CHAPTER 4

Schools, Local Communities and Communication: Above and Beyond the Stakeholders

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Abstract Schools, as parts of local communities, have the central role in communication among stakeholders in the educational process. Stakeholders comprise all those holding stakes in relation to schools and their students, and who can contribute to decreasing problems and improving results. Stakeholders aim to promote and clarify communication. It is essential for them to have an informed approach to communication and consider its fundamental principles. The authors concentrate on stakeholders in education and communication processes, emphasizing the health problems of schoolchildren and youth. Communication in the field of health promotion, in particular concerning obesity prevention, is presented as an issue that is of fundamental importance for society, which includes both internal and external stakeholders in schools.

1 Introduction

It is precisely the promising and desirable affinity of children for life that can only be realised in a stimulating environment which should, *inter alia*, be developed through community-oriented schools and families. The need for school activity in a child's environment is developed by creating activities through school curricula, which, as a rule, express the need of teachers and children for a certain type of communication within both the

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school and local community, based on the personal competencies of teachers and school administration and on projected student competencies and expected educational accomplishments. This also emphasizes that the issue at hand is to support the process of changing approaches to education and expectations about the character of its effectiveness, and to provide an answer to the question of whether formal education can contribute to the development of an affinity for life. In other words, in addition to the learning matrix designed for acquiring knowledge in certain subject areas, it is also important to develop the dimensions and characteristics of a school curriculum which prepares students for life outside the classroom. This is the way to contribute to one of the basic approaches to the curriculum, namely the capacity to recognize certain schools and the paths they follow in their work. Hence, teaching processes based on the curriculum are founded in expert school management. It is said that the school curriculum provides plans for the co-habitation of students, teachers, parents, school management and the local community (Topolovčan, 2011, p. 33). Consequently, curricula become areas for the development of co-operation and partnership. Co-habitation in the educational process and at the level of school governance primarily involves recognition and development of human resources within the school and student families, as well as local stakeholders. The development of a school curriculum is actually based on a "situational analysis" of the requirements of students, schools and local communities, resulting in diverse learning and teaching experiences and possibilities for all students (Puzić, 2015, p. 73).

The importance of the curriculum and its development was confirmed long ago through an opinion provided by John Dewey, who observed the educational process from both perspectives: that of a child and that of the curriculum (Dewey, 2009). Therefore, it is expected that this important school document will serve to inform stakeholders about co-operation and partnership, the character and level of communication and the priority areas characteristic of a certain school.

The relationship between the family, i.e., the home, and the school, or between the home and teachers has traditionally been integrated in the educational process in schools, and can be considered a partnership relationship. In contrast, it has been observed that relationships that extend to local communities are developed or built, and are initially characterised more as relationships of co-operation, which transform into partnerships, due to the importance of common goals concerning youth education and socialisation[1]. Consequently, co-operation between the school, the home

and the community is crucial in order to decrease problems and improve results (Adelman & Taylor, 2008, p. 7).

The identification or mapping of major community stakeholders who co-operate with schools is an inevitable starting point when considering this issue. Here, the accomplishments of extending traditional school-parent co-operation are emphasised in relationship to building, in the true meaning of the word, community-based schools. In addition to equality, responsibility and mutual appreciation and respect, the quality of communication is of high importance for high-quality co-operation and development of the partnership relationship, which is why part of this discussion will follow this path. Furthermore, we pay special attention to one of the latest challenges to the development of co-operation between schools and local stakeholders in Croatia, which arises from the growing need for direct co-operation between schools and expert institutions related to a specific goal: the preservation of children's health. School-management development strategy shifts in this sense toward the concept of community-focused schools, which is respected and verified in practice. The concept implies recognising and respecting those outside-of-school factors that have a significant impact on the well-being of children and youth, their learning potential and achieving educational effectiveness (Information sheet, Community Focused Schools, 2010).

2 Stakeholder Mapping and Networking

Along with previously established co-operation between home and school, current policy recommendations in Croatia suggest on-going strengthening of the dimension of co-operation in education, as confirmed by research findings which often emphasise the established co-operation between schools and their external stakeholders as a factor fundamental to increasing school effectiveness. (Kovač & Buchberger, 2013).

