School and Health 21, 2010, *Health Education: International Experiences*

LIFE SKILLS AS THE INDIVIDUAL AND SOCIAL HEALTH RESOURCES

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Abstract: *The approach oriented at developing life skills as one of the health education strategies is rooted in the wider context of social and cultural transformations influencing changes in the scope of human self-understanding and one's role and functioning in the world. In the sphere regarding health and health education these transformations lead to paying more attention to individual responsibility for own health. The wider dimension of social and cultural changes on the other hand shows the subjectivity of an individual as a key to economic, social or cultural society growth. Personal resources in this context become not only individual but also a social growth factor. In this sense, the health resources and particularly life skills are the foundation for actions aiming at taking individual responsibility for own healt and in the further perspective – responsibility for local community health and a society in general. The goal of this paper is to emphasize some of the determinants and consequences of such understanding of health and health education.*

Keywords: *health models, health education, life skills and competences, individual and society health resources*

1. Variability of understanding health. From social to individual responsibility for health

In the literature referring to this issue there are many definitions of health as it is one of the major spheres of human's life, what in consequence makes this issue a crucial field of interest not only on the medical or social ground, but in the context of individual, ordinary everyday life too. A number of definitions may be analyzed in continuum that presents the directions of change in understanding the term: from positive to negative ones. Generally, the negative definitions related the health condition to the lack of illness. The ground for positive term of health is the WHO definition from 1946. It perceives it as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (Woynarowska, 2008, p. 19). Although the definition is criticized for vagueness, it changed the way we tend to think about health and illness. Health as positive category is associated with terms such as quality of life, potential or resources. Many authors emphasize that the positive understanding of

health is based on combining the subjective and objective criteria (Woynarowska, 2008, p. 24). C. Herzlich described three types of informal understanding of health: superficial (occasional focus on health, mainly while falling ill), in the reserves categories (health as resources, capital) and the balance (as subjective standard of experiencing pleasure we strive after) (Juczyński, Ogińska-Bulik 2003, p. 10). From these three perspectives, the first one refers to negative meaning and the rest are positive.

In the health science, apart from the attempts to define health, there are broadened characteristics, so called health models. Their description should be analyzed in a broadened context of social and cultural changes that have been reflected in variability of philosophical ideas and ways of understanding human and his functioning in the world. These changes may be observed in the humanistic and social science dominated by the multidimensional perspective as physio-psycho-spiritual existence. Moreover, it is also noticeable in drawing attention to the world of individual experience and the sings of subjective reality inspection and intersubjective communication processes. The individual perspective, subjective and not collective, dominates not only in science, but it is also observed in mass media and day-to-day life. All the changes of the ways of thinking might be expressed by mutual definition of processing from the modern to postmodern reality project (Bauman, 2006).

The change of paradigms in social and humanistic science lead to crucial consequences in the patterns of perceiving health. The traditional perspective represents biomedical model of health (also called pathogenic) that came into existence due to dualistic and mechanistic Cartesian philosophy. In this case health is understood objectively, described by the medical criteria as the state of no disturbance in biological functions of the organism (Woynarowska 2008, Sheridan, Radamacher 1998). This model concentrated on the illness as the main issue and on the ways of copying with it, including determining the symptoms and eliminating them[1]. In other words, it came down to treatment or preventing the disease by creating proper external and internal conditions accompanying the "lack" of illness. The medical staff and appropriate institutions were responsible for such understanding of health. However, the individual responsibility was restricted only to respecting the external determined recommendations and standards. In biomedical model the individual responsibility for own health was of indirect and passive character and based on the obligation to "listen to" specialists.

In the second half of 20th century, the holistic model of health relating to systemic perspective was promoted. Health in such case is understood multidimensional, multifaceted and procesual. It may be analyzed in two dimensions. The first is broaden dimension when the body is perceived as living system and health understood in such way includes many subsystems and dimensions. This dimension emphasize a human being as integral part of social and cultural system and the health is both an individual and the environmental issue. Such perspective is called the social-ecological model of health. There are many interpretations of this perspective, the best known is the „health mandalas" (Kowalski, Gaweł 2007; Woynarowska 2008). The salutogenetic model, describing

1 Currently the domination of holistic model is recognized, hence biomedical model is referred to as the past one. However, it must be remember that there is a possibility of coexistence of all health models or making a subjective choice from them. It is a consequence of postmodern reality project, as pluralism and relativism constitute such reality.

the factors and mechanisms of reaching health is also worth mentioning. Here, health and illness are shown in continuum, where a human proceeds during life. According to Antonovsky the crucial question is what makes people retain health despite pathogens and why some recover and some do not. In this model emphasis is put on health, not the sickness and the risk factors as in the pathogenic model (Antonovsky 2005).

