Child and Adolescent Social Work Journal (2019) 36:317–327
https://doi.org/10.1007/s10560-019-00606-x

Health Promotion in Children and Youth: Contributions of Social Work in Building Collaborative Networks in Schools in Portugal

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Published online: 8 March 2019

Abstract
In Portugal, direct-practice with children and youth in schools was a traditional area of social work intervention especially with regard to health education. However, direct-practice by social workers in schools has significantly declined in recent years. This article presents a case study in this area highlighting the "Plataforma Saúde na Escola" (Health Platform at School), a program developed by the municipality of Cascais, located near Lisbon. The article explores new contributions for social work intervention with children and youth in schools. The program being described draws upon a collaboration of different areas and organizations in which social work is a component to promote/improve the social determinants of children's health. The analysis of the program focuses on the methodological and ethical-political dimensions. The major finding is that the collective function of social work with children and youth people is enhanced through collaborative networks and the strengthening of empowerment, both individual and structural.

Keywords Social work · Social determinants of health · Health education · Social intervention in schools · Collective action · Empowerment · Portugal

Within the Portuguese educational sector, there is a debate about the need for health promotion programs and health education in schools; namely schools as a place to implement programs focused on the prevention and control of diseases in oral health, nutrition, obesity control, prevention of tobacco use, alcohol and other drugs, and, sexual and reproductive health. This article intends to understand what represents, for the school community and for policies, a choice for health promotion in schools. Most importantly, how can Social Work intervention be reflected in this area of action?

In Portugal, schools were historically considered a primary location for health education. The school was perceived as a strategic place where hygiene could be easily disseminated to groups of children who would then introduce better hygiene into their families. However, can we expect a different role from schools beyond this deficit-based and professionally-driven model? Can we create a vision of health education where children and their families benefit from support without the culpability and fatalism associated to the pathologization of education? Moreover, what role can social work play? This study highlights the strategies of local health promotion policies in schools in Portugal. By engaging with the local community, it created the conditions for a holistic education and enabled schools to create a positive environment of learning and development in a healthy way. More importantly, the health promotion strategies in the school were enhanced from building a network within the community, and thus the interventions became tailored to the needs of children and youth.

There is a strong advantage when a collaboration between schools, municipalities, health services and local communities exists. This collaboration enables the interconnection of

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expertise between the entities and for their improved participation based on the sharing of common goals—structural and collective empowerment. Activation of health behaviors increases where components like learning-by-doing, active participation of the students in agency formation to replicate health practices, and the international arousal of youth leadership—facilitating individual empowerment exist.

Theory and Methods

The authors used a case study methodology, which is widely used in research in social work research. Yin (1984) describes three situations in which case study is indicated. In this instance, the case study is a qualitative investigation of a specific unit, situated in context, selected in accordance with predetermined criteria and using multiple data sources, which aims to provide a holistic view of the phenomenon studied.

A search of the literature was first conducted, containing a listing of the available scientific work on the topic, using an internet search after a primary database source—Scielo and B-on. The database search used as Key- words: in Portuguese "Promoção", "Escolas promotoras de Saúde", "Saúde escolar", "Promoção da Saúde" and in English "Health Promoting Schools", "School Health" and "Health". This was followed by an analysis of these documents, namely and focusing on the one release by the national authorities—Ministério da Educação (Ministry of Education) and Ministério da Saúde (Ministry of Health) and the one concerning the management and evaluation of the Platform Health in School by the Health Promotion Division, Câmara Municipal de Cascais (view Table 1). This analysis was based on identified analytical categories that allowed the discussion of the data, and its articulation, with the perspectives pointed out by the problematic, and, also, with the Social Work conceptual frameworks. Therefore, the study method increases the internal validity by using different sources.

The criteria for the selection of documents was the relevance in the current context of health at school (Saint-Georges, 1997; Krippendorff, 2004) and also the role that health development in the school played, in contemporary times, keeping in mind the qualitative research and the need to carry out an illustrative analysis of the phenomenon (Guerra, 2006). The content analysis allowed the structuring of the legislative and political process on health promotion theme in schools and the model developed by the Municipality of Cascais at this level.

Health Promotion: A Paradigm for Intervention

Concerns about health problems of Portuguese citizens are not new. Historically, the concept of health focused on the dimension/condition of disease and limited to an attitude of passivity (Ferreira, 1990). Moreover, the measures implemented to preserve health were limited for centuries, to repression, segregation and neglect of patients. Lack of knowledge about the etiology of human disease has led, for many years, to the absence of a collective consciousness of promotion of health and prevention of disease. Only in the twentieth century as etiologies of chronic diseases such as cancer, diabetes, cardiovascular disease, were known and the social determinants identified that disease prevention became possible.

