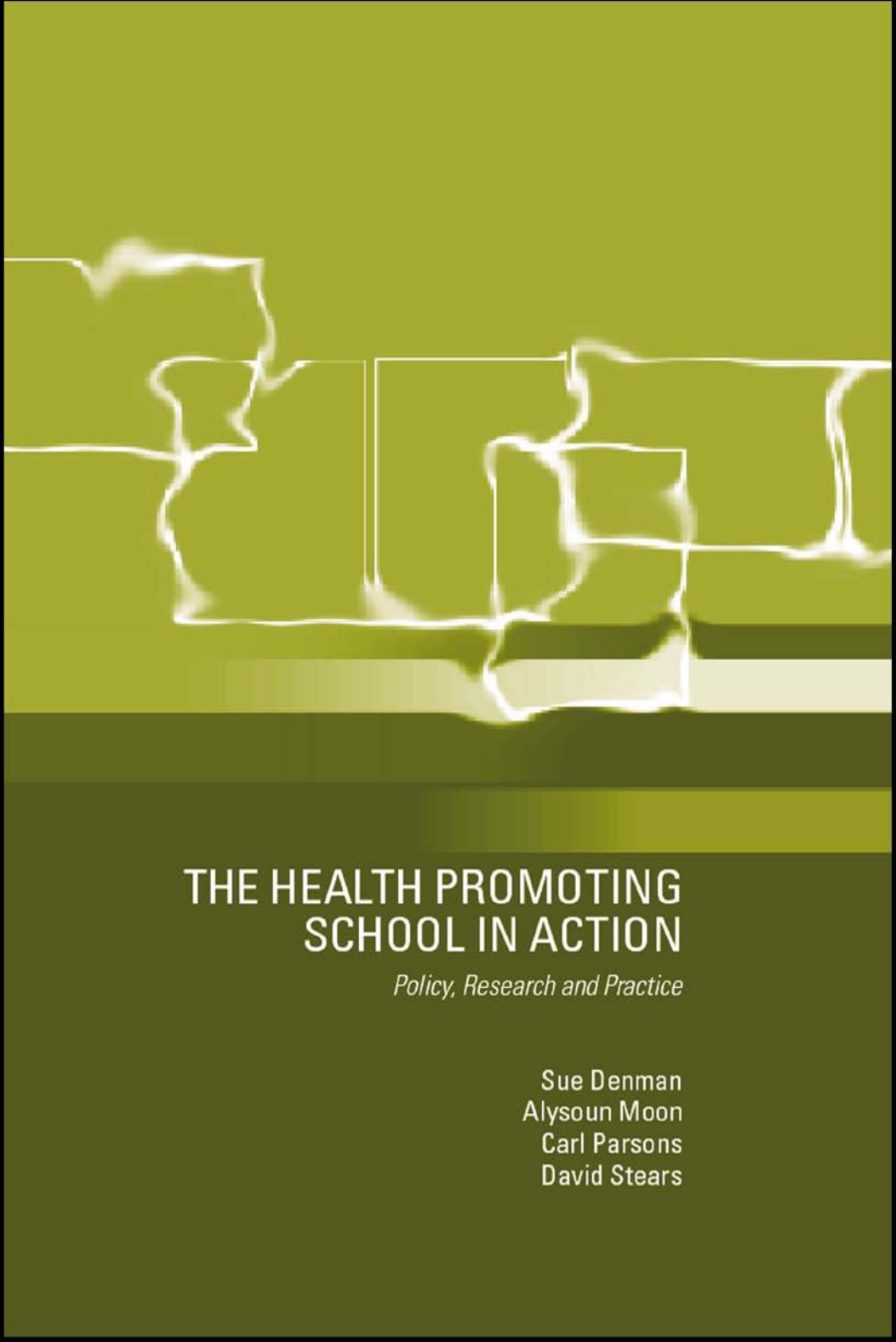

THE HEALTH PROMOTING SCHOOL IN ACTION

Policy, Research and Practice

Sue Denman
Alysoun Moon
Carl Parsons
David Stears

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The Health Promoting School

The healthy school incorporates health promotion ideas such as personal, social and health education, citizenship and democracy, self-esteem and empowerment, and environmental education. This timely book establishes a conceptual framework for the health promoting school which can underpin future evaluation and valuation of such institutions.

Topics covered include;

- The history and conceptual framework of, and challenges for research presented by, the healthy school movement.
- The politics, policies, evidence base and research methodologies associated with the development of health promoting schools.
- Case studies of different approaches to evaluating the health promoting school in Europe.
- An overview of the central themes connected with the development of the health promoting school into the twenty-first century.
- An appendix of research studies related to the health promoting school and research instruments available on the Internet.

It will be of great interest to student teachers and health professionals, examining the history, concept and challenges of the health promoting school. It will also be of particular interest to researchers and postgraduate students of health promotion and public health, engaging in detailed discussion of the politics, policies and evaluation of the health promoting school.

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London and New York

First published 2002 by RoutledgeFalmer
11 New Fetter Lane, London EC4P 4EE

Simultaneously published in the USA and Canada
by RoutledgeFalmer
29 West 35th Street, New York, NY 10001

This edition published in the Taylor & Francis e-Library, 2004.

RoutledgeFalmer is an imprint of the Taylor & Francis Group

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British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging in Publication Data
A catalog record for this book has been requested.

ISBN 0-203-16560-8 Master e-book ISBN

ISBN 0-203-26013-9 (Adobe eReader Format)
ISBN 0-415-23953-2 (Print Edition)

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Foreword from a UK perspective

The school curriculum is not an inevitable, God-given artefact (except perhaps in some religious institutions!). Rather it involves a selection from culture and represents what a particular society at a particular time in history – and its ruling class – considers worthwhile. The school is thus an agency for socialising each new generation and ensuring that it understands what is worthwhile, acquires appropriate skills and absorbs key social values. Those teachers who, in recent times, have been bombarded by demands for curricular change – often apparently in response to ideological fashion – will not need reminding of this fact of life. The fact that these demands are frequently conflicting reflects another iron law of the curriculum: power and politics, rather than science, academic analysis and the needs of parents and children, are at the heart of this often unreasonable pressure for change.

Health is, of course, one of the major concerns of most cultures and therefore becomes a kind of political football in the power game. This is hardly surprising since health and health care consumes a substantial proportion of the gross national domestic product. Accordingly, although there are disagreements about the meaning of health and the extent to which the family, the community at large and the health services should shoulder the burden of promoting health, few people would deny the important contribution that schools should make to this significant enterprise.

The centrality of the school in fostering health is, therefore, common to all cultures and has been so for many years. There are, though, quite significant differences between the situation obtaining today and what has gone before, and it is hardly surprising that different health concerns have emerged over the last 100 years or so. For instance, early anxieties about infectious disease and an associated concern with hygiene gave way to pressures on schools to persuade pupils to adopt healthy lifestyles that would contribute to the prevention of 'self inflicted', chronic degenerative disease. The curricular approach designed to achieve these goals was *health education*. However, in the last twenty years, health education has been largely superseded by *health promotion*. This development is not merely a change in nomenclature but involves a kind of value-added dimension in the form of 'healthy public policy' (to quote the Ottawa Charter). Health promotion

incorporates health education but also asserts the importance of implementing policies designed both to 'make the healthy choice the easy choice' and to remove the obstacles to health related actions. The relationship between health education, health promotion and 'healthy public policy' can be summarised in a simple formula: Health Promotion = Health Education × Healthy Public Policy. In other words, education operates synergistically with policy development. Without the supportive environment provided by healthy public policy, education may achieve relatively little. On the other hand, bearing in mind the possibility of political barriers, it may not be possible to create policy without the consciousness-raising function of education.