The alteration of thinking about health shifted the emphasis, as it is clearly seen in the holistic or salutogenetic model. Both models indicate health and its retaining as the heart of the issue. However, the are some differences between them. The holistic model puts pressure on multidimensional understanding of health. Hence, the question of retaining health comes down to caring of its different spheres, both assigned to a human himself and those beyond him. In this perspective health promotion and health education consist in supporting the individual in the effort of taking care of own health, and on the other side it is about creating the appropriate external, environmental conditions and directing the action to the entire societies in order to boost their health potential. That is the reason for importance of multidimensional understanding of health, where social and environmental factors (including health care) are as crucial as subjective factors and the lifestyle. In this model the responsibility for health is shared between the individual, society and specialists. Such perspective is also important due to the fact that it emphasizes not only the individual health, but the society and environmental health too.

The salutogenetic model on the other hand indicates the state of sustaining health despite harmful factors or recovering despite the illness. A. Antonovsky showed the difference between the ways of copying with the risk factors and difficult situations (including sickness) and retaining health despite influence of these factors. The problem of retaining health lies in creating subjective health determinants. It's therefore justified to assume that health promotion and health education come down to strengthening or creating subjective ways of copying (including various life skills) regardless being directed to individuals, groups or societies. On the other hand, the actions focusing on creating the appropriate external conditions may also in consequence concentrate on indirect shaping the individual strategies of copying. For instance, developing the social-cultural potential of societies may be the growth factor of social support for individuals, becoming also the compensatory actions as copying strategies. In the case of salutogenetic model, the responsibility for health is individual, as the human can develop his health potential himself.

It is clearly seen that the shift in understanding health are far beyond its scientific perspectives and might lead to domination of positive descriptions, concentrating on remaining and developing the health potential, but also making the individual responsible. Hence, each of us is responsible for our own heath in such perspective.

2. Practical skills as the basic resources of individual health

The theory of human potential developed since 1960's and then the theory of social potential both emphasize the human factor as the crucial resource in economic growth. The term "human potential" refers to knowledge resources, skills, health or vital energy of societies that might be a subject of growth by so called human investing. On

the other hand the "social capital" refers to social resources such as trust, standards and social relations that may boost the society competence by facilitating actions coordination and civic involvement. Such strong bonds and social trust are important both for individual and social growth, hence they influence indirectly economic growth (Młokosiewicz, 2003; Łyszczarz and others 2009).

In the light of these theories there is a growth potential seen in a human and societies that might be developed into individual, social and economic resources. These theories were widely echoed in social and humanistic science. Nowadays it is obvious to analyze the resources as the development potential in the context of health and life. In this paper I would also like to point at the individual and social resources as the potential crucial for health and growth.

It is emphasized that the term "resources" had already existed in economic and ecological science before becoming important psychological term. Psychology still lacks its clear definition (Mudyń, 2003). Generally it might be stated that the "essence of this term are the specific functional abilities, potentially existing in a human, his environment and environmental relations (Sęk, 2003, p. 18). The resources are of holistic, interdisciplinary, often unspecified, intuitive, relative and positively valued character. Being relative and positively valued seem crucial for the term, defining its condition at the same time. It is worth mentioning that the resources do not exist objectively but are of subjective character, always owned by someone, therefore are relative, i.e. referring to specific needs or goals of the individual, what also implies their accessibility. Positive evaluation of resources is also important, hence we can not refer to it as to something negatively assessed, for instance, the thief's skills won't be defined as resources. Moreover, positive evaluation of resources is related to their deficiency and restrictions in relation to other needs. The profile of resources facilitates the conclusion that "something" becomes a resource for a certain individual or generally people when it meets certain criteria, hence division between factual and potential resources. The factual resources ate those that satisfy needs or goals of a certain individual, that of their existence he's aware of and has the access to. The potential resources on the other hand are those that can be used in a specific situation, but under certain conditions, i.e. when individual gain or regain access to it in the future. What matters, combining knowledge about existence of "something" and its accessibility allows to specify factual or potential resources and the lack. Therefore, one might speak of one's knowledge, and the content of this knowledge (awareness) refers to the relation between possessing "something" and certain need or goal. Then, accessibility is the consequence of this awareness. If someone has such knowledge and access to the resources, this "something" becomes factual resource. If this knowledge connected with certain needs is shared by other people it becomes their potential resource. It might also happen that others will notice "something" in an individual not aware of it, then these resources are hidden for this individual, tough potentially being there (lack of access) (Mudyń, 2003). This division is important for the resources use. If the individual alone does not notice the resources owned, hidden from him but noticeable for others, it might bring about two reactions. First it might lead to making use of this resources by others to satisfy their own needs. Secondly, it might be the basis of strengthening his potential and growth in environment. Taking into consideration abovementioned theories on human and social capital, in the second option

