers, and parent group representatives to further integrate the health and education sectors. Some examples of successful collaborative efforts include training teachers of schools that participated in the Health-Promoting Schools (HPS) program, building a platform to allow for an exchange of HPS-related ideas and resources, and conducting demonstrations of merit schools.

Read more >>

Experience has taught us that, unless the non-educational sector/ministry can commit significant, ongoing funds and human resources to the inter-ministry partnership, it is likely better that the education sector to be the primary or lead entity in these partnerships in order that health & social programs can be integrated more effectively within school systems. This is based on our knowledge about professional bureaucracies, where we know that non-rational decision-making, constant re-negotiation of roles and priorities and other factors dominate much of the allocation of resources.

A summary on inter-ministry, inter-agency partnerships prepared by ISHN also suggests that, beyond the formal roles and discussions based on logic, there needs to be two critical aspects that will lead to and maintain stable partnerships between ministries. The first is that the resources and roles within the partnership need to be negotiated and re-negotiated periodically or as a consequence of changes in leadership or external demands.

The second is that the partnerships need to be strategic. The term "strategic" is often over-used and confused with regular operational planning. The term strategic in this summary denotes the fact that planners are considering the "why, why now, why this way and why with these partners" rather than just the standard operational questions such as what, who and how.

In essence, this summary suggests that negotiated, strategic and stable partnerships suggested here will consider the sharing of funding, how internal and external profiles will be enhanced,

which ministry or agency will form partnerships with which external agencies, leaders from other sectors as well as which elected officials will lead and comment on which aspects and more. Recent experience is suggesting that there are different ways to achieve this goal of having the education sector as lead actor. These include structural, staffing and data-based strategies.

1.1.2 Use joint budgeting, ministry/agency service plans, hiring/assignments of school health or multisector coordinators to ensure that budgets, initiatives, ministry/agency service plans and coordinator jobs/positions are serving more than one system.

(Text to be added here)

1.1.3 Examine different education system procedures and the fit of H&S programs within organizational routines at the ministry, agency and school levels.

The local institutionalization or "routinization" of an innovation, approach or program is an important part of a systems-based approach to school health promotion and social development. We need to be able to develop, implement, maintain, measure and monitor institutionalization or organizational routines that favour the integration of health and social programs within education systems.

Pluye et al. (2004) have elaborated on the concept of routinization in health programs as a key element of program planning. Based on organizational development theory they suggest that an innovation has become part of an organization's routines when:
People in the organization have a shared memory or shared interpretations of past experiences

- People in the organization share the values or beliefs underlying the objectives of a program or policy
- There are rules to implement and continue the routine
- The routines can be adapted to different circumstances, time periods or events.

Taking the Lead in Transforming Schools into Healthy Places: Ministries of Education Implement and Scale Up the Regional "Fit for School" Program

The Fit for School approach focuses on simple, scalable, sustainable, and systemic WinS interventions, which are integrated in the existing governance structures of the education sector. The main implementing partners in the four countries are their respective ministries of education, who provide personnel and in-kind support. Recognizing school-based management (SBM) as the cornerstone of success, the Fit for School approach strengthens management and institutional capacities at the district and school levels to drive effective WinS implementation. School principals and government officials at the district and community levels have also been instrumental in actively engaging parents and school communities as well as fostering a sense of ownership and responsibility for the program. This was accomplished by accessing the routine meetings of school administrators and by convincing key middle managers in the education system. The approach recognized that under school-based management practices, the final decision on implementing and maintaining the program will rest with school-based administrators. Inter-sector cooperation with other relevant ministries and sectors (e.g., local government, rural development groups, religious organizations, water utilities, etc.) is also encouraged and facilitated. Read more >>

1.1.4 Align/work with and within various multi-component approaches developed by educators to address barriers to learning and promote learning.

These include whole child education models, social & emotional learning, positive school climate, positive behaviour support, dropout prevention, inclusive schools, community schools, 21st century learning and effective schools and others.

1.1.5 Align/work within the various multi-component approaches that have been developed and are being used by other sectors to promote health, safety, inclusion, equity, student rights and other forms of human development so that the potential competition and confusion among these various approaches is reduced or eliminated.

These include healthy schools (health sector), full service schools/communities in schools (welfare sector), safe schools (law enforcement), school health & nutrition (development aid in low resource countries, emergencies in education (humanitarian/relief aid to countries recovering from conflict or disasters) and eco schools (environmental sector) among others.

1.1.6 Work through one designated team of people or one person in a ministry, agency of clinic/front line service agency when dealing with education ministries, authorities or schools.

Better issue management within sectors to reduce competition and duplication when approaching schools is possible when the health sector, for example, works with school systems through one team (e.g, a school health unit) rather than multiple teams focused on a variety of single issues such as obesity, drugs, mental health, HIV/AIDS, physical activity, infectious diseases, nutrition etc. that create competing materials, resources and activities.

1.1.7 The health, social, welfare and other sectors can establish, support and maintain inter-sectorial initiatives and long-term policies/programs that align with the priorities of education systems as well as achieve other sector goals. These could include:

- 1.1.7.1 the development and delivery of integrated student services, focused on learning and specially for vulnerable, chronically ill and disadvantaged students or preventing frequent/chronic student absences

- 1.1.7.2 redirecting or diverting troubled and misbehaving students away from suspensions from school and conflicts with the law

- 1.1.7.3 combining various violence prevention, hygiene/ sanitation (WASH), feeding and other interventions in low resource countries or in countries recovering from emergencies or conflicts to ensure access and participation in schooling

- 1.1.7.4 combining various services, inter-sectorial coordination, interventions and focusing on alternative schools, vocational programs and alternative academic tracks to reduce the number of students dropping out of school

- 1.1.7.5 using school meal and school feeding programs, which are highly valued by educators, as a vehicle for strengthening inter-sectorial partnerships in higher resource countries and as a tool for social development in lower resource contexts.