The historical dimension, mentioned above, is clearly explained and exemplified in Chapter 1 of this book; the importance of policy is comprehensively discussed in Chapter 3 and a model of health promotion in school is examined in Chapter 2. It is, however, worth commenting here on the factors and events leading up to and stimulating a particularly important development in school health promotion – namely the concept of the 'health promoting' or 'healthy school'.

The idea of a health promoting school can be seen as part of a movement labelled by World Health Organization (WHO) as the 'Settings Approach'. This movement was foreshadowed in the seminal Ottawa Charter, which established the key principles that are still embodied in health promotion. It reminded us that, 'Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love'. According to WHO, settings are not merely convenient locations where health education can be delivered. The school is not a mere building where teaching happens. Rather, an ecological approach is adopted in which key 'stakeholders' operate within a physical and social environment. The stakeholders are not just teachers but also all those working in the school. Parents and families must also be maximally involved; the school should be at the centre of its local community; other agencies should contribute – including the health services through GPs, school nurses and health promotion specialists. The not unreasonable assumption underlying this approach is that a 'local alliance' will have a much greater impact on students' health and wellbeing than if teachers have the sole responsibility. In short, a health promoting school approach is a total system approach.

Apart from the settings approach, WHO has vigorously espoused and propagated a particular philosophy of health promotion that is at the core of the healthy school. Apart from emphasising a broad holistic approach to defining health (enshrined in its Constitution of 1946 in which it stated that health was not merely absence of disease and infirmity but rather the pursuit of mental, physical and social wellbeing), WHO's more recent clarion call is for empowerment. In other words, the main purpose of health promotion is to enable people to gain control over their lives and their health.

Those of us who have been involved for some time in health promotion, health education and teaching generally can afford a wry smile at the thought that if we have not seen everything before, then we have at least seen quite a lot it! Plus ça change! For instance, WHO's definition of health is not only consistent with but a virtual replica of the philosophy embodied in the UK 1944 Education Act. Its social and empowerment agenda is not at all inconsistent with the guiding principles of that plethora of projects that started rather nervously with the anticipation of ROSLA (Raising of the School Leaving Age – to sixteen). Specific programmes in the social and humanities domain focused on PSE (Personal and Social Education) IDE (inter disciplinary enquiry), Lifeskills teaching, etc. The emphasis on organisational developments – particularly about the negative effects of streaming – are also completely attuned to current arguments about potentially damaging effects of structural factors on self esteem. In more recent time, in the 1970s and early 1980s, debates about the importance and nature of health education resulted in a consensus. In short, health education should not be taught as a single subject but should be seen as an ally of PSE (especially since the goals and methodology of PSE were so similar to the 'new' health education). Accordingly PSHE (Personal, Social *and* Health Education) was born and several projects were developed to support this new alliance. These included specifically designated health education projects such as Schools Council Projects for primary and secondary groups, together with broader PSE programmes such as Active Tutorial Work and Healthskills initiatives.

For many years, Her Majesty's Inspectorate had propagated the view that the curriculum comprised the whole way of life of the school (and thus not just its taught components). The effects, for good or ill, of the so-called 'hidden curriculum' were recognised. Moreover it was accepted that health education would be more effective to the extent that it permeated the whole curriculum in both a formal and informal manner. In addition to the former 'major' stakeholders (at the time, PE, Biology, Home Economics) Science, English, Art, Language Teaching, etc. could also be important vehicles for providing different aspects of health education. The goal of achieving integration and actually gaining effective collaboration between teachers and subject departments was, quite clearly, problematical. This was being thoughtfully addressed by various people and projects and, by way of example, 'My Body', a science/health education project for primary schools, sought to promote the project by demonstrating how it could be used to meet a wide range of curriculum goals (without further expenditure on resources!).

It could, then, be argued that the health promoting school was present (at least in UK) in a quite well developed embryo form by the 1980s. Its failure to thrive was, arguably, due to unfavourable political circumstances associated with central control of the curriculum, the deep suspicion of PSE during the Thatcher years and the 'back-to-basics' movement.

Although there are still as many, or even more, demands and expectations of teachers, there are, of course, differences between the 1970s and 1980s model of health education and the fully-fledged version of the Health Promoting School. For instance, it might be expected that the hidden curriculum would disappear as the would-be health promoting school subjected the 'concealed' negative effects of hidden curriculum to critical scrutiny and then developed health promoting policy to counteract and replace those negative influences. What is more, the political climate favours the kinds of curricular approach that created concerns for government in the 1980s. Many of the key social determinants of health and the subject matter of PSE – such as the effect of inequalities – are acknowledged. Government has provided these social problems encouragement and resources in the form of initiatives such as Health Action Zones and Healthy Living Centres to address. Such projects require collaborative working and community development strategies and would welcome the community involvement that is emphasised in the Health Promoting School model.

One of the most significant changes in recent years has been the contemporary demand for evaluation. Increasingly, throughout society and certainly in the health services, it is expected that practice should be thoroughly grounded in evidence of effectiveness. Apart from the fact that, at the very least, it is irritating to devote time and energy to teaching if it is having little or no effect, there is an emerging imperative that resources will only follow *demonstrable* success!

Apart from the thorough and perceptive reviews of past and present theory and practice in health promotion, the authors of this text have provided a clear and authoritative account of the 'healthy school'. Although its main focus is on UK practice, it draws on the authors' familiarity with the international scene. In fact, the book comprises a state-of-art examination of the major themes, strengths and weaknesses of current efforts. Perhaps its major strength is the extensive use it makes of detailed, research-based case studies. These studies draw on the personal experience of the authors. They are especially relevant to the point made above about the importance of providing sound evidence of success that may be used by teachers. The in-depth studies of schools in Wessex and Nottinghamshire – together with critical appraisal of six European projects carried out within the context of the European Network of Health Promoting Schools initiative – show what schools can achieve. Very importantly, they also demonstrate just *how* they can achieve them through policy, organisation and teaching methods. This detailed examination of schools provides the illumination necessary for learning from others' experience and transferring that experience of success to different areas of the curriculum and to other schools by providing genuine, practical insights into the difficult but achievable task of achieving health promotion goals.

Pursuing an earlier metaphor, we are at a point where the embryo that

existed for some time in a state of suspended animation can now emerge into a healthy thriving infant. I am confident that this book by Denman, Moon, Parsons and Stears will contribute to a successful birth!

I welcome their contribution to theory and practice and commend the book to readers.

Professor Keith Tones

Foreword from a European perspective

This book is timely. Many countries in Europe are addressing a variety of complex and integrated issues related to their education and health policies, some of them are doing so within an overall developmental framework. Schools, and in particular 'health promoting schools', have to position themselves within this complex and fast-changing policy context. In order to integrate policy and practice it is necessary to reflect on the increasing demands being placed upon schools to compensate for many of the problems which exist within societies. However, can health promoting schools help to address some of the key questions that national, regional and local governments are increasingly being confronted with? For example, is it possible to:

- produce life-long health education and learning opportunities in today's societies?
- promote the health and educational status of the population in a sustainable and equitable manner?
- identify effective intersectoral development strategies that in addition to bringing about population health gains, provide added value to economic and social outcomes?