we may speak of investing in the capital (i.e. personal resources) that might become a potential value both for the individual and society.

When it comes to resources classification, they are generally divided into internal and external, or personal and social (Sęk, 2003; Chodkiewicz 2005). External resources include:

a) biological resources i.e. biological resistance
b) mental resources i.e. all general and partial psychic features (such as temperament, cognitional-intellectual functions and structures, the feature of "me" structures, psycho-social competences and etc);
c) spiritual resources (the sense of meaning and transgression);

The internal resources include groups as:

a) physical environment resources (climate, quality of air, material environment);
b) biological environment resources (living organisms resources);
c) social-cultural resources, however:
   - cultural resources are of more general character and emphasize the quality of social resources (tradition, customs, standards, regulations, important reference systems such as cultural and art institutions, etc);
   - social resources include all the spheres of social support such as strong bonds, reference groups, associations and supporting groups along with social care systems, etc.

The above classification do not embrace probably all the resources, however it allows to characterize them generally, as the abovementioned external and internal and the division into personal and social resources are crucial for the issue. In many studies the personal resources are considered equal to mentioned internal resources, whereas the social are perceived as external. However, considering the most broaden understanding of personal resources as any sort of possibilities (internal and external) that one has and that influence his functioning and determine his resistance (Chodkiewicz, 2005, p. 152), the hierarchical dependence of both classifications is accepted. The division into external and internal resources hence becomes a part of personal resources of an individual. On the other hand, the social resources include all the resources disposable by the group or society.

In this study I'd like to pay attention to the resources (individual and social) that are used in order to satisfy the needs and goals connected with health and personal growth. I assume here that health sphere is a part of growing process, therefore speaking of health resources I assume their influence on growth possibilities at the same time. Such perspective is proper considering health as resources both for individuals and societies, what is confirmed by international documents (Ottawa Charter for Health Promotion, 1986). Personal resources held by an individual create certain conditions for functioning, hence become subjective determinants of health (and growth too). On the other hand external resources of the surrounding constitute the environmental determinants. Amongst many subjective determinants of individual health the most crucial seem to be the biological conditions and lifestyle regarding health promoting actions (Woynarowska 2008). In the context of analyzed issue factors related to shaping one's lifestyle seem to be particularly important, in contrary to biological determiants that are the part of exploitative resources. It is additionally complicated by the fact that the life-

style is shaped in the process of mutual influence of cultural-social determinants and the subjective properties of each individual. In the individual growth process the subjective determinants are becoming more and more important. Among them, the major attention is drawn to (Kowalski, Gaweł 2007 s. 114-150; Woynarowska 2008, p. 103-106):

a) cognitive factors (knowledge, beliefs, expectations and health attitude);
b) skills including:
   - instrumental (related to taking care of one's health);
   - psychosocial (so called life skils) related to copying with day-to-day challenges and establishing satisfying interpersonal relations.

Emphasizing the role of practical skills as crucial health resources was connected with the variability of perceiving the sense of health, especially its positive perspective. This pattern of thinking drew attention to a phenomenon called resilience (this term has no equivalent in Polish). It originated from research on children that did not share the negatvie experience of their parents despite living in unprofitable social and economic conditions. Resilience is the process of positive adaption in unfavorable situation where the protective factors lower or compensate the influence of risk factors. This process is connected with making use of the psycho-social competences and their growth, lack of emotional and/or behavioral disorders and undertaking developmental tasks (Ostaszewski 2005; Wojnarowska 2008). Next to resilience and factors related to it, the researchers found the term *resistance resources*, i.e. factors favoring boosting the resistance to stress, making the individual healthier at the same time (Antonovsky 2005; Chodkiewicz 2005). Both of these perspectives indicate psych-social skills (competences) as personal resources facilitating copying with difficult situations and by this mean retaining or returning to health.