Recommendation 2: Health system officials, decision makers, and researchers should examine and better understand, via dialogue led or facilitated by educators, the core mandates, constraints, attributes, processes, and characteristics of educational systems in order to better integrate within them. This includes a thorough understanding of the work lives, social backgrounds, and professional identities of teachers and other educators as well as developing different, more effective, longer-term work force development strategies for teacher education and development.

2.1 Recognize and understand the implications of the core functions of school systems, their values and norms and ideologies, the socio-political constraints and the current trends and demands being placed on schools will all affect the degree and manner in which health & social programs can be integrated within education systems.

2.1.1 Recognize the Importance and anticipate competition among the five core functions that schools perform for society.

The five basic functions performed by schools for society ((1) safe custody/care of children, (2) literacy/ academic, (3) vocational, (4) socialization and (5) selection/ accreditation) will determine how school health, safety, environmental and social programs will fit within schools. The non-education sectors should recognize how their goals fit within these five functions and how competition among these functions affects the importance assigned to H&S programs. For example, showing how H&S programs can increase safe custody of children, help to achieve educational outputs through jointly delivered programs, offer vocational training in health careers etc. rather than trying to promote a higher priority for socialization relative to the academic function of schooling.

Europe's Model for Multi-Disciplinary School Teams to Prevent School Dropout

In 2011, the European Union (EU) released two key documents on early school leaving, established in response to the EU's target of reducing the school dropout rate to 10 percent by 2020. Today, the European Union Commission is more strongly emphasizing the need to focus on multidisciplinary teams as part of its agenda, building on the report from Network of Experts on Social Aspects of Education and Training (NESET). These recent policy documents give clear policy recommendations to EU member states for ways to create a multidisciplinary approach to improving student retention. Consequently, the EU has recommended the use of school multidisciplinary teams as part of its efforts to reduce the school dropout rate to EU member states. Read more >>

Health & social programs can help to make schools more effective in achieving these mandates but the relationship may not always be reciprocal. For example, “effective schools” are supportive of health & social programs because they promote parental involvement, high teacher expectations, recognizing cultural differences, relevant learning, research-based instructional practices, personal responsibility, safe, orderly learning environments, a focus on academic learning, teacher encouragement and frequent monitoring of progress. However, closer analysis and strategic consideration of the “effective school” model, a reflection of the core beliefs of many educators, reveals that while some of the characteristics may support health/development, others may be competing with the values underlying school such programs (e.g. overly-strong focus on academic learning, frequent monitoring/testing of progress, social control through an orderly learning environment, grading students for graduation and post-secondary education that can be discouraging to at risk students and their connection to school).

2.1.2 Recognize how the core values/ideologies within education and other systems may clash.

For example, public health promotes “health for all” and will seek to engage all students in universal health promoting activities such as health education. Education may want to focus on health problems as an impediment to learning and therefore will want to focus on health services for specific types of students with chronic health conditions, behaviour problems, those in vocational/technical classes or alternative schools and on other risks. The medical side of the health system, which dominates the health sector, will want/need to focus on specific health problems while educators will want a more flexible, holistic approach that changes the focus to the needs of individual students and to the health and other services they need to succeed at school.

2.1.3 Identify and understand how community norms, parental privacy, professional norms/ taboos among educators and the perceptions of school administrators and community leaders will hinder or help the health or social program.

(Text to be added here)

2.1.4 Understand the limits and extent to which school systems and educators can moderate/modify their strong, traditional and necessary concern for orderly learning environments, social control and school discipline. Health, social, law enforcement and other agencies can support educators so that troubled students are suspended less frequently and supported by health, social and other services.

(text to be added here)

2.1.5 The health, social and other sectors need to work closely with the education system to overcome teacher concerns about monitoring and surveillance activities related to school health and development programs.

Education systems and schools are under greater pressure to be accountable for student learning. Some of this has resulted in inappropriate uses of high stakes testing of all students, school rankings and teacher evaluation schemes. This has a number of effects on health and social programs. The health, social and other sectors need to be sensitive to the damage done by these poorly planned and interpreted accountability schemes when suggesting steps to ensure that health and social programs are effective and reaching all students.

The narrowly-focused, incorrect, high stakes testing of knowledge in a few academic subjects and calls for increased supervision of teachers makes in more difficult to introduce periodic, low stakes, random-sampling of student knowledge, skills, attitudes in health, personal and social development (HPSD) education to ensure that such programs are effective. This is further complicated by the research in HPSD education that has constantly studied only optimal levels of student learning related to only a few health or social topics rather than defining minimal or basic levels of achievement for different contexts in a holistic and realistic manner.

2.1.6 Integrate health and social goals and programs within the appropriate, accountability and improvement systems used by educational systems.

Attempts to introduce large scale “reforms” of education systems have largely been discredited because of their repeated failures. Consequently, most education systems are using “school improvement” strategies that require schools to develop specific action/improvement plans and then to report on their implementation. If health and social objectives are not included in these school and school district plans, then sustained support for H&SD programs will be less likely. Consequently, the health, social and other sectors will need to integrate their efforts within these improvement/accountability processes and procedures.

2.1.7 Work with and within the prevailing management strategies and structures being used in the education system.

School-based decision-making is a trend in educational management that can affect if and how health/social programs can be implemented and maintained. If this trend is applicable to your jurisdiction or organization, then appropriate strategies and adaptations to top-down, system-wide strategies should be considered.