The context outlined above demonstrates the relevance and indeed the need for countries to analyse their capacity to facilitate, promote and sustain a policy for health promoting schools. This book offers many insights for this process including a detailed analysis of the history and concept of the health promoting school *which underpin the process*, evaluation and practice *which inform where we are in the process*, and policy and future developments *which determine how the process may move forward*.

The on-going development of the health promoting school has struggled in an inhospitable political climate but now support is growing. The new struggle may be between the radical and 'third way' approaches to health promotion through education.

The 'what works' and effective processes are still to be determined. Here the tension might be between measurement of specific health outcomes and the broader and deeper contribution health promotion can make to the

development of individuals and the fabric of society. A hard-nosed, evidence-based approach needs to be further fostered even though the field is complex and deserves long-term attention.

The future poses challenges but, in reality, may be one of a number of compromises. Attention could be given to health, narrowly defined or holistically interpreted; it could be directed to the amorphous 'all' or pay specific attention to the at risk and harder to reach, to our native populations or to refugees and asylum seekers equally. This is all to play for, but frames a serious, vital debate about the future we want for our young people.

There is little doubt that health and education are key to both individual well-being and social and economic development. There is also convincing evidence showing the impact of education and learning opportunities on health. The promotion of the health of school children, and the role of school and education in this are, therefore, crucial to the future of any society. Indeed, the cost to society of failing its children and young people is huge. There is an impressive and expanding research literature which provides evidence that young people's exposure to healthy (or unhealthy) environments, early experiences within the family and education institutions and their access to coping and supportive resources significantly influence the future course of their development.

The way in which society acts upon this evidence and the type of development pursued will strongly affect young people's conditions of growing in Europe. Furthermore, society can create the conditions for them to move positively from childhood to adolescence to adulthood with opportunities for healthy lifestyles and a sense of achievement and belonging. Failure here could be far too costly for European countries. There are, therefore, great benefits to be gained in creating a key alliance between health and education. The health promoting school, as described and analysed in this book, provides a very tangible and feasible means of cementing such an alliance. At the school level, of course, such an alliance needs to foster partnerships with school children, their parents, teachers, support staff and local communities.

The World Health Organization's Regional Office for Europe, in cooperation with the European Commission and the Council of Europe, and in partnership with our Member States, teacher organizations and school communities in over forty countries, are discovering that investing in the health and education of young people is an investment in Europe's development. Thus, one can safely conclude that this book plays an important part in highlighting and analysing the health promoting school as a potential catalyst for positive public health, social change and European development.

Dr Erio Ziglio
Regional Adviser: Health Promotion and Investment for Health
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Acknowledgements

The authors have a lengthy list of colleagues to whom thanks are due: teachers, colleagues and other professionals who participated in, or contributed to, the production of this book.

We would like to thank: with reference to the case study materials, (Chapter 2) the staff and pupils of the secondary school in Dublin, Republic of Ireland, (Chapter 3) the staff and pupils of the Leicestershire primary school; Kathy Gorman, Co-ordinator of the Derbyshire Healthy School Award, and Linda Hayes, Research Assistant of the Trent Healthy School Research Project; with reference to the Evaluation of the Wessex Healthy Schools Award Scheme (Chapter 6) the Hampshire PSHE team, in particular Joe Sidonio (South East Regional Co-ordinator for the National Healthy Schools Scheme); with reference to the Nottinghamshire Towards Health Project we would like to thank the project schools and project team: Veronica Skuriat, Chris Nield, Chris Wallbanks and Jill Lancaster; and with reference to the European Network of Health Promoting Schools Six Country study we would like to thank the national health promoting school co-ordinators, school staff and students within the six countries visited, the staff of the technical secretariat of the ENHPS and in particular Vivian Barnekow Rasmussen and David Rivett.

We would like to thank the following authors and publishers who have given their assistance and permission to reproduce work in this book: Health Promotion England for their permission to reproduce Caplan and Holland's Figure 3 – The Theories of Societies and Approaches to Scientific Knowledge, page 12, *Health Education Journal* Vol. 49, 1990; Professor Alan Beattie and Routledge for permission to reproduce Beattie's Figure 7.1 Strategies of Health Promotion, page 167 in Gabe, J., Canlan, M. and Bury, M. (1991) *The Sociology of the Health Service*; finally, our gratitude is extended to Dr Andrew Tannahill for his personal communications regarding the referencing of his model of Health Promotion in Chapter 2.

We are particularly indebted to close colleagues in our various institutions – the Department of Public Health and Epidemiology in the Faculty of Medicine at the Queen's Medical Centre, University of Nottingham, the Health Care Research Unit at the Wessex Institute for Health Research and

Development, University of Southampton, and at Canterbury Christ Church University College. Finally, we extend our sincere gratitude to Gillian Shaw who painstakingly checked the final manuscript and our close families who also endured aspects of our journey towards the publication of this book.

Introduction

Few would disagree that the health of children and young people today is of paramount importance and the environments in which they work, rest and play need to reflect the concern of caring communities to promote their health. Any country serious about investing in its future will have policies and legislation in place to safeguard the health of children and young people. There are compelling arguments for doing so. In western countries, infectious diseases have declined, only to be replaced by new threats to children's health, which are of social and behavioural origin. Alarming trends exist in teenage pregnancies, smoking levels, patterns of alcohol use and experimentation with illegal substances. The diet of an increasing proportion of children is unacceptably poor and exercise levels are on the decrease. The effect on health is not usually immediately apparent but manifests later in life, in the form of chronic illnesses and premature death.

It is also important to consider, alongside these modern epidemics, a legacy of the twentieth century, the effect on children of living in today's world. The dramatic rise in the divorce rate has increased the proportion of children living in one-parent households whilst the widening gap between rich and poor has excluded some sections of the population from participating fully in society. Greater cultural diversity has resulted in the subjection of some groups within the population to the threats of racism and discrimination. These cultural and socio-economic factors can have an adverse effect on children's mental, physical and social health. Poor health can affect children's motivation to learn and, importantly, reduce their ability to make the most of the opportunities available to them. Thus, the seeds of social exclusion are sown early.

Encouragingly, major advances have been made over the past twenty-five years in finding the most appropriate and successful solutions to meeting the health needs of populations. There is a clearer understanding and articulation of the concept of health and its determinants. A recognition of the importance of the total environment in determining health has led to a rejection of the lifestyle approach as the sole strategy and the emergence of a more radical concept of health promotion. But it is not only the developments on the theoretical and conceptual fronts that have exerted an influence

on progress. The growth of the new public health movement and the policies of the World Health Organization (WHO) have also played a major part in pushing the boundaries of practice. By acting synergistically, they have resulted in a reorientation of health promotion and placed supportive policies and a consideration of the context of people's everyday lives at the forefront of strategies designed to achieve health gain.

A reappraisal of the health needs of children has shifted the emphasis from curative medicine to health promotion. The implication for schools has been the need to adopt an approach that is inclusive of the health needs of the total population of the school and to utilise all opportunities that are available in the promotion of health. This means widening the focus from health education in the formal curriculum to health promotion through the whole school environment and the community beyond, in a co-ordinated approach to practice. This is the process behind the foundation of the *health promoting school* or *healthy school* and the theme of this book.