Currently in Portugal, health is considered a most valuable asset and as a form of human capital that we must learn to manage and invest. At this point, there is no doubt that prevention of disease must accompany the important investments in overall health awareness and positively affect the factors that determine success. Thus, investment in disease prevention has shifted to investment in health promotion (Pan American Health Organization, 2006). The pathogenic model considers the specific cause of disease, injury and medical acculturation while the salutogenic model proposed

Table 1 Documents and databases consulted

Documentary analysis	National School Health Program (Escola Nacional de Saúde Pública, 2010)
	The protocol between the Ministry of Education and the Ministry of Health (Portugal, Ministério da Saúde, Direção Geral de Saúde, 2006)
	Education System Framework Law (Decreto Lei no. 49/2005 de 30 de Agosto)
	Health Framework Law (Decreto Lei no. 27/2002 de 8 de Novembro)
	National Health Plan 2004–2010, 2011–2016 and revision and extension to 2020 (Portugal. Ministério da Saúde, 2011a)
	Health Promotion Platform—Evaluation reports 2016 and 2017 (Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2018)
Statistical data	Cascais Data (Câmara Municipal Cascais. Departamento de Inovação e Comunicação. Gabinete de Estatística, 2017b)
	Health Promotion Division of the Municipality of Cascais (Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2017a)
	Pordata (Fundação Francisco Manuel dos Santos, 2018)

by Antonovsky (1987) considers the structural factors that can positively influence the health of people (an individual). A salutogenic orientation, is basic for health promotion, directs both research and action efforts to encompass all persons, wherever they are on the continuum, and to focus on childhood and adolescence. Antonovsky (1993) uses the river metaphor. The river symbolizes life and one always finds himself swimming in a more or less dangerous river. The pathogenic orientation seeks to remove people, at great cost, from the dangerous river. On the other hand, in the salutogenic orientation, our capacity as swimmers consists of one of the defences against the dangerousness of the river. The individual ability to swim is analogous to the concept that Antonovsky called "sense of coherence." It thus encourages a paradigm shift from the pathogenic to the salutogenic paradigm, presenting the "sense of coherence" as an operative concept of the salutogenic paradigm. Thus the promotion of health stems from the salutogenic paradigm (Graça, 2000, p. 77).

In order to break the dominance of the biomedical model, the emphasis must shift to a promotion of health in an approach that advocates for inter-disciplinary actions to promote the quality of life of populations. It is crucial to realize that health promotion cannot be built solely in a reductionist way. According to the proponents of the paradigm, health promotion must occur by transforming complex health problems in individual misconduct, moving the "social body" for "biological or physical body", on the responsibility of producing effective responses (Flynn, Ray, & Rider, 1994; Heidmann, Almeida, Boehs, & Monticelli, 2006).

Empowerment is an important strategy in health promotion. Through social intervention and the empowerment of stakeholders, we can understand the determination of the health-disease process, and gain the right to life with ethics and human dignity (Duhl & Handcock, 1999). The determinants of health (Dahlgren & Whitehead, 1991) posit that health is a product of a wide range of factors related to quality of life including an adequate standard of food and nutrition; housing and sanitation; work conditions; educational opportunity throughout life; clean physical environment; social support for families and individuals; responsible lifestyle and an appropriate range of health care. The Ottawa Charter (World Health Organization, 1986) defines health promotion as a process whereby all stakeholders strengthen accountability and the rights of individuals and the community for their own health (Akerman, et al., 2002). Using this perspective, activities are directed to the community and the environment, understood in a broad sense (physical, social, political, economic and cultural).

The Historical Evolution of Health in Portugal

In Portugal, school health begun in 1901, and has since been subject to various forms of organization and supervision as dicatated by the government. Until 1910 the monarchy was in place, and from October 5, 1910 and May 28, 1926, there was a military dictatorship, followed by a national dictatorship, from 1933 until the Revolution of April 25, 1974. This revolution that started a democratic period, which remains to this day (see Table 2).

The schools never lost the goal to promote health status, placing ever-increasing new challenges to educate health alongside the transmission of knowledge organized in disciplines. The challenges arise when education, and health, and other institutions such as child protection must agree upon an agenda and work together. Yet, the development of the implementation of these principles empowers youth people to engage, change and lead to the full exercise of citizenship. Therefore, it should be a priority for all governments. All schools should be health promoting.

Recently in Portugal, medium and long-term health priorities have been set, model after the World Health Organization's priorities which supported the creation of

Table 2 Main steps in the evolution of health promotion up to 2006

1901	The first concerns about school health arise in an attempt to address emerging needs, both inside and outside of school
1971	Pedagogical Medical Centers in the municipalities of Lisbon, Porto and Coimbra (supervised by the Ministry of Education) aim to organize medical intervention at schools with medical and psycho-pedagogical activities (extinct in 1993)
1994	Portugal joined the European Health Promoting Schools Network
1997	The ministries of health and education, collectively, decided to expand in creating conditions, including legislation and support structures, so that health and education professionals could promote health in schools
2002	Ministry of Health has taken the protection of school health, conducting a nationwide coverage through its implementation in health centers
2004	4th Ministerial Conference on Environment and Health assume the emerging concern the influence of the environment on the health of children and of youth people
2005	Ministerial Conference on Mental Health recognized the promotion of health and prevention of mental illness as a priority
2006	Ministers of Health and Education reaffirmed, through the signing of a protocol, the commitment to increase partnership models for the implementation of the principles of health promoting schools