All those holding stakes in the educational and socialisation process, and having the capacity to contribute to the achievement of the well-being and success of schools and students, are considered stakeholders. The usual participants in this process are teachers and students, school employees, parents and families, members of the community, local business leaders, elected officials, members of school boards, municipal bodies and state representatives. Collective entities are also considered stakeholders, including local businesses, various organisations, advocacy groups, boards, the media, cultural institutions and expert organisations (The Glossary of Education Reform).

Against the backdrop of such a broad range of options, within the context of Croatia, one can discuss co-operation with the home, local government, expert institutions operating in the field of child and youth care, non-governmental organisations and higher education institutions, to name a few. Speaking of communication as a precondition for the development of co-operation, there are, conditionally, two levels in a communication system. The first is the interior level, which encompasses the following relationships: student-teacher, student-student, teacher-teacher[2], and all the relationships involving teachers, students and other participants (e.g., management, administration, expert and other services, etc.) involved in the functioning of a single school as an organismic system.

> In general, stakeholders are considered to be all those holding stakes in schools and students, and who can contribute to decreasing problems and improving the results, sharing at the same time their personal, professional, civil or financial interests or concerns (The Glossary of Education Reform).

The second level represents "the view from outside," where it is possible to research which stakeholders a school finds attractive, or are attracted to the school, and for what reasons. Consequently, for example, this includes those linked with caring for an optimum approach of children and youth to educational resources (e.g., elected officials, publishers, libraries, etc.), for the development of existing education programmes for the life of the community (e.g., local government, non-governmental organisations, etc.), for students' mental and physical health care (e.g., public health institutions), and for a school's involvement with its community's development projects (e.g., other schools, local employers, etc.). The list continues and, in reality, becomes endless.

In situations linked with work with abused children, the effectiveness of specifically developed co-operation between local stakeholders and schools was proved during the Homeland War in Croatia, in particular in the integration of various activity levels—individual, family and community—and various assistance groups—schools, social-service centres and non-governmental organisations. Since it takes schools and governmental organisations much longer to design programmes for abused children and their families, co-operation with non-governmental organisations on support programmes is, as a

rule, inevitable (Delale & Družić, 2002). The same applies to educational programmes for children with special needs, i.e., with inclusive education when various stakeholders are involved, in co-operation with schools and parents, in designing the measures and principles of education for children with special needs (*Smjernice za školovanje djece s posebnim potrebama*, 2013). Specific education programmes for democracy, multiculturalism and so forth, are also developed and implemented through building such partnerships (Puzić & Matić, 2015). However, according to the results of school-curriculum research in Croatia, programmes testifying to the presence of a previous "analysis of the current status" of local community requirements are lacking (Puzić, 2015, p. 83).

Without addressing the topic of all the specific features related to the aforementioned fields of co-operation at this point, we shall concentrate on communication as the key process in all the relationships described above, their parts and the wider structures of which they are a part. It should be noted here that the school itself is certainly the central aspect in the architecture of building co-operative relationships between the school and the community, as this is where the foundations are laid, in particular through initiatives whose goal should be directed toward strengthening the co-operative capacity and a friendly work culture among teachers (Kovač & Buchberger, 2013, p. 525).

3 Communication: At All Times and in All Places

All parts of an organism create a circle.
Thus each part is at the same time the beginning and the end.

Hippocrates

The communication process is the connective tissue of all relationships, being ubiquitous to such an extent that it is rarely paid attention to, nor is time dedicated to understanding and hence improving it.

> The basis of the success or failure of common action, the development of co-operation and the functioning of partnership relationships, all originate in the communication process.

Outside the circles of communication experts and psychotherapists, and with the exception of situations where relationships are disrupted and

facing a crisis, the role of the communication process is most often overlooked or taken for granted. However, this process needs to be understood in order to willingly participate in it and thus build relationships which, not only declaratively, but *de facto*, promote the realisation of common goals through transparency, mutual respect and appreciation.