Of all the possible settings that provide opportunities for promoting the health of children, schools arguably hold the greatest potential. Education and health are inextricably linked, with improvements in one dimension resulting in improvements in the other. Most children attend schools where they are in contact, at a formative age, with adults who possess specialised skills and knowledge. Schools also have a long-standing tradition of basing their care of children on a holistic notion of health. The contradictions in the health messages received by children, and the need for consistency, clarity and co-ordination, has always been recognised by teachers. However, it is only in the last twelve years with the emergence of the concept of the health promoting school that progress has been sufficient to provide a strong foundation on which to build. Yet, in that short time, the health promoting school has built an impressive following, nationally and internationally. It is now accepted as the most appropriate and acceptable way forward in delivering the public health agenda through the setting of the school.

Although the practical application of the concept is still in its early stages of development and implementation in the UK and Europe, we must not underestimate the progress made. Health education, the cornerstone of the health promoting school, has improved greatly in the quality and quantity of provision. Schools are showing an increased awareness of the concept of the health promoting school. Much is also known about the conditions needed for progress and change. At the level of the school, success depends on the management and organisational structures in place, which together have a bearing on how communication is effected and change is managed. Agencies with a remit in disseminating health promotion innovations have a better understanding of the change process in schools and how best innovations can be diffused within and across institutions. Policies are also significant factors in influencing progress. The presence (or indeed absence) of a policy for health promotion will determine the status of the subject, the resources apportioned to it and the degree to which schools are guided in

their practice. Inevitably, the fate of school health promotion is bound up with the ongoing debate on the purpose of education, the function of schools and who holds the ultimate responsibility for promoting the health of children.

At the time of writing, the health promoting school is developing in the UK, and elsewhere in Europe, in a climate characterised by the rationing and prioritisation of public resources, and a preoccupation with quality standards and value for money. Partnerships between communities and the statutory and voluntary sectors are seen as essential features of service planning and delivery. This environment presents considerable challenges for the advancement of the health promoting school in the twenty-first century. Constructive and enduring links need to be developed by schools with parents and the wider community. Artificial service boundaries and counter-productive protective professional cultures, which stand in the way of partnership and progress, need to be overcome. It is particularly important that the health and education sectors work closely together to build a shared vision for the future and find joint solutions to the challenges that lie ahead.

The health promoting school must achieve greater prominence in policy. The securing of a sound evidence base is essential if this is to be achieved. There is an increased urgency, therefore, to continue the debate on what we *mean* precisely by the health promoting school and, allied to this question, *what* constitutes evidence and *how* it should be collected. Notwithstanding the steady growth in the evidence-based literature on the health promoting school, significant gaps remain in knowledge.

The structure of this book

This book covers a range of significant matters related to policy, research and practice in the health promoting school, from the perspectives of education and public health. Historical developments in health education and health promotion are placed under scrutiny to identify the features of policy and policy making that have influenced the evolution of the concept of the health promoting school and its implementation. The building blocks needed for research and development are considered, in turn. These are given practical expression by the presentation of three evaluation studies, two local and one international, which have set out to establish the impact of projects on the development of the health promoting school. A number of key issues associated with current debates can be identified in the book. These are: funding; education and training; flexibility; curriculum; evidence-based practice.

The first part of the book explores the key components of a strategic approach to practice at the level of the school and project. Chapter 1 traces the historical roots of school health promotion, which lie in health education. Key policy decisions in health education and seed changes in policy in general education are explored to tease out the strategic factors that have influenced progress and change. Alongside a consideration of policy,

historical developments in general health promotion are explored in relation to the emergence of the settings approach, and the role of WHO as a driving force towards a radical agenda for action. Finally, the chapter summarises the main strategic considerations that have had a bearing on progress in the past, and that hold true for today.

Chapter 2 builds on Chapter 1 by examining the eco-holistic model of the health promoting school. It examines its roots in the radical approaches advocated for health promotion. It seeks to explain and clarify the model, the complexity of which lies in its individual, group, community, organisational and political dimensions. The aim of the second part of the chapter is to cast light on the change and change processes in schools and how innovations can be diffused within and across institutions. The importance of partnerships is highlighted and the features of good partnerships delineated. A case study of a school is offered to illustrate the application of the model to practice. The chapter concludes that capacity building is key to creating the best conditions needed to ensure the long-term sustainability of endeavours seeking to develop schools as health promoting environments.

Chapter 3 returns to the theme of Chapter 1, that of policy. The chapter starts by defining policy and moves on to a presentation of theoretical perspectives for explaining the policy-making process and policy outputs. These are then applied to specific policies to help understand their impact. The chapter is based on the premise that by better understanding the policy-making process, the more equipped we, as advocates for the health promoting school, are to influence it. The second part of the chapter turns to policies at the level of school. A model for content is provided and policy consultation highlighted as an essential feature of the process of the health promoting school.

Chapter 4 commences with the ongoing debate on what constitutes evidence and how it should be gathered. The debate on positivist versus humanist paradigms in health promotion research and evaluation is reviewed in relation to health promotion and the health promoting school. The message given is that evaluation models, based on simplistic notions of the health promoting school, will at best fail to reflect the scope of the success of the approach or, at worst, doom it to failure. Having argued for a broad approach to evaluation, incorporating quantitative and qualitative methodologies, the chapter reviews a selection of studies and summarises their findings. These are offered as a checklist for guiding good practice in development work.

Part 2 of the book extends and builds on the key issue of evaluation. In Chapter 5 the distinction is made between evaluation that examines the effectiveness of interventions, in terms of process and outcomes in seeking new knowledge, and evaluation that seeks to measure the extent to which good practice is adhered to and programme reach achieved. It builds on the evidence debate explored in the preceding chapter by setting out a framework for evaluation that is pragmatic and reflective of 'real life' contexts.

Three chapters then follow on a variety of projects and project evaluations

to demonstrate the eclectic nature of work in the area. Chapter 6 focuses on the Wessex Healthy Schools Award Scheme, which was evaluated using a quasi-experimental study design. Reflections on the success and limitations of the evaluation design bring into sharp focus the arguments explored in Chapter 4 on the difficulties posed by the application of experimental designs to measure the effectiveness of the health promoting school.

In contrast, the evaluation of the Nottinghamshire-based Towards Health Project, described in Chapter 7, was essentially action research in design, with a focus on perceptions of organisational change and change in professional practice as the principal indicators of success. Qualitative methods were used almost exclusively, with outcomes related to policy measured quantitatively, as a background trend.

Chapter 8 reports on the evolving methodologies that were used to develop a tool for measuring the assets for health promotion needed in the early stages of developing the health promoting school. The tool was prepared in the study of six European Network of Health Promoting School projects and further refined in Wales and Ireland at a later stage.

Chapter 9 synthesises the key messages presented in relation to research, policy and practice lessons, from historical and contemporary vantage points. Here, the main challenges facing the growth and sustainability of the health promoting school are summarised for the reader by revisiting the key themes of the book. Solutions are offered to shape schools as true democratic institutions with a concern for health, social justice and human rights. What follows in this book is an attempt to delineate the strategies that will maximise the chances of achieving that ideal, tempered with a realistic view of the scale of achievements possible in a pressurised public sector environment that is struggling with conflicting priorities.