the European Network of Health Promoting Schools, of which Portugal is a member. Goal 13 of the Health for All (World Health Organization, 1999) defines that health-promoting schools should include health education in the curriculum and have school health activities (1997 Conference: Thessaloniki-Halkidiki, Greece, World Health Organization Regional Office for Europe, Council of Europe and European Commission). The Health National Program for 2011–2016 thus framed one vision, based on input, to set strategic goals aimed at obtaining maximum gains in health in a sustainable, continuous, monitorable manner (Portugal. Ministério da Saúde, 2011a). This plan, based on consensus and consultation of all stakeholders and actors, integrated a comprehensive understanding of the health status of the Portuguese nation. The plan included the recognition of national and international best practices, the creation of clear and efficient processes, the quality of the performance of health professionals and the self-promotion of health by citizens and movement towards a centralized health system in its citizens.

The Health National Program for 2011–2016 allowed management and coordination of other national programs: School Health Program (2006); and the National Program of Integrated Intervention on Determinants of Health Related to Lifestyle. In this way, the intervention aimed to reduce the prevalence of risk factors for chronic diseases and to increase protective factors related to lifestyles (Escola Nacional de Saúde Pública, 2010). For example, activities targeting reducing the use of tobacco and alcohol have been implemented in primary health centers and schools, thus using and integrated, intersectional and multidisciplinary approach.

These approaches provide a path to follow for a multisectoral strategy for sustainable health, as school-age children can understand basic values of healthy lifestyles, social interaction and group work. At school, students and parents work with the local community and the health professionals, to identify challenges in the context of health, then design intervention programs and evaluate the results (Portugal. Ministério da Saúde, 2011b). All children have the right to be educated in promoting health and schools integrate this knowledge in a comprehensive approach, promoting physical, social and emotional health of students, staff, families and community.

Finally, the National School Health Program (Portugal, Ministério da Saúde, Direção Geral de Saúde, 2006) is therefore the technical and legal framework of the health system in the field of school health setting strategies for local programming. These strategies point in two complementary directions: surveillance and health protection, and the acquisition of knowledge, abilities and skills in health promotion. A School Health agenda therefore must include an individual and collective health, school inclusion, the school environment, as well as lifestyles.

Platform Health in School in Cascais: A Local Program

The municipality of Cascais is a municipality mainly dedicated to tourism. Situated in the district of the Lisbon metropolitan area, it has an area of 99.07 km^2, covering a population of 206,429 inhabitants (Portugal. Instituto Nacional de Estatística, 2012). The municipality took the local initiative and created a networking platform called the Health Platform at School. It is a collaborative program with several stakeholders, and its mission is to promote the health in the local public schools. It is founded on the structural principles that promote the individual health, without losing the autonomy of the schools, while respecting the local dynamic associations existing in the municipality. The aim of the Platform in Cascais is the integration of social networks in the school community around sustainable development objectives that lead to verifiable results in promoting healthy lifestyles for children and youth. This materialized in a first engagement letter signed by all partners (Governance), including the Municipality of Cascais, the group of primary health care centers of Cascais and all public schools, as well as five private schools and the federation of parents association and local associations, since October 2010. The commitment letter includes principles of positive health understanding of health promotion as the process that allows people and communities more control over their health and to change lifestyles that lead to gains in quality of life, according to the guidelines marked by the World Health Organization through the Ottawa Charter (1986).

Its specific objectives are to provide youth people the opportunity to develop personal and social skills that will enable them to:

- make informed decisions about the risk factors;
- improve health management by adopting the behaviour and the adoption of healthy lifestyles;
- support and develop the school's educational project to promote health education;
- joint sharing of health promotion responsibility between the various actors (local authorities, parents, teachers, health professionals and other community agents)
- construction of indicators and verifiable health goals at school.

The networking emerged as an opportunity for joint decision-making and exchange of experience and exposure of each partner on the different themes in approach. In 2014,

with some years of implementation on the ground, it passed a second commitment letter that revised the intervention model (Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2014).

Intervention Model

A new generation of Local Governance Agreements called Platforms was created in Cascais organized with particular focus on investment in local social cohesion. These Platforms had the agreement of partners for common principles and strategic objectives, guiding and propagating a predominantly collective action (Municipal Council of Cascais, Department of Housing and Social Development, Division of Health Promotion, 2014).

In 2012, the introduction of funding in new local policy measures presented a clear opportunity to target the development of social and health resources. The challenge, however, was to design a flexible management model adequate to the needs and priorities of the municipal investment. This second letter of commitment, 2014 (Câmara Municipal de Cascais, Department of Housing and Social Development, 2014). This letter established for the 2014–2018 period a governance model based on a participatory and integrated approach in which a working group meets monthly to define, plan and operationalize health promotion strategies involving two groups of coordination: a strategic coordination group and an operational management group (Municipal Council of Cascais, Department of Housing and Social Development, Health Promotion Division, 2014).

The Strategic Management Group discusses and defines the strategic vision of the platform based on the plans of school health, involving the Municipality of Cascais, Health Groups of Cascais and the Executive Director of all 11 School Groups which constitute the public education network, meeting twice a year (Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2014).