Watzlawick, Beavin Bavelas and Jackson (2011, p. 29), continuing the work of G. Bateson (Bateson, 2000), list the basic features of communication, three of which are described here in the context of communication between stakeholders in the educational process. The first feature they list is that it is impossible not to communicate. If we consider the fact that there is no opposite to *behaving*, i.e., a person always behaves in a certain manner, and that each behaviour implies a certain meaning, we can conclude that communication is inevitable in each situation in which there are two persons conscious of one another.

We can thus imagine two persons who, due to a recent argument, avoid and do not speak to each other. Yet, it would be entirely wrong to state that they do not communicate. In this case, each of them communicates a message saying that they do not want to be close. Furthermore, they send and receive a number of other messages which depend on the particularities of their situation. Here, it should also be noted that communication takes place regardless of whether its participants are aware of it, and that it is not necessary that the message sent by one person and the message and received by the other are the same. Hence, in this hypothetical case, one person, by avoiding the other, may send a message saying "I am afraid of starting a new argument with you," while the other may interpret the behaviour as saying "I do not respect you."

> The awareness of the inevitability of communication may to a large extent change the behaviour of all the stakeholders in the educational process.

It is only after a person, or an organisation, accepts the fact that they always send a message, regardless of whether they intend to do so or not, that they can stop and decide which message they want to send, and whether the other party received and understood the message in the same way it was sent. The next key feature of communication is that it exists at two levels: the level of content and the level of relationship. Its content

refers to facts, to what can be perceived objectively—words spoken, texts written, etc. On the other hand, messages communicated at the level of relationship serve to qualify the content, i.e., tell us how to perceive the content. In general, most misunderstandings, arguments and problems that might be avoided are grounded in communication at the level of relationship. According to Shulz Von Thun (2006), the relationship level consists of messages about how their senders perceive themselves, how they perceive the other person, how they perceive the relationship and their own and the receiver's role in the relationship, what they do or do not want, etc. All that information is sent almost exclusively by non-verbal or para-verbal signs simultaneously with the "objective" content of the message.

Communication at the level of relationship takes place, as a rule, at the subconscious level, and rarely are those signs sent intentionally and consciously. In the majority of "healthy" relationships, this information mostly flows quietly, in the background. On the other hand, "unhealthy" relationships are typically characterised by difficulties at the level of relationship. Hence, it often occurs that the content aspect of communication becomes irrelevant and serves only as a stage for hidden fights related to the relationship. When individuals and organisations recognise that communication exists at these two levels, they will find it easier and be faster to recognise the real sources of possible problems in co-operative or partner relationships. Moreover, being aware of this principle enables the creation of a climate of trust and respect in daily communication, such as between a principal and teacher or a teacher and student[3], which are, as previously stated, inevitable components of efficient co-operation and partnership.

The third basic feature of communication relates to the interaction of persons included in the communication process and the fact that its causes and effects are always arbitrarily determined, depending on where the starting point is set. Thus, for example, it may be established that one person in a group is dominant, as he/she behaves in a certain manner, while the other person is submissive, as he/she behaves differently. Yet, on second glance, such distribution of roles may lead to the question of where the dominant behaviour of one person or the submissive behaviour of the other originates, as well as the issue of whether these categories might exist one without the other. This feature is called punctuation and basically relates to the fact that an arbitrarily set starting point determines the interpretation of communication and directs the entire interaction. Discrepancy regarding where the starting point of a sequence of events lies is at the root of a vast array of difficulties in relationships. For example,

a teacher may feel uncomfortable due to a feeling that a child's parents are attacking him/her and therefore may avoid a conversation by backing away and holding his/her position rigidly. On the other hand, the parents may perceive the teacher as unavailable and unwilling to listen to them, which is why they intensify the pressure. As a consequence, the teacher could back away even further, and the parents increase pressure, and a closed circle may be formed in which inefficient behaviour intensifies on both sides. It should be noted that in such a case the teacher and parents see entirely different interaction sequences. While the teacher sees "they attack me, which is the reason for my avoiding them," the parents see "he/she avoids us, therefore we attack him/her." Such interaction may, in theory, last forever. However, it is more common for a case to escalate and end in mutual accusation and blame. The understanding and awareness of this principle enable seeing the situation from the other's perspective and creating the possibility for mutual understanding and acceptance. Simultaneously, understanding that one vainly searches for the starting point of a sequence of events, even at the level of meta-communication, the participants may concentrate on the present moment and, instead of wasting their energy and time on questions concerning what caused the current situation, they may focus their attention on the type of situation they wish to create at that particular moment.