2.2 Recognize and respond to the latest and changing pedagogies and teaching/learning strategies being used in education systems as well as the resources available to schools in resource-challenged contexts.

For example, the health and other sectors should redesign their instructional programs using constructivist/project-based learning pedagogy and adapt their materials to trends in education such as blended learning, flipped learning, personalized learning, inter-disciplinary projects, brain-based learning, multiple intelligences, and more.

2.2.1 Recognize the dichotomy between the "behaviourist" learning theories underlying traditional health, personal and social development (HPSD) education curricula and programs which define specific knowledge, attitudes and behaviours to be taught and the movement in the education sector towards constructivist learning, which uses experiential, personalized and/or inter-disciplinary learning often across several subjects in the core curriculum.

(Add explanatory text here)

2.2.2 Adapt to the increased use of technology in the classroom to better assist teachers in their HPSD teaching.

"Flipped" and "blended" learning, which have students access and read/view materials online before discussing them in class means that teachers need access and support to find and select relevant videos, readings, quizzes, and other materials categorized by learning objectives. Traditionally, the health and social sectors have prepared packages of lesson plans which quickly become out of date.

2.2.3 The health, social and other sectors and donor organizations need to recognize and adapt their educational programs to fit within the resources available in low resource and conflict/disaster-affected countries.

Classrooms instruction in all types of contexts can benefit from accompanying co-curricular activities at the class and school level as well as modification of school routines to reinforce the classroom teaching.

However, in low resource and conflict/disaster affected countries, this use of multiple educative channels is even more important. In some cases, this will require other sectors or donors to provide simple, durable equipment or technology that can be maintained by the school (e.g. using pipes with holes for handwashing and tooth brushing stations rather than faucets that often get stolen.)

In these contexts, effective HPSD education can be delivered through a combination of classroom instruction, co-curricular activities in schools/classes as well as in supportive school/class routines that support the educational objectives. In some cases, this will require

other sectors or donors to provide simple, durable equipment or technology that can be maintained by the school (e.g. using pipes with holes for handwashing and tooth brushing stations rather than faucets that often get stolen).

2.3 The sectors seeking to work with and within school systems should truly understand the work lives, beliefs, professional identities, social background, professional norms and concerns of teachers with a view to modifying and improving the strategies they use to engage educators in school health and social development and to sustain their engagement over their teaching careers. As well, the organizational culture of the school, local educational authority and the school climate prevalent in the school will dramatically affect how health and social programs can be implemented and maintained in the schools.

2.3.1 Understand and address the beliefs and perceptions that educators have about the health and social issues that need to be addressed.

The sociological makeup/backgrounds/beliefs and perceptions of educators will affect their ability and willingness to address these issues. Understanding these characteristics of teachers and the teaching profession is very important if they are to be willing to implement and sustain health, safety, environmental and social development programs. However, little research and reporting on the backgrounds of teachers has been done in relation to health promotion and social development.

2.3.2 Help teachers and educators to understand the communities in which they teach and to reflect on how their own beliefs/values, often derived from the same or similar communities, will affect how they address various health or social issues.

Many, if not most teachers, graduate from high school and university and return directly into schools without working in other industries. Many are hired by school districts similar to the one in which they experienced as students. Teachers are often uncertain and untrained in cooperating with others outside the school. In some cases, teachers will be working in communities very different from those in which they grew up or live in currently.

2.3.3 The work lives, professional identities and career paths of educators will affect their ability and willingness to engage in health & social programs.

2.3.3.1 Understand how the daily work routines of educators will affect their willingness and ability to engage in health & social development programs.

The daily work routines of educators will affect their willingness and ability to engage in health & social development programs A lack of planning time in the regular work day, isolation from other adults when working and reluctance to collaborate with other teachers or professionals are all features of these daily routines. Effective H&SD programs address and alleviate these barriers caused by daily work routines in the school. There is substantial support for the potential of collaborative cultures to improve teacher work and, consequently, student achievement. However, there is also ready recognition that creating and sustaining such collaborative teaching and learning environments is difficult.

2.3.3.2 The health, social, development and other sectors need to recognize how the extremely accessible and visible, multiple roles of the school principal as the front-line manager instills a high degree of responsiveness to parental and community concerns as well as to the directives from local and national educational authorities. This visibility, immediacy of parents, directives from the local and national education authorities will affect the school principal's role in starting, supporting, maintaining and succession planning of school programs.

We need to know more about the different roles played by school principals. Sectors and systems seeking to work within the education sector should also recognize and address the different roles played by front-line managers in education, the school principal or headmaster. Many education studies, as well as an increasing number of studies from other sectors have noted that support from the school principal as the educational leader in the school is critical.

Health & social programs often focus on the "gatekeeper" or boundary management role of the principal. However, the role of the school principal in continuing or maintaining programs may be more important, especially since school administrators are usually transferred to different schools every few years, and as CEO's of the institutions, will often seek to start new programs when they arrive in a new school.

We also need to delve more deeply into the roles, training, perceptions and current work assignments of these front-line managers. For example, unlike many other managers who are insulated by other staff receiving and dealing with customers, school principals are actually the first contact point for parents & community members. Their decision-making is therefore very visible and necessarily must be seen to be responsive to various public/parental concerns. Health & social program developers could start with the abundant research already done in the education sector about the leadership roles played by school-based administrators. 2.3.3.3 Ensure that the focus is on the whole child in all sectors rather than just one or two aspects of health, development or learning.

2.3.3.3 The organizational culture of a school, health or social agency or ministry will affect the willingness of teachers, agency staff or government employees to adopt and implement programs and approaches such as school health promotion and social development.