Note

Throughout this book the terms 'health promoting school' and 'healthy school' will be treated as a single concept and used interchangeably.

Part I

Foundations of the Health Promoting School

1 Historical perspectives: the development of school health promotion

Introduction

When an exciting and seemingly new concept or theory emerges, which offers a solution to meeting the challenges ever present in the field of education and health, it is important to reflect on its origins. The knowledge that such reflection generates helps to build understandings of the way in which theory influences practice and, in turn, how practice can influence theory. This chapter traces the evolution of the health promoting school. In the first instance, it focuses on the historical development of school health education, which is not only the cornerstone of the health promoting school but has a longer history, thus offering insights into how progress is effected. Attention is then given to the theories of general health education and health promotion, the relationship between them and with that of the concept of the health promoting school. The role of the World Health Organization in supporting the advancement of theory and practice in health promotion and the health promoting school is highlighted. Finally, the fluctuating fortunes of school health is considered in the UK and contemporary issues examined with respect to national project work in the field.

The origins of school health education

The origins of health education can be traced back to the health concerns of the late eighteenth and early nineteenth centuries. A combination of factors contributed to the health problems prevalent in that period. There was a steep rise in the population, followed by the onset of the period commonly known as the Industrial Revolution, with its profound effects on the social and economic structure of the nation. It was the migration of people from the countryside to the towns and the consequent desperate overcrowding, combined with the poor state of housing and lack of sanitation, that led to the flourishing and transmission of life-threatening infections such as diphtheria, cholera and pulmonary tuberculosis. The effects of regular epidemics on these impoverished and overcrowded populations were devastating. Attempts to tackle these problems made slow progress on all fronts. Medical

knowledge was undeveloped and central and local government insufficiently organised to make systematic reforms possible. Furthermore, both the education and health services were poorly developed. However, some advances were made, particularly in the latter half of the nineteenth century, as physicians continued to amass information about the association between disease and environmental factors such as water supply (Sutherland, 1979).

The appointment, in 1850, of medical officers for health was a major landmark in progress. Local government became more efficient as a consequence of the Municipal Reform Act of 1835 and the Local Government Act of 1888. Central government also started to exert greater control and influence. A general Board of Health was formed in 1848, to be replaced by the Local Government Board in 1871. Both of these bodies were established to implement the provisions of the Public Health Acts of 1848 and 1875, the latter being concerned with consolidating improvements in housing, water supply and sanitation.

Education also contributed to the general improvement in health and living conditions but its impact was limited by the absence of systematic primary and secondary education. Teaching about cleanliness, physical environment and hours of work featured in the curriculum of the industrial Secondary and Voluntary School movements of the eighteenth century. Later, the school curriculum played an important part through the inclusion of a range of subjects such as cookery, laundry work and housewifery. There was a growing interest in improving the health of the population and an increased awareness of the contribution that education could make.

In his observations of this period in our history, McCafferty (1979) notes that although the two services of education and health developed concurrently, it was not until the turn of the eighteenth century that they co-operated and achieved some degree of integration in their aims. The first decade of the twentieth century is therefore an interesting period in the background to health education teaching. The gradual decline in major epidemics and the improvement in living conditions resulted in preventive medicine changing its focus from the purely environmental aspects of health to the more personal.

There was widespread concern about the physical condition of the population, triggered by the medical examination of recruits during the Boer War, 40 per cent of whom were found unfit for army service. Among the recommendations of the report of the Interdepartmental Committee on Physical Deterioration (1904) was the need to include instruction about the effects of alcohol on physical health, dental hygiene, and instruction to older girls in cookery, hygiene and domestic economy in courses of teacher training. However, the only recommendation to be acted upon by the Board of Education was that concerning the topic of hygiene, which immediately became a compulsory part of the teacher-training syllabus. This reflected the narrow view of health prevalent during the period, a view which was completely out of step with the child-centred, developmental approaches to

learning advocated by the educational literature of the time (Tones *et al.*, 1990). From today's vantage point it seems inexplicable that, given the fundamental changes in the principal causes of disease, such a narrow view of health persisted into the 1960s and early 1970s. The challenge mounted by the World Health Organization with its holistic definition of health in the 1940s; 'health is a state of complete physical, mental and social well-being, and not merely the absence of diseases' (WHO, 1946) went largely unheeded. Health education seemed unable to progress from the antiquated view that placed hygiene as the foundation for total health.

In considering the advances made in the first decade of the twentieth century it is important to include the measures taken to improve the health of children attending school. In 1906, an Act of Parliament authorised the spending of public money for the provision of school meals for deprived children. A year later the local education authorities were required to organise the medical inspection of schoolchildren, a development that led to the establishment of the School Medical Service. The discovery and use of vaccines and antibiotics also greatly improved child health. More generally, from the 1930s onwards the centralisation and development of the health services continued, culminating in the National Health Service Act of 1946.

Health education in the first half of the twentieth century

Little progress was made in the development of school health education in the first half of the twentieth century. The reasons for this may be attributed to the low status of the subject. It did not have a niche in the curriculum but was taught mainly through the subject areas of Physical Education, Domestic Science and Biology. This limited the number of teachers who were in charge of the subject and who taught it.

Two positive developments during this period merit attention. The first was the formation, in 1927, of the Central Council of Health Education, which, according to Sutherland (1979) was the first occasion that the term 'health education' was used, probably with the intention of making health propaganda more acceptable to schools. The second was the publication by the Board of the Education (1939) of a handbook for teachers entitled *Suggestions on Health Education*. Enlightened for its time, the document included a section on mental health and recognised the contribution that the whole school environment could make to health education. Nevertheless, its general philosophy was still very much in line with a narrow interpretation of health and the belief that good health could be achieved simply through the inculcation of healthy habits.

Moving on to the 1950s and 1960s, health education continued to receive official attention but in the form of such broad statements that it was unlikely to impact on progress. The Department of Education and Science (DES, 1968) *Handbook of Health Education* was the standard text for teachers

in training. It gave prominence to such topics as cleanliness, movement and rest, and care of the body, but did not deal with teaching methods. It regarded health education as an important subject area but not necessarily justifying its own place in the timetable. Instead, it advocated coverage by the main subjects of the curriculum, namely: science, English, history, geography and home economics. This pattern of organisation, never generally adopted, again received attention during the 1980s as attempts were made to find a place for health education in a curriculum rendered even more congested by the Education Reform Act of 1988.

It is difficult, in the absence of any systematic surveys during the 1960s and 1970s, to give an accurate assessment of the proportion of secondary schools in England and Wales that actually undertook some form of health education. As for the nature of the health education taught, the abovementioned publications provide the principal source of information. They would have contributed to the main motivating forces affecting this area of the curriculum whilst, at the same time, influencing the direction of development. Assuming that some of the ideas and emphasis on their content were at some stage adopted by some secondary schools, a number of trends may be discerned. Health education teaching was based on a narrow concept of health and centred on the giving of information. It was didactic and covered by a narrow range of subjects whose contributions were unco-ordinated. Progress did not take place until some of these ideas and practices received serious and consistent challenge in the 1970s.