The Group of Operational Management serves as an organ more operative in nature, that involves an education coordinator for health, elected by each of the groups of schools and various technicians of the local municipality and health workers, the Federation of Parents Association, Public Security Police and National Republican Guard. This group was responsible for creating an action plan on health promotion according to sectoral policy documents. It also monitors the platform intervention; promotes regular sharing of experiences and knowledge; prepares annual progress reports on the platform intervention; develops the areas of planning/monitoring; provides project support and training; proposes schools for local certification; and meets monthly.

The network resources, public and private entities with health promotion intervention, involves all other partners to develop programs/education activities for health within the defined areas of intervention. Finally, it introduces the use of consultants, both scientific and pedagogical, with the task of collaborating in the preparation of the action plan and forms an opinion about the evaluation of the intervention. Health Platform at School then follows the illustrative diagram in Fig. 1.

Important to note that in the context of health promotion in schools, the Health Platform at School is based on several structural principles including the development of a network that involves the whole community, not being restricted to the school community. This is based upon the belief that this reforms the network through the integration of the schools in the community, thus enhancing not only the promotion and protection of health, but also facilitates the development of a healthy and safe school environment, enhancing the adoption of healthy lifestyles by the whole community (Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2017a).

The School System in Cascais

With regard to the characterization of the recipients of Health Platform at School, this includes, as stated above, all students enrolled in public schools and five private schools in the municipality of Cascais, with levels of education ranging from pre-primary education to secondary schools.

According to the school census conducted in 2017/18 by the General Directorate for Education Statistics and Science, the geographical area of the municipality of Cascais hosted 267 schools (view Table 3), mostly 58.43% from private sources. It is noteworthy however that the majority of private education institutions is focused on establishments of Preschool Education (69.72%) and 2nd Cycle of Basic Education (64.52%); already in the 1st Cycle of Basic Education there is a slight majority of public schools (54.32%); Finally, the 3rd of Basic Education and Secondary Education, public and private, are equally represented (50.00%) In Portugal, compulsory education is divided into: Basic education: 1st cycle—1st, 2nd, 3rd and 4th year; 2nd cycle—5th, 6th year; 3rd cycle—7th 8th and 9th year; Secundary school: 10th, 11th and 12th year (Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2017b).

Overall, in 2017/18 the number of students in all schools, public and private, represent 17.66% of the population living in Cascais, as can be seen in Table 4.

Most of the students enrolled in schools in 2017/18 are male (51.87%). It also stands out that 25.61% of students are enrolled in the 1st Cycle of Basic Education, as the