Concerning the features of communication, the stakeholders in the educational system need to develop relationships and communication channels that promote mutual support and trust[4]. As a result, social activities like promoting a healthier lifestyle may become more than a formal process. The promotion of children's health, primarily with respect to the prevention of obesity, may serve as an example of a socially important problem that includes a school's external stakeholders.

4 The Link Between the School and the Community: Children's Health as a Result of Joint Effort

The school is considered an important part of the local community. Yet, schools are often "islands" with no bridges to connect them with the "mainland." Families live in the neighborhood, but are frequently insufficiently interconnected or insufficiently connected with their children's schools. However, considering that communication necessarily starts

taking place as soon as persons or other social entities become aware of one another, families necessarily influence one another, whether in a positive or adverse manner, and whether intentionally or not (Adelman & Taylor, 2008).

One of the indispensable goals that transcends school tasks and extends from individual homes to a wider social system is children's health. Protecting children's health is an important social goal, the achievement of which requires communication and co-operation of all stakeholders, and this was emphasised during the Fifteenth Croatian Pediatric Symposium held in 2014. A positive shift in the curve of the health of children and youth is achieved by involving parents as role models, with the support of expert recommendations and leading health workers, as well as with the indispensable support provided by the school (Pintar, 2014, p. 225).

5 Schoolchildren's Health: Status and Issues

During the last decade, statements about public-health problems of children and youth have been heard with increasing frequency in Croatia. Physicians note earlier pubescence, unhealthy lifestyles, irregular diet and the issue of being overweight, physical inactivity, abuse of addictive substances and various forms of disruptive behaviour, as well as a continuously increasing number of neglected and abused children (Dabo, Tomac, & Mrakovčić, 2007). Youth health status has continuously been proved to be a growing problem which demands expert elaboration and solutions[5]. The data on youth health status indicates a growing trend in existing health issues and the arising of new ones[6].

The issue of overweight school children is an urgent one. Croatia ranks seventh with respect to childhood obesity in Europe. According to the Croatian Institute of Public Health, one-quarter of school-age children are overweight, while one-tenth suffer from obesity. The data shows youth with eating disorders, e.g., only slightly more than half have breakfast on weekdays, while between two-thirds and three-quarters take insufficient quantities of fruit and vegetables. Only every third boy and every fifth girl is involved in physical activity for at least one hour a day (Mrvoš Pavić, 2015). Obesity affects the quality of childhood, and in adulthood, when it most often continues, it is considered a serious health and social problem. Health status and the problems of children and youth are monitored in Croatia on a regular basis and presented in expert and scientific papers as well as the media. Consequently, an analysis of the problem, as well as the

awareness of competent institutions, stakeholders and the broader public, are not in question. This applies primarily to the obesity issue, which has been continuously emphasised, in light of increases in its rate and the severity of its consequences, and hence urgent interventions and measures are imperative. Warnings concerning the severity of the problem in Croatia have been issued for quite some time and can be found in literature from over a decade, along with the forecasts of escalation. Directions and activities have been defined for prevention and treatment both at the individual and the general levels[7]. Due to the worrisome data, prevention programs concerning healthy eating habits and the importance of regular physical exercise were implemented within a limited territorial scope[8].

The obesity problem in Croatia has not been sufficiently presented from the perspective of children, families or schools, and hence research on this issue is both required and seen as a challenge. Highlighting the problem at the level of all stakeholders might contribute considerably towards improvement.