The organizational cultures in the education, health and other sectors will trickle down to the school level and influence the nature of the school climate or social environment. Consequently, health and social programs need to consider how the school climate (student, staff, parental perceptions and practices) can be influenced in a sustained and balanced manner.

If the health and sports/recreation sectors focus only on physical health and activity, then their influence on schools will overlook important social, safety and equity issues that may be more relevant to educators. If the education sector is focused only on test scores and academic achievement, then the "failing" students will feel less welcome. If the police/law enforcement sector takes a punitive approach, then some students will feel less included.

2.3.3.4 The relatively high rates of teacher turnover, especially for new teachers and for health teachers, will affect the delivery of health & social programs. Health and social program staff need to plan for these turn-overs as part of their sustainability and succession planning.

These high turn-over rates are caused, in part, by the low professional status accorded to HPSD teachers relative to other teachers and their comparatively weak professional identities. There is also a high turn-over rate in teacher and school administrator assignments. Schools systems often transfer school principals to new schools every few years. In order to be sustainable, health, social and other programs need to address the causes of these staff turn-overs and plan accordingly. For example, when school principals are moved between schools, they often seek to initiate changes in the school's priorities, much like CEO's do in other private and public sector organizations. Consequently, focused attention during these administrative turnovers is warranted.

2.3.3.5 Address the "adopter concerns" of teachers.

Most researchers and program developers have studied fidelity of teacher implementation of specific programs in externally funded research or demonstration projects. It is not surprising that studies of these controlled trials have found that teacher training helps with implementation of the program as intended. However, several some studies have noted the immediate fall-off in fidelity, once those external supports from the research project or external were removed. Very few studies have examined the "adopter concerns" of teachers, nurses, school social workers, school principals or others regarding their current practices and capacities before testing the implementation of a particular program or multi-component approach. Such adopter concerns are a bulwark concept in most theories and models of innovation, organizational development and systemic change and need to be applied more to the education system by other sectors promoting health and social programs.

2.3.3.6 Alleviate and address teacher wellness, particularly stress which can be heightened by student behavioural problems and classroom management issues.

Teacher health & wellness and their personal beliefs about health/social issues will likely affect their engagement and effectiveness in health & social development programs. In particular, teacher stress & burnout will likely have an impact. Consequently, the development, implementation and maintenance of health & social programs should explicitly consider how teacher wellness and beliefs will affect their work in promoting health and social development.

2.3.3.7 Understand, support and work with many types of educators as well as professionals from other sectors.

Most often, the focus is on teachers when implementing H&SD programs in schools. However, other educators employed by school systems play more specific roles and require specific education, training and development. These include guidance counsellors, school principals and local school district/educational authority consultants/coordinators. Further, other non-education personnel such as school psychologists, school social workers, school nurses, public health nurses and others employed by other agencies also play important roles and need well-defined roles, funding & support and specific training and skills to work with the education sector.

There are many kinds of teachers and teaching assignments. Different strategies should be developed for these different types of teachers. These include: early childhood/ kindergarten teachers, elementary school teachers, middle school/junior high school teachers, senior high school specialists in Health- Personal-Social Development, Career Education, Physical Education, and Family Studies/Home Economics as well as special needs education teachers, guidance counsellors, moral/religious teachers, private school teachers, teachers in religious schools and teachers in alternative schools for preventing dropouts or for promoting certain athletic or artistic talents.

2.4 Use a long-term, life-long learning, work force development approach to teacher education and development

Most efforts to include health or social concerns in initial teacher education pre-service programs have been short-term, workshop style sessions done by external visitors that have been added on to existing university courses

A long-term, systematic, work force development and life-long learning approach should be used in teacher education and development related to the health promotion, safety, humanitarian and relief aid, safety, social and sustainable development. Classroom teachers play several roles in promoting health, safety, social, economic and sustainable development. Traditionally, teacher education and development has focused on their teaching role, with activities designed to help teachers to know more about what to teach (learning outcomes) in a specific, topic-focused instructional program, the teaching/learning methods or processes to reach those outcomes and occasionally, more appropriate methods for assessing student learning relative to these social goals of education. This training has most often been done in relation to a specific instructional program often focused on one or a limited set of health & social issues.

However, the other roles played by teachers are also important. These include teacher awareness and knowledge about the issue (sometimes called topic-specific literacy such as

mental health literacy or physical literacy), their ability and willingness to identify and refer students or fellow staff who may be experiencing difficulties to various sources of support, their ability and willingness to help students and parents manage their illnesses or problems within the school day, their use of appropriate classroom management techniques and their willingness to enforce school guidelines as well as participate in whole school and community activities related to the issue.

This wide-ranging and extensive list of issues that teachers may be asked to address as well as the generic list of competencies or attributes required to teach health, personal and social development education underlines the need for a long-term, life-long learning approach to teacher education and development.

2.4.1 Health and other sectors should work with national and local educational authorities to develop a long-term and strategic plan to develop both the generic teaching competencies required for HPSD education but to also prepare teachers to address the many issues that will challenge their students and be covered in their respective HPSD education curricula and programs.

Most of the work done in teacher education and development related to health promotion and social development programs has focused on preparing practicing teachers to introduce a specific instructional program or on adding a bit of issue-specific content into a university course as part of their initial teacher education. Even with limiting the number of issues to be addressed in the curriculum and by teachers by three different contexts (high, low and conflict/disaster affected), there are over 20 topics for which teachers will need to be prepared to teach as well as to address in other ways such as referring students to support or treatment, providing support and communicating/cooperating with parents. (See this list of teacher attributes delineated by context and topic) Rather than addressing these many issues in an ad-hoc way as they emerge as a concern, the non-educational sectors should develop a work force development plan for teachers that covers both in-service training as well as initial teacher education programs.