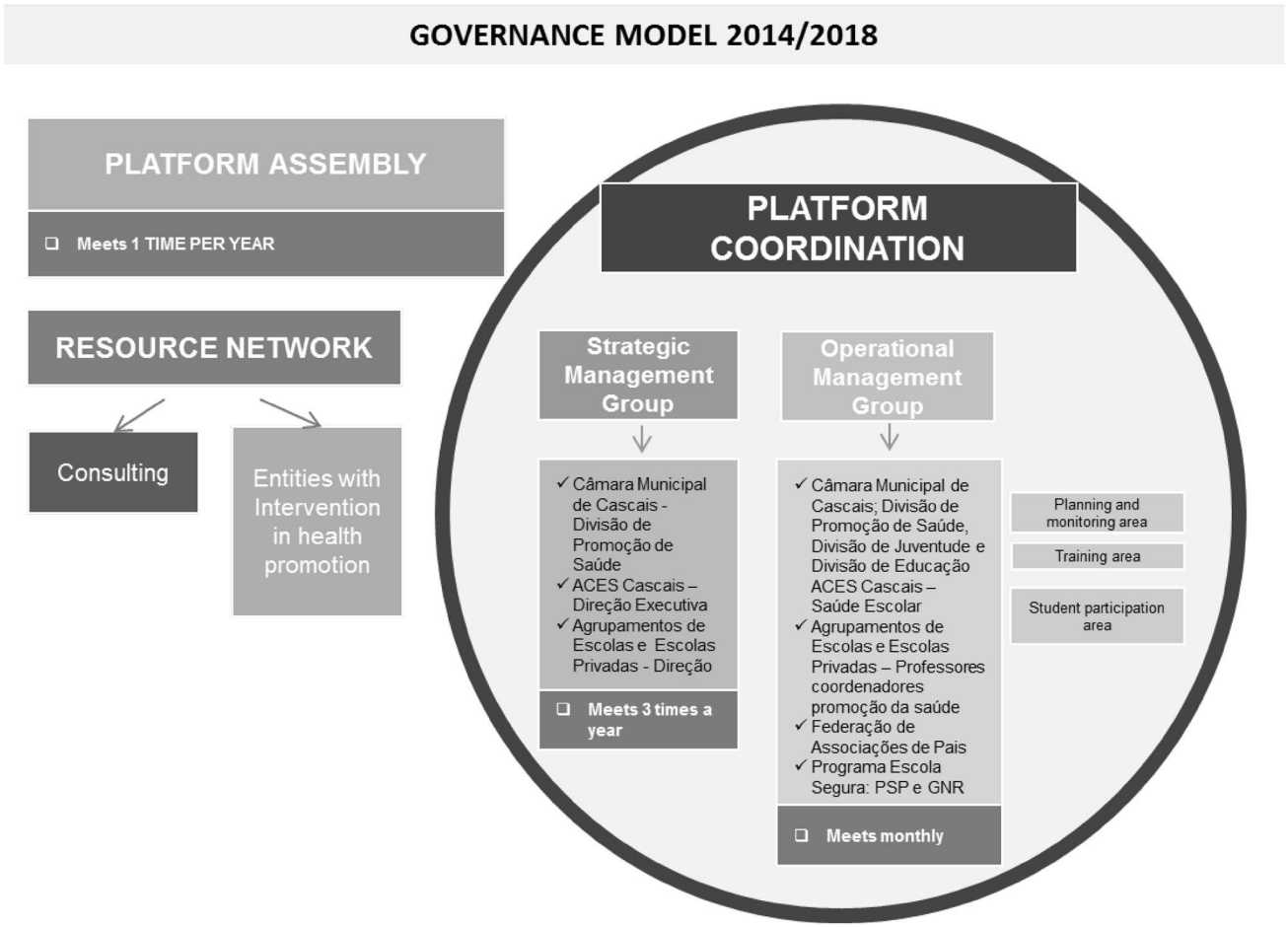

Fig. 1 Health Platform at school—Governance Model 2014/2018 in Cascais. Source: Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2014

Table 3 Number of schools in Cascais, public and private by level of education in 2017/2018

	Level of education					
	Total	Pre-school education	Basic education 1st cycle	Basic education 2nd cycle	Basic education 3rd cycle	Secondary education
Private schools	156	76	37	20	13	10
Public schools	111	33	44	11	13	10
Total schools	267	109	81	31	26	20

Source: Fundação Francisco Manuel dos Santos (2018)

3rd Cycle of Basic Education is 22.29% of students in the municipality of Cascais, followed by Secondary Education occupy the last three places in the percentage (21.31%) of students. At pre-school levels and 2nd Cycle of Basic Education with 16.57%, 14.22% respectively.

Developed Projects/Actions Developed

The Health School Platform aims to carry out actions anchored in health promotion strategies. The number of actions and covered students increased 21.93% and 34.50% respectively. However, the number of teachers involved decreased by 22.29%, as shown in Fig. 2 (Câmara Municipal Cascais. Departamento de Inovação e Comunicação. Gabinete de Estatística, 2017a; Câmara Municipal Cascais.

Table 4 Number of students in Cascais by gender and level of education in 2017–2018

	Level of education					
	Total	Preschool education	Basic education 1st cycle	Basic education 2nd cycle	Basic education 3rd cycle	Secondary education
Male students enrolled	19,290	3185	4907	2793	4358	4047
Female students enrolled	17,896	2975	4615	2496	3932	3878
Total students enrolled	37,186	6160	9522	5289	8290	7925
% Students enrolled in the resident population	17.66%	2.92%	4.52%	2.51%	3.94%	3.76%

Source: Fundação Francisco Manuel dos Santos (2018)

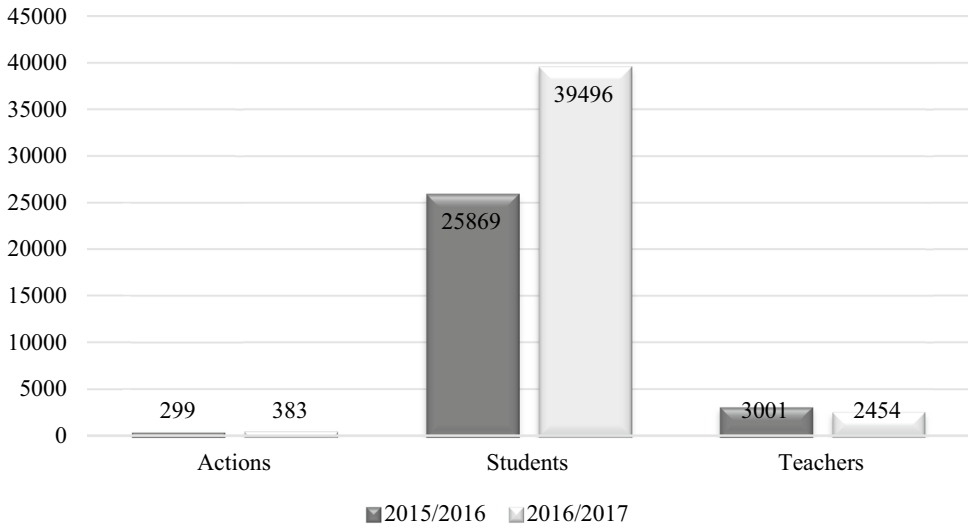

Fig. 2 Number of actions held, covered students and teachers involved in the Health Platform at School in the academic years of 2015/16 and 2016/17. Source: Câmara Municipal Cascais. Departamento de Inovação e Comunicação. Gabinete de Estatística (2017a) and Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde (2018)

Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2018).