The life skills are defined as "skills (abilities) facilitating positive adaptation behaviour that allow the individual to cope with tasks and everyday life challenges effectively" (Sokołowska 2008, p. 444). Skills understood in such way function in order to reach satisfying life, make geting to know oneself possible, help in copying with problems, decide on the possibility to make aware decisions, choices and actions. They are also the condition of establishing good and satisfying relations with other people, facilitating active engagement in social life, dealing with job market and are favourable to health improvement and protection, including lowering the number of risky behaviors (Sokołowska 2008, Woynarowska 2001). In the scope of health education and promotion, this issue appeared as approach designed for shaping the life skills (*life skills approach*) studied by WHO in 1993 to1999. It was expressed in the WHO policy Health for Everyone as a task related to shaping youth health. " Unill 2020 in the region young people shall become healthier and better prepared to play their role in the society" (Health No. 21, 2001). Consequently, two more organizations got involved (UNICEF i UNFPA). This approach was designed for education of children and youth considering them as particular subjected to risk of violent social and economic changes in contemporary world. The size and speed of changes demands from the youth more and more each time and in consequence it demands changes in their education. Hence attention is paid to the goal of education not only as preparations for the next stage of education or taking up a job, but first of all to cope with life. This approach was practically used within the European Network of Health Promoting Schools. In Poland within the pilot

project in 2001 and 2002 the strategy of implementing such approach in schools was designed (Woynarowska 2001, Sokołowska 2008).

In the literature on the subject there is a wide range of life skills classifications. This variability is due not only to the way of understanding it (as the definition is rather general) but mainly due to recognition some of the functions as superior in relation to others. Therefore, initial division made by WHO took into consideration the character of prevention and health problems that children and youth might face in everyday life. On this account there were two life skills groups specified (Woynarowska, 2001):

a) skills basic for everyday life: making decisions, creative and critical thinking, communication and positive interpersonal relations, self awareness, empathy, copying with stress and emotions;
b) specific skills related to copying with risk such as addictions, violence, risky sexual behavior.

UNICEF on the other hand in the life skills classification from 2000 (Woynarowska 2001, Sokołowska 2008) presented following division:

1. interpersonal skills (empathy, active listening, verbal and non-verbal communication, assertiveness, honesty, negotiations, solving conflicts, cooperation, team work, relationships, cooperation with community);
2. the skills of stimulating self-awareness (self-assessment, identifying weak and strong sides, positive thinking, building up a positive self-image);
3. the skill to build one's own system of values (understanding of various social standards, beliefs, cultures, tolerance, establishing own system of values, attitudes and behaviors, discrimination and stereotyping prevention, acting in favor of law, responsibility and social justice);
4. the skill of decision making (critical and creative thinking, problem solving, identifying own and others' risk, searching for alternatives, gaining information and assessing their value, foreseeing the consequences of own actions, setting goals);
5. the skill to cope and manage stress (self control, copying with pressure, time management, copying with fear and difficult situations, seeking help).

However, in the WHO document dated 2003 there were only three life skill groups specified (Sokołowska 2008):

1. communication and interpersonal skills (verbal and non-verbal communication, assertiveness, empathy, team work, advocacy);
2. making decisions and critical thinking (storing information, assessment of solutions and their consequences, analysis of the influence of attitudes and values on motivation and action);
3. self-management (stimulating self-esteem, self-awareness, self-assessment, determining own goals, emotion managing, copying with stress).

Interpreting shifts in classifying life skills in the context of changing the way of thinking on health and prevention gradual shift of emphasis may be observed in few directions (Woynarowska, 2002):

- within the scope of the goals: from preventing risky situations to supporting accomplishment of growth tasks, facilitating copying with everyday life problems;

- within the scope of the addressee of prevention tasks: from the risk groups to the entire population of children and youth;
- within the scope of those that carry out the programs: from external specialists to teachers from the environment cooperating with students;
- within the scope of the duration: from short trainings to long-lasting, multistage programs (called *spiral*).

The analyzed changes in life skills classification, as well as various experience in implementing programs to promote them in schools indicate that they are one of the key resources of human health. It's worth to ponder on their importance for the social and society resources too.