The majority of targeted intervention is directed towards information and education, focusing primarily on the aspects of communication content, while generally no attention is paid to the level of relationships, where communication also continuously occurs. On the other hand, the foreign marketing industry, promoting the consumption of unhealthy foods and primarily targeting children, uses emotional communication, linking products with psychological needs. Consequently, when creating public-health interventions, it is of crucial importance to take into consideration all the levels at which a message is transmitted (e.g., Simson, Wilson, Ruben, & Thompson, 2008; DeBar et al., 2009).

It has been confirmed that obesity-prevention programmes, as well as the entire nutrition disorder spectrum, require a multi-disciplinary, harmonised approach from families, as well as all education and health-care system levels, with an emphasis on the promotion and adoption of healthy eating habits and of healthy lifestyle in general (Bralić, Javančević, Predavec, & Grgurić, 2010, p. 40). On-going communication among all the participants involved, from individuals to the broader social community, and their co-operation in achieving results, would contribute to an improvement of the current situation. Research has already shown the fundamental importance of schools in the implementation of child-obesity

prevention programmes, as schools bring all children together. Diverse stakeholders consider school as a place where child-obesity programmes may be implemented and accepted (Bucher Della Torre, Akre, & Suris, 2010). Hence, schools are venues where, through development of high-quality relationships, an environment may be created where children may satisfy their psychological needs (Glasser, 1998), and build a climate of trust on those foundations, and where children might also be given high-quality information on their health and be protected from the toxic effects of false images of lives and values they are exposed to through the media.

6 Stakeholders in Context: Croatian Case of Children and Youth Health-Care Changes

Irrespective of an unfavourable social and political position, the development of youth health care in Croatia kept pace with the commencement of this activity in Europe. For example, the first school physician in Sweden was appointed in 1840, and in Croatia in 1893. Croatia followed the first European ideas on school hygiene. The activity of Dr. Andrija Štampar in 1923 concerning the development of public-health services led to the development of systematic health care for schoolchildren and youth. The beginning of the twentieth century saw the foundation of the first school polyclinics where ill children were treated. Dental polyclinics were established simultaneously. This continuity was disrupted during WWII; nevertheless, since 1951, school health care has been continuously developed, and by 1998 student health-care units and an integrated health-care model were established (Lančić, 2009, p. 238). During the 1970s and 1980s these were unique aspects of the school health-care organisation. Health centres had clinics organised for school health care, where school teams worked, consisting, as a rule, of school health-care specialists or physicians with postgraduate education in school health care, a senior nurse, a nurse with a secondary-education diploma and provision of the services of a psychologist and/or defectologist. The integrated health-care model was the basis for this organisation. The principle of competence was ensured by having one school team responsible for health-care prevention and treatment for students of individual primary and secondary schools. This type of health-care model provided for the continuous monitoring of students from the beginning of their education, ensured good and comprehensive insight into student health status, and enabled an integrated approach in health care (Jureša, 2007).

With the changes in the early 1990s, an organisational "disorder" was created and prevention-related activities saw a significant decrease (Lančić, 2009, p. 238). The issue of contracting student preventive health care remained unsolved. The principle of free choice of a physician (which is, certainly, one of the fundamental human rights), under the circumstances of fighting for *per capita* quotas, made primary health care physicians compete (a positive, in principle), and "struggle" for their patients. Hence, student preventive health-care measures failed to reach the expert level. Since 1998, following the decision to implement preventive educational health-care measures in primary and secondary schools, school and university health-care services have been dissociated from health centres and merged with institutes for public health. The two aspects of health care of school children and youth were thereby separated: Treatment was performed by selected physicians (e.g., parents might choose for their children to be treated by the family physician, a school health-care specialist—who remained in the treatment sector—or a pediatrician), while preventive health care remained within the competence of school health-care teams. It is interesting to note that pilot research conducted in 2005, seven years following the introduction of the new organisation of schoolchildren's health care, which encompassed all school health-care specialists experienced in working in integrated care, showed that the majority of specialists in treatment and more than half of prevention specialists participating in the research, were not satisfied with this organisation, which indicated that the student health-care organisation, divided between prevention and treatment, fails to provide effective care for the population (Džepina, Čavlek, & Đanić-Kojić, 2011).