The strategies are anchored in the vision and mission of Health Platform at School Program (Câmara, Guerra, & Rodrigues, 2010). Thus, the main strategies of Health Platform at School and are:

- *Development strategy of personal, social and emotional skills of students* which promotes healthy lifestyles, develop protective factors and reduce risk factors for children/youth people.
- *Strategy to promote training of teachers/assistants and operational/technical* that strengthens the skills of teachers through training activities and their application to students.
- *Education for affections and sexuality and preventing HIV/AIDS* which aims to contribute to the strengthening of information on HIV/AIDS from the perspective of health education, with a view to adopting behaviours with informed and conscious attitudes.
- *Strategy for oral health* aimed at improve the oral hygiene of the target group and internalization of basic concepts of tooth decay and associated pathologies, as well as the basic rules on tooth brushing and complete cleaning of the mouth.
- *Child safety promotion strategy* aiming to reduce the number of accidents involving children and youth people, as well as the severity of its consequences, by performing actions to promote child safety.
- *Healthy eating promotion strategy*, dissemination of healthier eating habits in which invited participants prepare and exemplify the suggested recipes and take them home to be reproduced with the support of the family.
- *Strategy for the prevention of psychoactive substance use* has the intention to increase information and thus contribute to the modification of the wrong perceptions of youth people and the general population in relation to alcohol issues and contribute to the adoption of healthier lifestyles (Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2018).

The set of defined strategies results in the realization of several actions which are listed in In Table 5 it can be seen

Table 5 Number of actions held in the school years of 2015/16 and 2016/17 and respective percentage variation

Actions developed	Years	
	2015/16	2016/17
Mental health and socio-emotional skills	686	532
Education for affections and sexuality	236	373
Healthy eating and physical activity	907	535
Body hygiene and oral care	311	138
Sleep habits and rest	87	100
Smoking prevention, alcohol and other psychoactive substances	295	311
Education for consumption	125	141
Safe mobility	286	109
Education for posture	15	152
Environmental education	53	63

Source: Câmara Municipal Cascais. Departamento de Inovação e Comunicação. Gabinete de Estatística (2017a) and Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde (2018)

that there was a strong reinforcement of actions in the academic year 2015/16 to the year 2016/17. Posture Education (increased 15 actions carried out in 2015/16 to 152 years 2016/17), as well as Education for Affections and Sexuality (increase of 236 actions to 373, representing an increase of 58.05%) to the detriment of actions on Safe Mobility, Body Hygiene and Oral Care, Healthy Eating and Physical Activity and Mental Health and Socio-Emotional Skills, where there was a decrease of 61.89%, 55.63%, 41.01% and 22.45% respectively.

Data also shows a moderate increase in actions for Environmental Education (18.87%), Sleep Habits and Rest (14.94%), Education for Consumption (12.80%) and Smoking Prevention, Alcohol and other Psychoactive Substances (5.42%).

These changes of increasing or decreasing the actions do not suggest that a particular action/strategy ceased to be minor; these changes are themselves of social intervention programs where it is necessary to meet the real needs of the recipients as well as the use of effectively and efficiently the resources available in the community.

Results: Involvement of Students and Teachers

In reviewing the analysis of data regarding the number of students covered by various actions developed and grouped by subject areas, as shown in Fig. 3.

In the academic year 2015/16 there was a strong mobilization of students for participation in actions around Healthy Eating and Physical Activity (907 actions with the participation of 5.148 students), Sleep Habits and Rest (87 actions with 5.040 participants) and Body Hygiene and Oral Care (311 actions with the participation of 3.719 students).