3. Copying with everyday life problems. From individual health to healthy community

The problem of life skills is connected not only with health education but it also tackles the issue of mental health, copying with stress and emotions or emotional intelligence as such. This entire issue might be placed in the stream of positive psychology. For instance the understanding of mental health is nowadays being redefined more and more frequently expressed as positive mental health. The change in this scope is to shift the focus from the lack of illness to the ability to control the symptoms and by this – adaption to changeable living conditions (Persaud 2006). Self-control is associated with terms such as copying or managing, concluded from research on stress and critical events. In this research stream, the shift of emphasis from difficult situation to the process of copying and overcoming is noticeable. Generally speaking, the entirety of changes may be characterized in the ways of shifting the emphasis from passiveness to involvement i.e. from the perspective of external observer (what difficult situation may result in) to the attempt of activating individual by showing possibilities of own management of this situation. On the other hand, the research on emotional intelligence (Goleman 1997) indicate that life prosperity is greatly influenced by copying with emotions, building up the motivation, ability to understand oneself and other people and establishing relations with others. Gained education or general intelligence level is marginalized as the term of emotional and social intelligence is connected with broadening the scope of research on personal and social competences.

The research themes characterized above draw the attention towards the process of self-managing with difficult situations. Managing is understood as "complex and dynamically changing set of physical processes and behaviors reaching to shape new ways of meeting the demands of goals in a situation when external and internal conditions important for an individual cause physical strain and the condition of interfering with human's adaptive resources" (Sęk 1991, p. 34). It must also be noticed that this term refers to dynamical and positive understanding of health in the categories of reserves (resources). The process of managing is creative as bases on individual search for new paterns of action. It's also a dynamic process as the individual is not passively expecting changes, but the situation evokes the need to search for solution. The area of searching includes individual or/and social resources. As the researchers involved in this issue indicate these resources are perceived in the competence criteria. It seems that the terms

"competence" and "skill" are often equated, however having a lot in common, there are fundamental differences between them. It is therefore worth having a closer look at their nature as in this context the health education focused on life skills development becomes broadened.

The analysis if the term *competence* indicates its broad range including the term *skills*. Competences mean "the way of making use of own abilities to handle some skills, supported by a certain theoretical knowledge for effective managing in the surrounding world in a certain aspect" (Skrzypczak 1999, p. 404). Shaping competences includes therefore few related tasks (Skrzypczak 1999):

- developing certain knowledge (that must be comprehended and absorbed),
- developing certain skills (abilities) on the grounds of the gained knowledge,
- equipping in certain instrumental predispositions, i.e. the tools of sensible action in a certain situations,
- developing the motivation connected with the aims of action and influencing the efficiency,
- equipping in certain directional dispositions, i.e. shaping the value system that enables making use of competences in appropriate way (it must be remembered that being competent is also dependent on the power of conviction of the need to use certain skills).

Competences understood in such way are the subject of interest in various spheres of actions aiming at human development, especially educational actions in a broad sense. It is reflected in such documents as educational policy papers of EU in the scope of Lifelong Learning Programme (Key competences 2005; Recommendations 2006). It seems that emphasizing the competence theories is a sign of changes in paradigms of perceiving human in social and humanistic science. Indeed, this term indicates human freedom, individuality and own responsibility for life.

Within the range of health education, underlining the importance of competence aims not at simple definition change from skill to life competence. It is more about noticing important consequences of such change for education, not only health education itself. The variety of tasks related to developing competences suggests that it stall be a long-lasting, multistage process that gradually broadens range and stages of developing competences. Secondly, competences are related to a certain range, therefore are connected with improving actions referring to a certain goals or needs, hence they require to be included by the individual to the scope of own life activities and due to that shall not be imposed. In the context of these two conditions positive direction of changes in the scope of educational health must be emphasized. The experience of health promoting schools seem to support this conclusion (Wojnarowska 2002). Besides, these competences are mutually related to each other and make up a certain hierarchy. Hence, the most broad competences should be developed at the begging, acting as a foundation for the rest. Such approach is reflected in the action undertaken within the EU policy in the context of lifelong learning, as one of the goals is to determine the key competences and including them in the process of education. Therefore it seem reasonable to combine actions of directional approach towards developing life skills (health education) and actions aiming at working out and implementing key competences (general knowledge) as they aim at mutual goals (lifelong learning and learning in the environment). With

reference to hierarchic process of building up life skills it is noticeable that the role of developing accomplishing competences is favoured, marginalizing the evaluative and cognitive competences that enable establishing the actions in the broadened process of decision making, based on the value system (Borowska 1999). The education focused on developing skills implies such potential threat.