2.4.2 The health and other sectors should work with educational authorities to address the normative beliefs, self-efficacy, personal beliefs, professional norms, professional identities and perceptions of teachers (and the local community) that will have an impact on the teaching of specific issues. Building on strengths and anticipating problems should be part of the long-term planning to educate and develop teachers in addressing health and social issues in their classrooms.

The sociological makeup/backgrounds/beliefs and perceptions of educators will affect their ability and willingness to address health & social issues. Understanding these characteristics of teachers and the teaching profession is very important if they are to be willing to implement and sustain health, safety, environmental and social development programs. However, little research and reporting on the backgrounds of teachers has been done in relation to health promotion and social development

Recent studies about the beliefs, concerns, professional norms and identities of all teachers as well as Health, PE and Family Studies teachers, suggest that many hold misinformed, inconsistent views, beliefs and misconceptions about student health and social development. Often these perceptions and beliefs will mirror those of the communities in which teachers work, as the hiring practices/choices of many educational authorities will result in hiring teachers of similar social and economic backgrounds of their communities.

Fairness, providing equal time and opportunity to all students (even those doing well), maintaining social control of your class, not discussing work in the staffroom (where colleagues are recharging their emotional batteries in between classes), not getting too personally involved with students and more. All of these are deeply engrained professional norms that are rarely examined explicitly in research, nor planned for in health, safety, environmental and social development programs.

The development of specific and durable teacher professional identities will affect their engagement in health & social development programs. Most teachers identify with the careers related to their teaching subjects. History teachers with historians, math teachers with mathematics and so on. If PE teachers over-identify their work with sports, will it be difficult to persuade them to use non-competitive physical activity as the basis of the teaching? Will the extremely low social/professional identities of health teachers mean that there will be a perpetual high rate of teacher turn-over as teachers seek assignments other than that of health education?

2.4.3 Recognize and trust the professional judgement of teachers in preparing, selecting and adapting educational materials and teaching strategies by creating and maintaining banks of lesson ideas and materials rather than preparing one set of lesson plans and expecting teachers to follow and use them for years.

One of the few professional prerogatives of the low status, high stress occupation of teaching is the ability to close the classroom door and deliver lessons they feel best match their needs of “their” students. In professional systems such as schools, knowledge is a source of power and influence. We also note that knowledge is an important concept in the work life and socialization of teachers. For decades, teachers have been dispensers of knowledge. Deciding on lesson plans and the sequence of lessons is one of the few professional decisions that they can make. This is especially true if the nature of the work life and careers of teachers taken to account. With relatively flat career ladders and a lack of attraction to administration within schools, most teachers will stay in the classroom for their entire careers. Consequently, it is very important to teachers that they can personalize lessons for their students. Yet most prevention programs seek to have teachers follow detailed lessons designed by experts. Teachers will welcome these detailed lesson plans and will likely use them immediately. However, inevitably, these same teachers will be looking for new materials and new lesson ideas. Consequently, the sectors that hope to have sustained teacher interest in their issues and topics would be better advised to create banks of lesson plans and teaching ideas linked to the learning objectives that are most effective and relevant for their respective issues. This is even more important as technology is changing the order of learning in the classroom, and more and more teachers are “flipping” their classrooms so that students read materials before being engaged in discussions and projects in the classroom. Experience and research studies have shown that this lesson bank strategy is

effective and less costly than traditional strategies aimed at controlling teacher practices in the classroom.

2.4.4 Integrate a work force development plan for teachers within the existing stages and structures used by the education system to educate and develop teachers

Proponents of different aspects of the social role of the school should be aware of the different stages and structures in the education and development of teachers. These structures will be different for high income, middle income and low income countries. As well, each university and teacher training program will have different contexts and be based on a variety of learning theories and pedagogical orientations.

2.4.5 The training activities and strategies used by the health, social and other sectors should fit within the current models used in teacher education and development, including support for induction, coaching, mentoring, adult learning and developmental approaches

Most projects and studies of teacher education & development in health & social programs are based on top-down thinking, where the onus is narrowly focused on teachers to follow a behaviourist curriculum designed by experts. Most of the work done in teacher education and development related to health promotion and social development programs has focused on preparing practicing teachers to introduce a specific instructional program or on adding a bit of issue-specific content into a university course as part of their initial teacher education.

Advocates of the various health, safety, social, economic and sustainable development programs going into schools should be aware of the different models and approaches to teacher education and development that have emerged and are widely used in the education sector. These should be taken into account when planning specific sets of competencies, qualifications, literacy or skills for educators. There should also be exchanges among the different sectors such as health, law enforcement, social and sustainable development so that we can all benefit from what we learn when working with educators.

2.4.6 Invest more in the education and training of non-educational personnel that will work closely with educators so that they can maximize their effectiveness when working within schools.

There are several front-line professionals that work directly with teachers, other educators, parents and students within schools and at higher levels in the education system. These include school/public health nurses, school social workers, school psychologists, police officers assigned to schools, security officers working within schools in high crime and conflict-affected countries and communities and others, Many of these front-line workers will assume health promotion, community development and organizational development roles for which they are not trained. Knowledge about pedagogy, teacher/staff development and other aspects will also be missing from their initial training.

Consequently, any long term work force development plan for school health and development programs will need to include plans, programs and activities for these non-education sector personnel.

Recommendation 3: Health and social sectors must join the education sector in focusing on the growth and development of the whole child rather than directing attention and resources only toward specific diseases, behaviors, or conditions as separate or siloed entities.