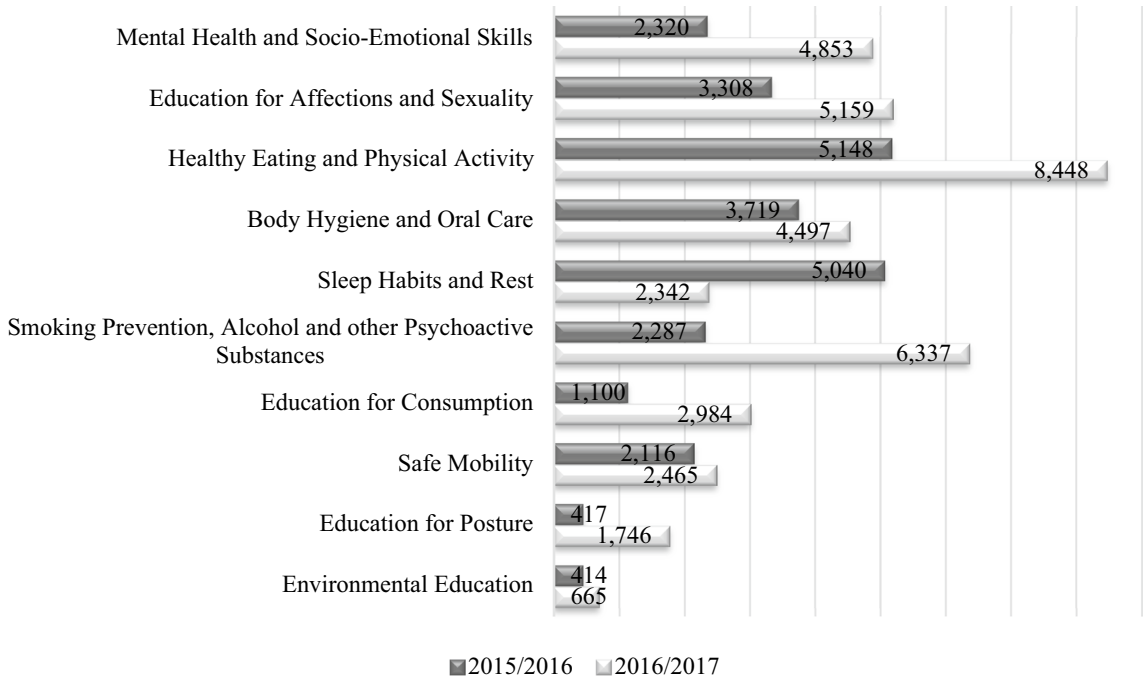

Fig. 3 Number of students covered by the different thematic academic years of 2015/16 and 2016/17. Source: Câmara Municipal Cascais. Departamento de Inovação e Comunicação. Gabinete de Estatística (2017a) and Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde (2018)

In the school academic year 2016/17 the Healthy Eating and Physical Activity remained the subject area (with over 535 actions and more students covered 8.448 students). In second place the actions of Smoking Prevention, Alcohol and Psychoactive Substances (311 actions with the participation of 6.337 students), and in third place the Education for Affections and Sexuality (which included 373 actions with 5.159 students) (Câmara Municipal Cascais. Departamento de Inovação e Comunicação. Gabinete de Estatística, 2017a; Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde, 2018).

Environmental Education and Education for Posture, although with a significant increase in the number of actions of the academic year 2015/16 to 2016/17, these were the thematic areas in which there was less participation of students.

With regard to the involvement of teachers in the actions developed, Fig. 4 indicates a decrease in Healthy Eating and Physical Activity (school year 2015/16 = 907 and 2016/17 = 535) and Mental Health and Socio-Emotional Skills (school year 2015/16 = 686 and 2016/17 = 532).

The areas where there was lesser involvement of teachers in the academic year 2015/16 were Education for Posture (15) and Environmental Education (53). In the year 2016/17 Environmental Education was maintained, with the participation of 63 teachers followed by Sleep habits and rest with 100 teachers participating.

Both in the scope of the students as in the involvement of teachers there was an increased participation of the academic year 2015/16 to 2016/17, in particular the Education for Posture, where there was an increase of 419% and 1013%, respectively. This is a greater reach of the Health Platform at School that contributes to the adoption of responsible behaviour leading to healthier styles of life.

This work was also subject of a national recognition through two awards, both in first position: Hospital of the Future Award 2012/13 in the Education category; and Hospital of the Future Award 2012/13 in the Community and Partnerships/Protocol category.

These engagement data and participation of students and teachers in the various thematic actions of Health Platform at School allowed the strengthening and development of psychosocial skills of children and youth people; the integration of participatory and integrated methodology that reinforces school integration of social networks in the community; the standardization of language in health promotion brings us to intervention strategies based on structural and individual empowerment.

Additionally, the increasing involvement of many educators (teachers, operational assistants, families) endowed with knowledge and skills needed for an integrated intervention in the field of health promotion, student participation in the planning and promotion of health projects, the confluence of local synergies and the implementation of a shared network