School health care, which today is part of the public health-care system, provides specific preventive and health-education measures in the health care of schoolchildren, youth and university students. Each primary and secondary school and faculty has a responsible team, which includes, as a rule, a school health-care specialist and a nurse with secondary or higher education (Jureša, 2007). Lately, a change has been observed in child and youth mortality. In place of the former prevention and treatment of infectious diseases and malnutrition, current school health-care specialists focus on risky behaviour-linked illnesses (e.g., engaging in sexual activities at an early age, an increase in the number of partners, drug abuse), chronic illnesses and accidents. The turmoil of the war and post-war period, transition-related changes and the recession affected general social processes and family dynamics. These substantial changes also affected mental health. Aggressive

and violent behaviour among children is increasing, along with depression, suicide and disruptive-behaviour rates. Increasing demands by the school and society have an adverse effect on youth health. The above-stated health issues require a new approach to solutions. Polyvalent "open-door" consultancy centres employing both school physicians and other health-care and non-health-care workers have proved to be the most effective model for resolving current youth problems (Lančić, 2009, p. 240).

7 Conclusion

The creation of a stimulating environment for children's education implies, above all, the development of a school curriculum that states that good internal communication is the foundation for creating community-oriented activities aiming to meet specific requirements of students and teachers for a more efficient education process and for students' lives outside their classrooms. The specificity of the school curriculum is, in this sense, also determined in relation to identified stakeholders in the community, who develop co-operation with schools, as well as to levels of communication within the school and with stakeholders, in the light of the problems and issues that create their ties with schools. Desirable community schools are developed as a consequence and the sustainability of educational programmes is ensured. One of the latest challenges faced by such co-operation is related to the increasing need for co-operation between schools and expert institutions and non-governmental organisations, with the goal of ensuring children's health. The importance of communication among children and youth health stakeholders was confirmed in previous research. Improvement in the sophistication of the manner in which school health programmes are designed, distributed and evaluated is encouraging. Furthermore, studies indicate good experiences, and also good co-operation between the health and education sectors in children's health planning, and in particular in programme articulation (Lawrence, 2006, p. 728).

The development of children's and youth health care in Croatia has always had the same goal: to preserve and promote children's and youth health and also therefore the health of the adult population (Dabo, Tomac, & Mrakovčić, 2007). Since its foundation in the early twentieth century, school health care has changed its content, organisation and operating methods; however, despite all the efforts invested in it, children's and youth health problems remain both an individual and a social concern. Taking into consideration the efforts invested thus far into the organisation

and scope of children's and youth health care in Croatia, and considering the importance of the issue, one also needs to consider the possibility of searching for improvement through more efficient communication and closer co-operation among those involved, i.e., the participants, the family, the school and the health system. Schools are an ideal environment for the implementation of health care programmes among children and adolescents. This was also confirmed by the 2005 Dubrovnik Declaration on School Health Care in Europe, which demands that school health care should be of the highest political priority (Lančić, 2009, p. 240).

Notes

1. The cooperation mainly determines the relationship between individuals and groups as regards their agreement in the share of responsibilities when achieving a specific goal, while partnership may be interpreted as the highest level of cooperative relationships of individuals or groups directed toward achieving a common goal within a certain time frame.
2. Communication relations may be observed on an individual, but also on the level of a group, while the principles described below are applicable to both. Therefore, and even more so for the purpose of simplicity, when writing, e.g., student-teacher, we consider all iterations included: student-teachers, students-teacher and students-teachers.
3. In case of teachers and students, it is the teachers that bear the primary responsibility, since they have more power within the relationship both in the formal sense and in the sense of development capacities (cognitive and emotional). In certain other relationships, the power is distributed in a different manner, which results in various possibilities of influencing the situation. Yet, in a relationship of adults, the awareness of the relationship level of communication is the responsibility of both sides.
4. Examples of more recent research of the communication process among stakeholders in the field of education for the area of South and South-East Europe include the issues of the development of the possibility of intercultural communication (e.g. Šulistová, 2009), the influence of the manner of communication within a family on the behaviour of children (e.g. Pšunder and Milivojeveić Kranjčič, 2010; Lebedina-Manzoni, Delić, and Žižak, 2001), the influence of communication competences on the part of the teachers on the development of students' social competences (e.g. Valjan-Vukić, 2010; Scotti Jurić, 2006), and the influence of distance learning on the quality of communication (e.g. Duh and Krašna, 2011).
5. The social importance can also be observed through demographic trends which indicate a gradual decrease in the number of school children and