The health, social, safety, environmental, relief/ humanitarian aid sectors and donor organizations should focus on health, safety and development of whole child, while continuing their absolutely necessary, often-dictated and urgent priorities to address urgent, specific health problems, conditions and behaviours.

The challenges associated with a balanced management of competing pressures and demands for short term issue-specific responses while still building long-term, inter-sectorial responses is not unique to school-based or school-linked programs. However, it is a challenge that must be examined openly and honestly if a lasting partnership between education and other sectors is to be forged, maintained and sustained.

Several studies and reports on the capacities, decision-making and current organizational practices in the health and other sectors working with schools have shown that it is very challenging for these systems to truly implement and maintain long term, holistic, whole child approaches in their work. Because of the external and internal reward/recognition practices, it is absolutely necessary for these systems to be seen to be responding to the immediate threats and problems of their populations. As well, limited resources allocated to the promotion/prevention aspects of these issues (as opposed to the treatment/recovery aspects) makes it difficult for these systems to even consider the funding of individual programs/interventions over the long term. Other studies have noted that many of the decisions about the allocation of resources are made on pragmatic, short term, expedient criteria rather than on the basis of the accumulated evidence, data and experience.

3.1 The health, social, development and other sectors should maintain a focus on the needs of the whole child, including educational access and attainment, while still responding to specific urgent problems related to their respective mandates.

(text to be added here)

Look for valid clusters of issues and synergies between programs addressing those clusters

Build multi-intervention approaches

Put the MIP's within MCA's

3.2 The health, social, development and other sectors should develop contextually sensitive, long-term joint policies with education, including models and plans for work for which multiple sectors are responsible.

For example, integrating and coordinating a variety of school-based and school linked services for students and their families is an area of work that involves the health, social services, child protection, youth employment, housing, police/security sector and education.

These joint inter-ministry and inter-agency policies should use a comprehensive and multi-level, multi-system structure and a well-planned, cyclical policy-making process that recognizes the shared sectorial responsibility for such policies.

The health, welfare and other sectors and systems should identify,

UCLA Model Policy on Integrated Learning Supports

The following is an example of policy written to help align and unify the school and community systems and agencies in order to develop a comprehensive, equitable, and systemic learning supports component for every school. Such a component joins the instructional and management/governance components as a third primary, essential facet of school improvement for educational systems. This joint policy should also be situated within similar key policy mandates established for the health, social, welfare and other sectors/systems.

Model School District Policy (Jointly Developed)

"It is the intent of the Board of Education that a unified, comprehensive, and equitable System of Learning Supports be fully integrated with other school and district program efforts to improve instruction and maximize the use of resources at individual schools. All interventions are to be tailored to the diversity of students and families in our schools. Learning supports are defined as the resources, strategies, and practices that provide physical, social, emotional, and intellectual assistance intended to enable all pupils to have an equal opportunity for success at school.

Model Policy from Other Agencies (Joint Developed)

"It is is the intent of the Local Health Authority that a unified, comprehensive and equitable system for providing health promoting, preventive, referral and follow-up health services for children and adolescents include school-based and/or school-linked components. These health services are to be delivered in coordination with the educational support services provided by the education system as well as other services provided by other sectors. These services will unify child and adolescent services provided by physicians, local health clinics and hospitals in regards to their interactions with school personnel and other agency professionals delivering services in schools or in coordination with school professionals."

implement and maintain similar, jointly developed, policies to ensure contextually-sensitive, different models and applications of integrated student, health social and other services, especially those that can be used to support students in disadvantaged communities or higher levels of vulnerability.

We need to identify ways in which the challenges and barriers to delivering such integrated student services from different sectors can be addressed or alleviated. Models and samples of policies and procedures from the health, social, welfare and other sectors, as well as in education need to be identified, examined and disseminated.

3.3 The health, social and development sectors should support a well-rounded, whole child approach to education as well. This multi-sector support for a whole child approach to education should be maintained as schooling is re-invented in a variety of ways such as personalized learning, culturally relevant pedagogy, 21st Century learning and other emerging paradigms.

The health, welfare and other sectors and systems should advocate for a holistic, whole child approach to education and educational goals that creates more time not only for health & development but a wide range of subjects, content and pedagogical strategies. These well-rounded approaches to education view schooling as being more that basic literacy/numeracy skills and vocational preparation and one which includes health/personal development, the arts, social studies and more. A whole child approach to education also includes more than teaching facts and intellectual skills to include social and emotional learning, character development, engaging and personalized learning and more

Jurisdictions should also examine how the breadth of a whole child approach to education can be maintained in emerging paradigms for schooling/learning such as indigenous learning frameworks, 21st century learning, interdisciplinary studies, personalized learning and project-based learning.

3.4 The health, social and development sectors should work together and the education sector to define a minimum, common set of contextually sensitive set of student learning objectives that can be taught in a mandatory Health, Personal-Social Development (HPSD) Curriculum/life skills education program as well as across all subjects in an inter-disciplinary manner.

Sectors outside of the sector should work together to define core minimum sets of learning outputs in health, safety and social development rather than competing for optimal learning on their particular topic. These minimal learning objectives should include basic health & safety literacy, critical life, social-emotional and coping skills, and universal values such as social inclusion, responsibility and sustainable development.

The health, welfare and other sectors and systems should work with the education system develop practice-based, context-relevant models of health-personal-social development (HPSD) education that determine realistic, minimum levels health literacy/life skills/social inclusion rather than compilations of competing, optimal levels of student learning by individual health and social topics. The number of hours of instruction, co-curricular and/or non-formal learning possible in high resource, low resource and conflict/disaster-affected contexts should be determined or estimated in these models. Then education systems should be enabled to select the key issues and learning objectives that can be achieved for all students.