Progress and change in the 1970s and 1980s

The turning point in curriculum development came in the early 1970s, a period which Williams (1986) describes as the 'renaissance' of school health education. Three seemingly unconnected reports – Cohen (Central and Scottish Health Services Council, 1964), Newsom (Central Advisory Council for Education, 1963) and Plowden (Central Advisory Council, 1967) – were instrumental in creating a climate in which change could take place. The reports stimulated discussion and debate about a range of issues indirectly relevant to health education.

The recommendations outlined in the Cohen Committee's report led to measures which resulted in the formation, in 1968, of the Health Education Council (HEC). This was closely followed by the establishment of the post of Health Education Officer within health authorities. The Newsom and Plowden reports were concerned with general education at secondary and primary level, respectively. Both emphasised the need for a balanced curriculum in which the physical, social and emotional needs of children were recognised as essential components – thus creating a broad educational base which was philosophically in tune with health education.

The publication of the Newsom report was followed by the raising of the school leaving age to 16 years. This necessitated the development of appro-

priate curricula to meet the 'needs' of pupils attending school for an extra year. It was the result of being identified as one of the subject components of such curricula that health education gained a foothold in the curriculum. But this was not an entirely positive development for health education as for many years to follow it was seen as being of relevance only to the 'less able' pupils, a euphemism for those incapable of taking a full complement of examination subjects.

It was against a background of intense educational debate and change, generated by these reports, that the interest in health education gradually started to gain momentum in the early 1970s. Compared with the period of slow progress that preceded them, these years appear as a particularly exciting and challenging time in the history of health education. A variety of pressures and initiatives focused attention on the subject and stimulated its development. Whilst it is acknowledged that some of these originated from general changes within the health and education services, the more specific influences are considered below.

The development of quality resources

Formed in 1964, a part of the remit of the Schools Council was to engage in curriculum development and research in England and Wales. By the 1970s an increasing number of its projects were concerned with health education. The HEC was also well established by the 1970s and founded a number of innovative curriculum development projects, including: Active Tutorial Work (1979), Lifeskills (1979, 1981, 1983) and My Body Project (1983). It also established a network of regional co-ordinators for the dissemination of the Schools Council Health Education Projects (SCHEP): All About Me 5–8, Think Well 9–13 and Health Education 13–18 (Schools Council 1977).

The dissemination of these projects included an intensive in-service training element. The materials were based on an educational model of health, which required teachers to explore young people's feelings, attitudes and experiences of health, to provide a valid and relevant context for learning. Considered ground breaking and innovative in their time, the materials centred on the development of self-esteem and the acquisition of skills in decision-making, thereby establishing clear links between health education and the personal and social development of children. The HEC's support of these predominantly personal and social education projects was continued by its replacement organisation, the Health Education Authority (HEA), formed in 1986. Further work brought to the fore the role of the tutor and the use of less formal teaching methods; the teacher acting as a facilitator as opposed to a purveyor of knowledge. Another organisation that was to play an important part in the provision of in-service training for teachers was the Teachers Advisory Council for Drug and Alcohol Education (TACADE). It forged close links with the HEC and subsequently with the HEA through a number of national collaborative projects.

This was an era in which professional judgement was trusted and valued. There was consensus and shared control in education, with the Government, LEAs and teaching unions achieving unparalleled levels of co-operation and collaboration (Stenhouse, 1980).

The provision of practical support

The creation of the post of Health Education Officer (HEO), later to be called Health Promotion Officer and Health Promotion Specialist, led to the formation of an infrastructure, at the local level, to guide and support development. The task of the HEO was to develop health education in schools and the wider community. Initially, few of the post holders had experience of school life at the time of their appointment, but nevertheless were welcomed by schools as a much needed resource. They had a similar role to teacher advisers employed by Local Education Authorities (LEAs) but were paid considerably less and were deployed differently – issues that remain a source of tension in some parts of the country to this day.

In the early 1970s there were no government directives to stimulate action at local authority level. Under their own volition some authorities, such as Derbyshire and Nottinghamshire, attempted to guide schools by devising health education programmes and proffering advice. The extent to which LEAs collaborated with their Health Education Units was also an important factor in the progress of health education at a local level. In Nottinghamshire, for example, the quality and organisation of the support and guidance available for schools must have benefited from the level of co-operation. There was collaboration on many issues, from the planning of training days for teachers to the writing of guidelines for health education in schools.

At the national level, Her Majesty's Inspectorate (HMI) provided invaluable guidance and support for schools over a period spanning fifty years. HMI was an independent body, with legal right of entry to schools. It was responsible for assessing the performance of schools, identifying trends in provision and advising Departments of Education of any improvements needed. This responsibility included health education. HMI produced many influential publications related to the subject including survey reports and pamphlets. It also officially endorsed quality curriculum resource projects and their products. Thus, HMI played a crucial role in the formulation and implementation of policy in health education, a role which was subsequently extended to the development of Personal, Social and Health Education (PSHE).

Nationally, the Government's strategy from the early 1980s onwards was to target the development of selected 'sensitive' curriculum areas by the use of special grants. It was through such a centrally administered grant that in 1986 it sought to stimulate the development of drug education and later health education in schools. Although criticised for being under-resourced,

and in conflict with policies encouraging broad-based curricula, the Drug Education Coordinators Initiative, as it was called, was welcomed as a sign of support and building on the curriculum projects already in place. A major evaluation project carried out by Turner (1989) indicated that the hundred co-ordinators across the country had a considerable impact on the development of drug education in their respective areas.

The content and influence of key documents

A plethora of documents was issued by government departments and other official bodies. Most of them emanated from the DES and HMI and were intended to challenge ineffective practices, whilst at the same time offering guidance for a positive way forward. Collectively, the documents emphasised:

- the important contribution made by health education to children's learning and development (DES 1968);
- the key role of teachers in teaching the subject; the inappropriateness of relying too heavily on visiting speakers; the broad range of content needed and the use of participatory teaching methods (Scottish Health Education Department, 1974; Schools Council, 1976; DES, 1977);
- the crucial role of LEAs in school support; the importance of adopting a broad curricular framework based on PSE; the need for a shift away from a medical model (DES, 1978);
- the political support for health education (DES, 1985; DES, 1986; DES, 1989).

All of the influencing factors considered above acted in concert to drive progress and change. A survey carried out by Southampton University in 1981 showed that 85 per cent of secondary schools in England and Wales made provision for the teaching of the subject. Of these, 69 per cent based their teaching on planned programmes (Williams and Roberts, 1985). Most schools included health education within the framework of Personal and Social Education (Jones, 1986). There was a trend towards broadening the concept of health on which courses were founded and the adoption of active learning methods (Whitehead, 1989).

Compared with the period of erosion which characterised the period following the implementation of the Education Reform Act (1988), and which will be subjected to analysis in Chapter 3, the 1970s and early 1980s represented what Lewis has aptly called 'the halcyon days' in the development of health education (Lewis, 1993). However, political commitment always fell short of putting measures in place that would have given health education a firm foothold in the curriculum. It was left to the discretion of individual schools how, when and what they taught in health education.

By the late 1980s, at a time when the need for finding effective solutions

to the health promotion needs of young people gathered new momentum, the strategic foundations that had been so effectively built up started to crumble. Health education was pushed to the margins of the national curriculum. Funding for teacher professional development in health-related matters was squeezed. LEAs contracted in size thereby reducing the scope of their services for schools (Whitehead, 1989; Lewis, 1993). The national Drug Education Coordinators Initiative, which had been broadened to health education, ceased to exist in 1993. Yet, paradoxically, the concept of the health promoting school actually emerged in that period characterised by a lack of official support. We must therefore look for other sources of influence to explain this phenomenon: wider developments in health promotion and public health, international developments in school health promotion and the growth of a grassroots movement in the UK.