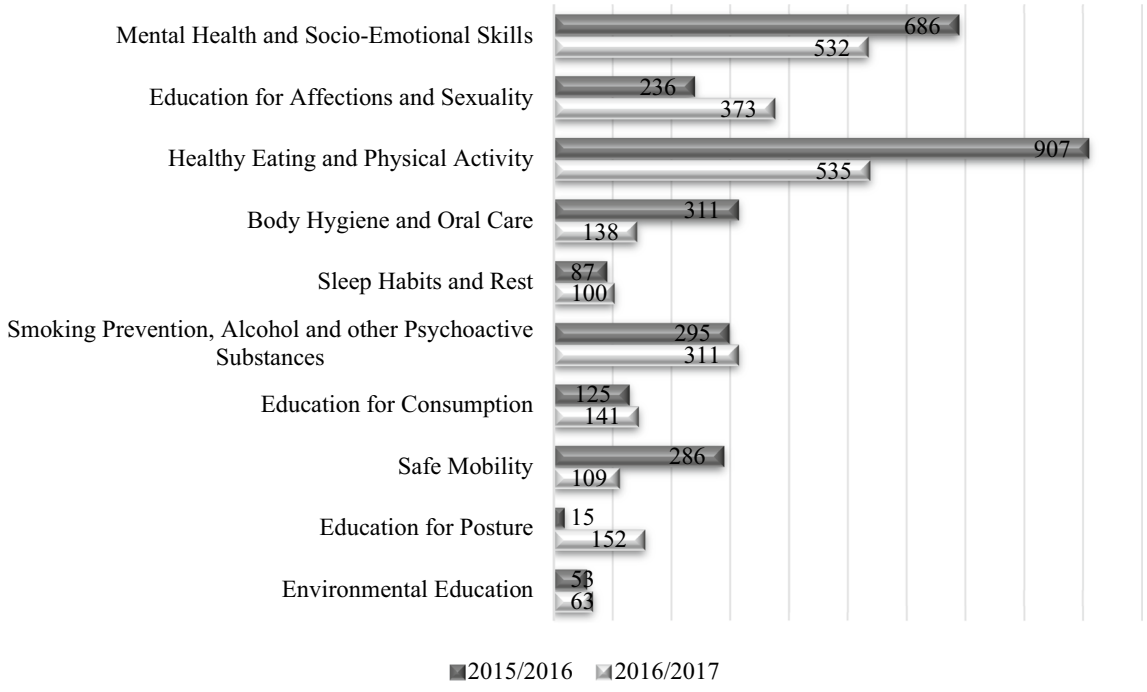

Fig. 4 Number of teachers involved by different thematic academic years of 2015/2016 and 2016/2017. Source: Câmara Municipal Cascais. Departamento de Inovação e Comunicação. Gabinete de Estatística (2017a) and Câmara Municipal Cascais. Departamento de Habitação e Desenvolvimento Social. Divisão de Promoção da Saúde (2018)

of resources and knowledge, are fundamental elements for the creation and the integrated and sustainable development of a collaborative network in the promotion of health which is embodied in the Health Platform at School.

Discussion: Challenges in Building Collaborative Networks with Children and Youth

In order to trigger an intervention with children and youth, it is agreed that schools constitute the best environment for the implementation of health promotion programs.

In this study the municipality of Cascais, with the intervention of the local authority, the focus is made possible by creating a collaborative network among students who attend all the compulsory education of public schools and some private schools. The development of the School Health Platform is expected to improve significantly the health of students in general, since it is a fairly comprehensive program encompassing several thematic areas and focuses on the most important determinants of health. Each school, however, after diagnosis of needs can also define and implement the actions that they consider priority.

The intervention starts from the premise that health literacy is a predictor of health promoting behaviors, that is, the group of children and youth with a high level of health literacy also presents higher levels of health promoting behaviors.

For this reason, the assessment of health literacy has been performed using mainly the questionnaire surveys, conducted before and after the implementation of actions under the various projects to promote health. This measurement is an essential step because it allows validation of interventions or adapts them to the needs of children, youth, parents or guardians and teachers. However, further in-depth and longitudinal study is needed.

In this context, it is argued that the role of the social worker in these collaborative networks can and should assume a management structure. By developing a mediating practice based on the capacity to defend a model of health promotion with this public, the social worker can better manage and monitor projects, activities and budgets and still build bridges with theory and social reality.

Cognitive mediation, which facilitates processes to resolve or deal with conflicts, transforming personal representations of health. Situationally, this area approach *empowers the* individual in health promotion, as defined in *the Ottawa Charter* (1986), the process by which individuals, groups and/or communities become able to take control of their circumstances and achieve their own goals, being able to work to help themselves and others, to maximize the quality of their lives. It consists of the experience of the individual in relation to power, especially on their individual perceptions.

Furthermore, a structural mediation relates to cases that resolve or manage conflicts arising from the transformation of forms of interaction in the educational community.

In this range, therefore, parents, students, teachers and institutions, as social and technical organizations, are called to build instruments to collect the experience and the needs of the actors involved in social processes that lead to the construction of knowledge, the configuration of social subjects, ensuring their social relevance and projects or programs to streamline. It drops techniques of static and quantitative functions that served as mere gatherers of information and enables them to generate possibilities of meaning and to structure processes that provide feedback for professional practice.

Thus, in the case of Cascais and specifically Health Platform at School, there is a performance about the influence of macro and micro determinants of health present in the lives of children and youth, i.e. it takes into account the various intrapsychic, intersubjective, family, community and ethnocultural instances, viewing this category as a *continuum* that occurs from the individual level to the macro level.

Networking allows rethinking the scope, impact and ethics, human and cognitive responsibility, dialogue, listening, creativity, critical reflection and observation to illuminate the selection and use of the techniques to be implemented in different family processes, group, individual or interactive community understandings, that make it possible and relevant to contemporary professional practice, providing all a path to social innovation.

At this time, the first evidence is being collected and the first lines of causality established. At a micro level actions on the determinants of health involves developing the knowledge, skills and motivation of students, parents and teachers towards health thereby producing more information, more access, greater understanding, greater application and internalization of such knowledge. On a more macro level, it implies better use of health services which will allow a reduction in health care costs; an improvement in health behaviors which will result in more *outcomes* in health; greater participation which will lead to *empowerment; and*, more equity which will translate into greater sustainability.

In short, this collaborative network - Health Platform at School in Cascais - is therefore a proposal for action that has been reconciling both an intervention at the individual level and collectively that provides a structure that is plural, multifunctional and humanist, governed by ethical responsibility, efficiency and quality in the management and community service. The consultation, reconciliation and harmonization of interests, actions and decisions are present in this convergence approach, providing the social management of a humanistic sense, in accordance with the need to build healthy community and improving the quality of life of children and youth in Cascais.

Compliance with Ethical Standards

Conflict of interest All authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in this study.

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