Subsequently, education systems can then finally and reasonably be asked to measure, monitor and report on student HPSD learning in periodic, random-sample, low stakes student assessment surveys.

Cooperative planning to make use of all curriculum structures and subjects that can convey health, safety and personal-social development knowledge and skills is also recommended. These include subjects, curriculum strands such as family studies, career education/life planning, physical education, moral/character education, religious education, language arts/literature, mathematics, science and others.

3.5 The health, social, development and other sectors should work together to develop a joint work force development plan for educators and non-education personnel.

Similar inter-sectorial cooperation in teacher education and development activities would also reduce duplication and competition. (See the earlier discussion above). The classroom teacher's role in health & social development is very broad and variable. Rather than competing to develop knowledge and skills about specific health/social issues within teacher education programs, the non-education sectors can work together to develop integrated teacher education and development programs.

Recommendation 4 This realignment of health and other sector efforts should be founded on a systems-based, organizational development approach focused on investments in capacity-building and continuous improvement.

The realignment of health and other sector efforts should accept the rationale and begin to use a systems-based, organizational development approach focused on capacity building and continuous improvement. Systems thinking, systems science and systems change models should be used explicitly to pursue greater integration within education systems

4.1 Health & social programs should fit within or seek to modify a variety of school structures, practices and organizational routines.

Recent work on nutrition and physical activity and nutrition has recognized that school routines such as recess and lunch as well as using food and exercise as rewards and punishment are important. LGBT students and their parents are now challenging schools who don't allow equal participation in important school rituals such as school graduation dances and dinners. Graduation and award ceremonies in schools can recognize a variety of forms of student success and not simply those related to academics and athletics. The age at which younger students mix with senior high school students has significant consequences on youth risk behaviours. The use of teams and home room advisors as well as academic streaming in schools will also have health and social consequences. Increasingly, schools and other sectors are paying attention to the increased vulnerabilities associated with transitions from elementary to secondary school and from high school to work, training or college/university studies. All of these bits and pieces need to be examined and a coherent understanding developed for program planners and decision-makers.

Consideration of organizational routines should also be done at higher levels within the education system. Education systems have annual, long term planning and operational cycles that should be taken into account when trying to introduce or maintain health/social initiatives. For example, changes to the "curriculum" (i.e. the mandated, required learning outcomes for courses such as health or the overall curriculum involving all subjects occurs very infrequently because it takes 8-10 years to roll out a major change over the 12 years of schooling. Consequently, introducing new requirements for all student learning in health is a major task . "Curriculum supplements" can be published by education ministries in a shorter time frame but they will still take 2-3 years of development and piloting before they are published. Packages of lesson plans or instructional programs can be published and distributed to schools, but their uptake will depend on teacher individual choices and they will compete with other instructional programs or materials that are already available or that are also being published.

4.2 Advocates, officials and program leaders in school health promotion and social development should recognize and address the bureaucratic and other characteristics of education systems.

There is increasing interest and attention being paid to ecological and systems-based approaches to school health, safety, environmental and social development programs. There are a number of specific aspects that relate to characteristics such as openness, loose-coupling, professional bureaucracies and managing across multiple systems. These include aspects such as the nature of open, adaptive systems, professional bureaucracies, organizational and departmental boundaries, non-rational-decision-making, organizational cultures and readiness to innovate, loose and tight coupling within education systems, social networks within organizations, the narrowing influence of expertise about specific topics, policy-making in multi-level organizations different forms of cooperation among organizations and more.

The health, social services and other sectors should use a systems-based approach to address the segmented, loosely-coupled layers and differentiated assignments/roles in education systems. Education systems in most countries are structured in multiple loosely-coupled layers, with national, state/provincial, regional and local neighbourhood entities. The job assignments/roles within education ministries are also differentiated with curriculum, student services, guidance, and other specialists. School districts often have consultant specialists in PE, safety, student services, health, environmental studies and other assignments who are often asked to assume dual roles. Consequently, it is easy for a long-term, multi-component approach such as healthy or safe schools, to be sub-divided into several small pieces with no overall coherence or strategy.

4.3 The health, social services development and other sectors that want to work within schools should seek to align their strategies with current theories and models being used by educators that describe and guide educational change.

Theory relating to effective schools, school reform and improvement and education management is another untapped resource for school health promotion & social development. There are many potential applications of case studies and educational reform/improvement techniques that have not been considered. For example, the role of the Department Head and

departmental structures/teams in secondary schools could be a potential impediment or facilitator of change.

Complexity and complexity theory are emerging as a replacement or precursor to the linear thinking and controlled trials of most of the research on school health, safety, environmental and social development programs. New research methods such as multi-level modelling, narrative inquiry, realist reviews and others are gaining greater acceptance. As well, attempts to codify different types of professional experience into hierarchies similar to those used with more formal research are being made. These new research methods and conceptual frameworks will help the health, social, development and other sectors to understand and address the true nature of the ecologies of schools and school systems.

4.4 The health, development, social and other sectors that want to partner with schools should make ongoing investments in capacity and capacity-building that go beyond the transfer of knowledge about effective programs to employees to define the human and financial resources that will be committed.

Investments in capacity and capacity building are necessary from the health, social, development and other sectors are necessary if a different kind of partnership and bargain with education systems are to succeed.

Health and other systems/sectors should commit to using & maintaining long-term, multi-component approaches and to providing ongoing human and financial resources to work within education systems at the national/state, local agency and neighbourhood level. Sustainability has emerged as a critical issue in school health promotion practice and research. Educators are now much more skeptical about other sectors simply dumping their problems and mandates onto schools By using an explicit capacity-building approach and by describing the human and financial resources that they will bring into schools and education systems, the health and other sectors will be able to re-assure educators about their intent of a long term and equal partnership

4.5 Health, social services, donors of humanitarian and relief aid, safety, law enforcement and other sectors need to establish and enforce over-arching policies on holistic approaches to child/youth health, development and protection. Health ministries need to have policies on health promotion, police services on community policing and youth diversion, and so on.