youth in Croatia. A continuation of the trends is forecasted for the future (Kuzman, Pavić Šimetin, Pejnović Franelić, 2011).

6. The statistical data from regular medical check-ups in 2014 show the following: improper posture of 15 % of primary and 21 % of secondary school children. Almost half of the students smoke cigarettes, drink alcohol, and the same number has certain experience with drug abuse. Physicians report an increase in emotional problems, a decrease in self-confidence, and an increase in the level of stress and aggression. In the Split-Dalmatia County, the improper posture, flat feet and visual impairment were most common. Physicians diagnosed a 6 % increase in testicular varicose veins during the period between 2005 and 2014. Girls are frequently diagnosed with thyroid gland enlargement—in 2014, 4 % of eight-grade girls were diagnosed with it (Zenić Rak, 2015).
7. Grgurić draws attention to the problem of children obesity in 2004. The directions and activities are emphasised by Pavić Šimetin et al. (2009).
8. As an example, in the early 2015, the school-age children obesity prevention program was launched under the name of "PETICA—igrom do zdravlja" ("FIVE—play to health") at eight schools in Zagreb.

References

Adelman, H., & Taylor, L. (2008). *Fostering school, family, and community involvement. Effective strategies for creating safer schools and communities.* Hamilton Fish Institute on School and Community Violence. The George Washington University.

Bateson, G. (2000). *Steps to an ecology of mind: Collected essays in anthropology, psychiatry, evolution, and epistemology.* Chicago: University of Chicago Press.

Bralić, I., Javančević, M., Predavec, S., & Grgurić, J. (2010). Childhood obesity – A new domain of the multidisciplinary preventive program. *Paediatrica Croatica, 54*, 33–42.

Bucher Della Torre, S., Akre, C., & Suris, J. C. (2010). Obesity prevention opinions of school stakeholders: A qualitative study. *Journal of School Health, 80*(5), 233–239.

Dabo, J., Tomac, V., & Mrakovčić, I. (2007). *The health care of young people in the third millennium.* Conference Hrvatski dani primarne zdravstvene zaštite, Labin, Hrvatska 25–27. Listopada 2007.

DeBar, L. L., Schneider, M., Ford, E. G., Hernandez, A. E., Showell, B., Drews, K. L., et al. (2009). Social marketing-based communications to integrate and support the HEALTHY study intervention. *International Journal of Obesity, 33*, S52–S59.

Delale, A. E., & Družić, O. (2002). Suradnja vladinih i nevladinih organizacija u radu sa zlostavljanom djecom. *Ljetopis socijalnog rada, 9*(2), 295–302.

Dewey, J. (2009). *The child and the curriculum project Gutenberg*. (Reprint of 1902 edition) Retrieved August 2, 2015, from www.gutenberg.org/files/29259/…h/29259-h.htm.

Duh, M., & Krašna, M. (2011). Distance learning—Communication quality. *Informatologia, 44*(2), 131–136.

Džepina, M., Čavlek, T., & Đanić-Kojić, M. (2011). Advantages and shortcomings of the new school medicine structure. *Hrvatski časopis za javno zdravstvo, 7*(28).

Glasser, W. (1998). *The quality school*. New York: Harper Perrenial.

Grgurić, J. (2004). Obesity prevention beginning in childhood. *Paediatria Croatica, 48*(1), 35–39.

Information sheet, Community Focused Schools, Community Focused Schools, *Circular* No 34/2003, National Assembly for Wales. Retrieved October 9, 2015, from https://cyp_3__sp_07a__community_focused_schools_e_-English.pdf.