Towards a concept of the health promoting school

Prior to the 1980s the term 'health promotion' was virtually unknown and 'health education' used almost exclusively in the UK. In the 1970s there was a burgeoning in interventions targeting health improvement. Despite knowledge of the wider determinants of health, in the main they were aimed at influencing personal lifestyles by modifying individual health behaviour. Health education practice was located almost exclusively in public health and preventive medicine and the theoretical basis of practice was limited (Beattie 1991). This narrow, so-called 'medical model' of health education was challenged from two different quarters. The first came from health education practitioners who had worked in school-based education. These practitioners were proponents of the 'educational model' at the heart of which lies the notion of freedom of choice in health actions. School health education practice therefore had an actual bearing on the development of theory in health education. The second challenge was political and came from health professionals who regarded the preoccupation with individual behaviour change as unethical or 'victim blaming' (Crawford, 1977) and pressed for a reorientation towards social change models of health education (Freudenberg, 1981).

As the boundaries of health education widened, theoreticians tried to classify the growing range of approaches but achieved varying depths of sociological insight. The most comprehensive of the classifications can be attributed to Tones (1981). He offers four separate approaches which may be used to describe the philosophical basis of practice:

- the 'preventive model', in which the educator seeks to persuade individuals to adopt behaviours which will prevent disease;
- the 'radical political model', which is concerned with raising critical consciousness to trigger political action in achieving social and environmental change;

- the 'educational model', the goal of which is informed choice and is, at its most basic level, concerned with the building of knowledge but on a more sophisticated level involves attitudes and values clarification and opportunity to practise the skill of decision-making; and finally
- the 'self-empowerment model', which seeks to empower individuals to change their environment by developing their social skills and promoting personal growth, self efficacy beliefs and self-esteem (also known as lifeskills).

Tones's models in health education were important in that they broadened the vision of health education from its dominant focus on lifestyles to the notion of empowerment and social and environmental change. They also, by implication, determined the methods that should be used in health education and promoted further debate in the school sector on what the goals of health education should be and how those goals could be achieved. A manifestation of this was production of curriculum resources based on the different models (Weare, 1992).

WHO's all embracing definition places social policy and empowerment as the central principles of health education:

> Health education is the combination of planned social actions and learning experiences designed to enable people to gain control over the determinants of health and health behaviours, and the conditions that affect their health status and the health status of others.
>
> (WHO, 1991, p. 1)

Thus, the considerable debate that took place in the 1970s centred on questions to do with the extent to which health is the responsibility of the individual or a collective responsibility. There was also a growing recognition that health education alone had a limited effect on meeting the health needs of the population (Parrish, 1995).

On the international scene, WHO launched a series of initiatives that contributed to the conceptual development of health promotion and helped to legitimise it. In 1977, the thirteenth World Health Assembly (WHA) initiated Health for All, which identified the importance of governments achieving, by the year 2000, a level of health that would enable the world's population to lead a socially and economically productive life (resolution WHA 30.43). Health for All embodies the principles of equity in health, community participation and intersectoral action. It also includes health promotion, based on the notion of the provision of the right environment and enabling people to develop skills (WHO, 1978).

This was followed by the summary report of the WHO working group on the concepts and principles of health promotion. The report maintains that health promotion involves the whole population, within the context of people's everyday lives, and should not focus solely on people at risk from

the specific diseases. It also asserts that health promotion is directed at the determinants of health and involves diverse but complementary approaches (WHO, 1984). By highlighting an approach that focuses on people and places, rather than diseases, the document will have helped to pave the way for a 'settings' approach, e.g. hospitals, schools, workplaces. The Ottawa Charter further legitimised the settings approach by specifying five principal areas of action for health promotion: the building of healthy public policy, the creation of supportive environments, the strengthening of community action, the development of personal skills and the reorientation of health services (WHO, 1987). This was a significant development for the health promoting school.

In parallel with these international developments was the considerable debate that took place in the UK on the definitions, purpose and methods of health promotion. This debate gave rise to a wide range of models and typologies, the most frequently cited of which are those constructed by French and Adams (1986), Tones (1986), Tannahill (1990) and Beattie (1991). Given the extensive involvement of a considerable number of individuals and organisations in the development of the theory and practice of health promotion, it is perhaps not surprising that there is no agreed definition of health promotion. The definitions do, however, possess common themes: the individual (lifestyle) and the structural (fiscal and legislative, ecological and environmental measures) (Macdonald and Bunton, 1992). WHO's definition of health promotion encapsulates these themes: 'Health Promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health' (WHO, 1986).

The broadening in the scope of health education to health promotion and the growth of the settings approach has had important implications for the scope of the work of schools and the way in which they plan, implement and evaluate their interventions. An approach that is confined to the teaching of health education does not make full use of the potential of the setting and is unlikely to impinge on the health of children. The contribution of the school environment and the influence of parents and the wider community must be harnessed, co-ordinated and embedded in positive policies at all levels. The concept of the health promoting school will be explored more fully in Chapter 2.

Developments in the theory of health promotion have also indirectly influenced the nature of school health promotion through its relationship with the new public health movement. Health promotion has preceded the new public health movement and subsequently developed in parallel with it. The concepts of health promotion and the disciplines from which it draws have been instrumental in the UK in orientating public health towards social models of health and influencing its priorities, interventions and processes. This has created a better fit between school health promotion and public health strategy, an important factor given that school health spans

concerns in both education and public health and should involve both sectors.

WHO's influence on school health promotion

The contribution of WHO to the development of school health promotion has extended to specific initiatives intended to stimulate and support the development of school health promotion. As long ago as 1950, the Expert Committee on the School Health Service recommended 'the importance of developing satisfactory health education programmes, supportive teacher training and use of innovative methods in schools' (WHO, 1951). It reinforced these recommendations in a further report three years later and subsequently listed a number of criteria for schools (see below) that are similar to those now accepted for the health promoting school.

a The physical environment and facilities, and the standards of cleanliness that are observed.
b Feeding practices in the institutions (schools and college meals, cafeterias, snack-bars, and the like).
c The general content of the curriculum including the direct instruction in health.
d Physical education and organised games.
e Teaching methods, including the way in which rewards and punishments are used.
f Participation of children and students in community projects.
g The health behaviour of the teacher as an example to children and students.
h Human relations among all the individuals concerned (parents, teachers and students).
i Experience with school health services, including health and growth records.
j Handling of health emergencies, such as sudden illness, epidemics, and accidents.
k Group activities, clubs, associations, informal meetings.

(WHO, 1954, p. 7)

During the 1960s, 1970s and 1980s, WHO published a number of reports and documents, sometimes in collaboration with organisations such as UNESCO. It drew attention to the special role of teachers and the community in determining the health of students and offered the following principles and recommendations (WHO, 1983):

- the recognition of a two-way relationship between health and education;
- the importance of using need as a basis for programme planning;

- the need to enhance the role of schools in the community by developing closer relationships between pupils, teachers, parents and community members;
- the need for greater co-operation between health, education and social authorities;
- the need for more collaborative, inter-disciplinary research and training;
- the use of innovative teaching methods;
- the active involvement of pupils in the assessment of needs and in the planning, implementation and evaluation of programmes.