(text to be added here)

4.6 The health, social, development and other sectors should establish comprehensive policies to guide their partnerships with the education systems.

The health, social services, law enforcement, donor organizations and other sectors/systems should:

4.6.1 define explicit goals for working with their respective education systems and them codify them in joint ministry statements, service agreements and protocols,

4.6.2 establish requirements for their local agency service delivery regarding their local partnerships with local education authorities,

4.6.3 identify and then provide the funding for the staffing and training for the front-line workers or local agency (e.g. school nurses, social workers, resource officers, youth workers, psychologists and others) that will work with teachers and within schools

4.6.4 designate how their respective core sections/mandates will function when working with school systems. For example, the health promotion function/section within public health departments and ministries should take the lead with regard to schools with regard to promotion and prevention activities and the health care section should focus on school-based and school-linked health services.

4.7 The health, social, development and other sectors should define minimum service delivery levels as part of their relationship building with education systems.

The health, social services, humanitarian & relief aid, law enforcement, sports/recreation and other sectors should define minimal levels of school-based and school-linked support services that can be supported/delivered by their respective sectors. Bench-marks and then standards, similar to those developed for health care delivery, can be developed for minimum wait times for services and treatment delivery to students whose needs have been identified or referred by educators.

4.8 The ministries and agencies in health, social, development and other sectors should review the structures within which school-related programs and services are delivered. Optimal structures, derived from the needs of children, youth and educators, should be considered as alternatives to the traditional, often ad-hoc structures which reflect the low status of school programming in other sectors, ministries and agencies.

The sectors wishing to partner with education systems also need to establish various structures in the bureaucracies and agencies that are needed to support the implementation and maintenance of these holistic policies in those sectors. Structures within bureaucratic systems can be enabling, restrictive or supportive, so the various sectors, including education, need to consciously decide on the ones that will most favour integrative policy making and program.

4.9 All sectors should develop, implement and maintain “no-blame”, incremental, long-term strategies for working with the education sector that emphasize shared responsibility and leadership.

The concept of continuous improvement, an approach to system change most often used in school systems, should be adopted and used by other sectors which want to work with and within education systems.

4.10 The health, social, safety, welfare, development, education and other sectors should jointly develop and maintain a joint monitoring and reporting system for assessing the reach and status of relevant policies, programs, practices and qualifications of personnel, agencies and ministries in several sectors that work with schools.

This monitoring and reporting system should be used for program planning and system improvement rather than accountability and payment for performance measures. This system for policies and program capacity should be linked with other parallel systems for monitoring child/adolescent health and development/behaviours and for monitoring on student learning about health, life skills and social inclusion.

Signatory Organizations (Consensus Statement)

- ASCD, Alexandria, Virginia, United States
- International School Health Network, Vancouver, British Columbia, Canada
- American School Counselor Association, Alexandria, Virginia, United States
- American School Health Association, McLean, Virginia, United States
- Boundary Family and Individual Service Society, Grand Forks, British Columbia, Canada
- British Columbia School Trustees Association, Vancouver, British Columbia, Canada
- California School-Based Health Alliance, Oakland, California, United States
- Canadian Association of School Psychologists, Richmond, British Columbia, Canada
- Canadian Association of School System Administrators, Oakville, Ontario, Canada
- Canadian Counselling and Psychotherapy Association, Ottawa, Ontario, Canada
- Canadian Nurses Association, Ottawa, Canada
- Canadian School Boards Association, Montréal, Québec, Canada
- Educational and School Psychology Section of the Canadian Psychological Association, Ottawa, Ontario, Canada
- Canadian School Boards Association, Montréal, Québec, Canada
- Center for Health Education and Health Promotion, The Chinese University of Hong Kong, Shatin, Hong Kong
- Coalition for Community Schools at the Institute for Educational Leadership, Washington, District of Columbia, United States
- Directors of Health Promotion and Education, Washington, District of Columbia, United States
- Education International, Brussels, Belgium
- European Trade Union Committee for Education (ETUCE), Brussels, Belgium
- Global Citizenship Advice and Research, The Hague, Netherlands
- Health Promotion Administration, Ministry of Health and Welfare, Taiwan
- Health Practices, Orcines, France
- HOPSports, Las Vegas, Nevada, United States
- LifeCollege, Puerto Princesa City, Palawan, Philippines
- NEA Healthy Futures, Washington, District of Columbia, United States
- New Zealand Post Primary Teachers' Association (PPTA), Wellington, New Zealand
- Ontario Healthy Schools Coalition, Ontario, Canada
- Ontario Psychological Association, Toronto, Ontario, Canada
- Schools for Health in Europe (SHE), Utrecht, Netherlands
- School for Teaching and Education (ESPE) Clermont-Auvergne, Chamalieres, France
- School Social Work Association of America (SSWAA), London, Kentucky, United States
- Shape America - Society of Health and Physical Educators (Formerly AAHPERD), Reston, Virginia, United States
- Society for Public Health Education, Washington, District of Columbia, United States
- Southeast Asian Ministers of Education Organization, Regional Center for Innovation and Technology (SEAMEO INNOTECH), Quezon City, Philippines
- Special Olympics, Inc., Washington, District of Columbia, United States
- TNO Youth: Growing Up Healthy, Leiden, Netherlands
- Unires, Chamalieres, France

End Notes