At the end I would also like to tackle one more issue. Directional approach being implemented within the health education is directed to those under 18, similarly as the key competences proposal in obligatory education. It is understood if we consider the perspective development of societies, taken into account in actions undertaken within the framework of educational and health EU policy. Still, the directions of actions aiming at adults shall be considered as far as the increase of individual responsibility for health is considered. The need to develop life skills among them supporting the process of copying with everyday life or critical situation seem to be more and more urgent. The increase of mental problems is striking (Persaud 2006, Chodkiewicz 2005), with the sources found in the speed of social and economic changes and problems with copying and adjusting to it. Undertaking institutional actions supporting the solution of abovementioned problems seem rather impossible, perhaps except from action directed to narrow groups, for instance the unemployed. Besides, institutional actions are contradictory to the same idea of shaping life skills and the process of self management of difficult situations.

It seems that one of the proposals is the adult education. As M. Malewski notices (2001), the direction of changes in adult education is related to the attempt to using the theory of individual and social potential. Social potential is particularly worth mentioning as it leads to shaping the idea of situated learning. It was practically implemented in two spheres of actions: professional sphere as learning organization, and in public sphere as community learning. The ideas mentioned mainly point out the shift in focus from education to the learning, i.e. individual involvement in the process of gaining knowledge, skills, adjusted to own needs, possibilities and motivations, situated in the context of one's life situation and in relation to social problems. In this meaning, the process of adults' learning is closely connected with their involvement in acting in favor of their community. The knowledge, skills and competences used in a certain problematic situation constitute personal resources, being a part of a human capital, acting in favour of community development. The community itself may become a source of individual growth by the range of social relations and trust (social capital). Individual and social resources as well as certain situation become linked to each other making a certain context of individual and social growth.

It might appear to some that I strayed from the subject of health and health education. However, it is difficult to separate each spheres of human development and perceive them separately. The process of learning, interspersed with day-to-day situations, contributing to personal development, is a source of shaping health at the same time. On the other hand, the level of individual health determines the range and quality of actions in other spheres, hence it is impossible to neglect the issue of social health. The quality of individual health is not simplified and directly interpreted as the health condition of a society. The personal resources of each member of the community make up a potential of growth that might be used not only by the individuals but certain groups or entire

society. It must be remembered that adult's engagement in solving day-to-day problems regarding their community or more general - society contributes to developing their (life) competences. They may counterweight the phenomenon of trained helplessness, particularly noticeable in post-communistic societies. Moreover, creating conditions to use the life competences (skills) is important factor of further growth of children and youth. Therefore it seems necessary to create favourable conditions for social involvement, which might be one of the key resources of social and individual health. Developing the life competences lead not only to the increase of individual health potential but it establishes a healthy community too.

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DOVEDNOSTI POTŘEBNÉ PRO ŽIVOT JAKO INDIVIDUÁLNÍ A SPOLEČENSKÉ ZDROJE ZDRAVÍ

Abstrakt: Přístup, orientovaný na rozvoj životních dovedností, jako jedna ze strategií výchovy ke zdraví má své kořeny v hlubším kontextu společenských a kulturních transformací, které ovlivňují změny rozsahu sebeporozumění a roli člověka a jeho fungování na světě. V oblasti zdraví a výchovy ke zdraví tyto transformace vedly k poznání, že je třeba věnovat více pozornosti odpovědnosti jedince za vlastní zdraví. Širší dimenze společenských a kulturních změn na druhé straně ukazují subjektivitu jedince jako základ k hospodářskému, společenskému nebo kulturnímu růstu. Osobní

zdroje se v tomto kontextu nestávají jen faktorem individuálního, ale také společenského růstu. Takto chápáno, zdroje zdraví a zejména životní dovednosti jsou pilířem pro činnosti, směřující k převzetí zodpovědnosti jedince za své zdraví a v širší perspektivě – k převzetí zodpovědnosti za zdraví místní komunity i celé společnosti. Cílem této práce je zdůraznit některé determinanty a důsledky takového chápání zdraví a výchovy ke zdraví.

Klíčová slova: modely zdraví, výchova ke zdraví, životní dovednosti a kompetence, zdroje zdraví jednotlivů i společnosti