Jureša, V. (2007). Health protection of school children and youth – School and high school medicine – Advantages and disadvantages of individual health protection model, *Hrvatski časopis za javno zdravstvo*, 50(3)

Kovač, V., & Buchberger, I. (2013). Suradnja škole i vanjskih dionika. *Sociologija prostora, 51*(3), 523–545.

Kuzman, M., Pavić Šimetin, I., & Pejnović Franelić, I. (2011). Health and health risks in school age children – What we know and are we managing to help them. *Hrvatski časopis za javno zdravstvo, 7*(28).

Lančić, F. (2009). Organisation of healthcare for school children—School health service in the past and today. *Medicus, 18*(2), 237–241.

Lawrence, L. S. (2006). Developing indicators to enhance school health. *Theory & Practice, 15*(6), 719–728.

Lebedina-Manzoni, M., Delić, T., & Žižak, A. (2001). Children's perception of family communication. *Croatian Review for Rehabilitational Studies, 37*(2), 153–170.

Mrvoš Pavić, B. (2015). *Zvono alarma: Četvrtina školske djece u Hrvatskoj s prekomjernom težinom*. Novi list, October 13, 2015.

Pavić Šimetin, I., Perković, N., Kuzman, M., & Jureša, V. (2009). Prevention of childhood overweight and obesity – Development of guidelines for school health care. *Medix, 80*(81), 226–229.

Pintar, V. (2014). Sretno dijete – zdravo dijete. *Paediatria Croatica, 58*(3), 244–245.

Pšunder, M., & Milivojević Kranjčič, A. (2010). Improper communication conditions deviations in behaviour. *Informatologia, 43*(3), 180–188.

Puzić, S. (2015). Školski kurikulum u Hrvatskoj: primjeri i iskustva. In B. Baranović (Ed.), *Školski kurikulum: teorijski i praktični aspekti* (pp. 63–86). Zagreb, Croatia: Institut za društvena istraživanja.

Puzić, S., & Matić, J. (2015). Interkulturna dimenzija školskog kurikuluma. In B. Baranović (Ed.), *Školski kurikulum: teorijski i praktični aspekti* (pp. 87–114). Zagreb, Croatia: Institut za društvena istraživanja.

Schulz von Thun, F. (2006). *Kako međusobno razgovaramo 1 – Smetnje i razjašnjenja*. Zagreb, Croatia: Erudita.

Scotti Jurić, R. (2006). Conversazione in classe: la strategia educativa delle domande e del silenzio. *Metodički obzori, 12*(2), 71–84.

Simson, S. P., Wilson, L. B., Ruben, K. A., & Thompson, L. M. (2008). Humor your way to good health: An intergenerational program to address a critical public health issue: The epidemic of overweight and obesity among children. *Journal of Intergenerational Relationships., 6*(1), 83–100.

Smjernice za školovanje djece s posebnim potrebama, 2013. Sarajevo, Bosnia and Herzegovina: Društvo ujedinjenih građanskih inicijativa. Retrieved August 3, 2015, from http://www.unicef.org/bih/ba/media_24319.html.

Šulistová, R. (2009). Education of primary and high-school students with goal of developing intercultural communication. *Informatologia, 42*(2), 133–136.

Topolovčan, T. (2011). *Školski kurikulum kao prepoznatljivost škole*. Retrieved October 21, 2015, from https://bib.irb.hr/datoteka/527516.KOLSKI_KURIKULUM_KAO_PREPOZNATLJIVOST_KOLE.pdf.

Valjan-Vukić, V. (2010). Communicational competences of teachers and pedagogically formed communication – Basis for the development of students' social skills. *Magistra Iadertina, 5*(1), 131–143.

Watzlawick, P., Beavin Bavelas, J., & Jackson, D. D. (2011). *Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes*. New York: W.W. Norton & Company.

Zenić Rak, D. (2015). *Rezultati sistematskih pregleda osnovaca, srednjoškolaca i studenata u Splitsko dalmatinskoj županiji*, Slobodna Dalmacija, July 5, 2015.