The term 'health promoting school' has been attributed to a consensus conference sponsored by WHO and held in Edinburgh in 1989. The conference generated the material contained in the publication *The Healthy School* on the concept of the health promoting school (Williams and Young, 1989). The foundations for the health promoting school were further strengthened at the Education for All world conference held in Thailand in 1990 (WHO, 1990). Here, the following principles were endorsed and challenges for the future identified:

- the key role of teachers;
- the necessity for high-quality teacher training in health education;
- parental involvement in curriculum development that is context based;
- health education and health-related policies in schools;
- the development of personal and social education in schools;
- health education which is put into the context of pupils' homes, families and the wider community;
- schools to become health promoting communities.

A joint WHO/UNESCO/UNICEF committee (WHO/UNESCO/UNICEF, 1992), which met in 1991, called for more research on the effectiveness of health education and made explicit the links between WHO's principles of health promotion and the concept of the school as a health promoting community: that schools should be empowering, participatory, holistic, inter-sectoral, equitable, sustainable, and multi-strategy (WHO, 1998). It is important to note, however, that tensions exist in some countries over being signatories to the concept and its underlying principles and their implementation. This is especially so where these principles are in conflict with current records and practice of human rights, for example in Uganda and Burma, and where empowerment of ordinary individuals in any sphere is not acceptable.

On a more practical level, WHO has actively supported the global application of the concept of the health promoting school. In Europe, WHO Regional Office has taken the lead. It has defined the health promoting school as one that 'aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promo-

tion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing environment' (WHO, 1995). This rather limited definition was further developed at the first conference of the European Network of Health Promoting School:

> The HPS sets out to create the means for all who live and work within it to take control over and improve their physical and emotional health. It does this through changes in its management structures, its internal and external relationships, the teaching and learning styles it adopts and the methods it uses to establish synergy with its social environment.
>
> (WHO, 1998)

Following pilot testing in 1991, a major Europe-wide project, called the European Network of Health Promoting Schools (ENHPS), was launched in 1992. It is run and funded in partnership by the European Commission (EC), the Council of Europe (CE), and the WHO Regional Office for Europe. A national co-ordinator is appointed in each country to work with a limited number of schools for three years. Co-ordinators meet at least once a year at a 'Business Meeting' to exchange experiences, share good practice, identify challenges and support each other. The Technical Secretariat, based in the WHO Office in Copenhagen, supports the co-ordinators by keeping them informed of European developments, providing technical assistance and running workshops and conferences. Currently there are 500 schools involved in 40 countries across Europe, with a further 2000 schools linked to the Network through national or regional arrangements. The countries are at different stages of development, some at the initial stage, others consolidating and expanding their activities or disseminating their products. Participating schools and countries are asked to:

- develop a three year project plan;
- form a school project team and prioritise health-related needs within the school;
- implement projects to tackle issues of both local and European relevance which can then be used as models of good practice;
- implement activities that promote the health of young people and foster a spirit of collective responsibility for personal and community health;
- maximise the project's visibility and credibility, and facilitate the evaluation and dissemination of results.

Schools participating in the ENHPS are required to adopt an integrated, holistic approach to health promotion and to prioritise it within the curriculum, its school management structures, and the physical and social environment. The notion of partnership is central to the ethos of the project in relation both to the school community and the wider community. ENHPS

has had a variable but nevertheless important influence in Europe and will be subject to further scrutiny in Chapter 2, with respect to its project methods, and, in Chapter 8, its effectiveness.

Health promoting schools in England

England provides an interesting and perhaps unique case study in how shifting priorities and issues of control can affect the nature and growth of the health promoting school. As stated earlier in the chapter, political support for school health promotion was waning by the late 1980s. Reference was made in the Education Reform Act to the importance of personal and social development but this was not reflected in the curriculum that was prescribed. There was no evidence of central leadership or guidance, the exception being the production and distribution of a guidance document for health education. *Curriculum Guidance 5: Health Education* acknowledged the contribution of the whole school to health but specified objectives only for the curriculum and, disappointingly, mostly in the domain of knowledge (NCC, 1990b). Education authorities at all levels seemed to distance themselves from health promotion and the onus was left to the health sector to lead the formulation of strategy and to ensure the availability of support.

Nevertheless, in the 1990s there was a proliferation of local projects and schemes seeking to promote schools as health promoting environments (Rogers *et al*., 1992). Operating in parallel with these projects was the ENHPS, which was at the pilot stage in the four countries of the UK. The project methods used by ENHPS contrasted sharply with the local projects, the former being centrally co-ordinated by the HEA, led by the international organisation, WHO, and influenced in its recruitment strategy by the scientific model aspired to in the evaluation design. The ENHPS in England never reached its next stage of development, nor were its products adequately disseminated. It may have been abandoned on account of its lack of integration into existing development work and because political imperatives dictated that a 'new' project, emanating from the new administration, had to be launched.

Instead of extending the ENHPS project, building on the policy statements and programmes specifically related to schools and school-aged young people contained in the education and public health White Papers *Excellence in Schools* (Secretary of State for Education and Employment, 1997) and *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999), the Government announced the launching of a Healthy Schools Programme. Originally designed as an award bearing scheme, following the concerns expressed by health promotion specialists on the inappropriateness of the structure and the practical difficulties which would be experienced in implementing it, the project was changed to a non-award-bearing scheme and finally the Healthy School Standard. The term 'standard' lacks congruence with the ideology of the health promoting school (or the healthy school as it

is called in the initiative), but undoubtedly it has succeeded in bringing the health promoting school within the parameters of mainstream concerns in education. Indeed the Department for Education is again centre stage in leading developments, ostensibly in partnership with health.

The present project structure has evolved in response to consultation, feedback and research (Sinkler and Toft, 2000). Local projects and their schools work towards quality standards, using the resources available at the local level (DfEE, 1999a). Flexibility has been built into the National Healthy School Standard project to allow for the variations in the local projects already in place. Partnerships between health and education are encouraged and, to this end, joint applications have to be made to access funding opportunities. Regional co-ordinators have been appointed to provide the conduit for the ideas and information from and to the central project team.

In summary, the concept of the health promoting school has drawn on and developed from the theories of general health promotion and the settings approach. In school it has built on health education teaching in the formal curriculum, which has a much longer tradition and a clear framework in place for good practice. The evolution of the health promoting school in the UK has demonstrated the importance of a supportive educational climate, political endorsement, an infrastructure for support and quality resources for the development of school health education and health promotion. It has also shown how a diverse range of national and international agencies and services can be a source of influence but that the champions of school health can change over time. Political support can be cyclical and in its absence grassroots movements can be powerful instigators of progress and change.

2 The concept of the health promoting school

Introduction

This chapter consists of two sections. The first examines the concept of the health promoting school, or healthy school as it has become known in England and Wales. It begins by relating key developments in health promotion, outlined in the previous chapter, to ideologies, theoretical perspectives and models that help to explain the concept of the health promoting school. A holistic and ecological model of the health promoting school is introduced to draw out the basic elements of the concept, which can be used as a framework for analysis and evaluation of the initiative. The key elements reviewed are: partnerships; professional roles and training; personal, social and health education, and citizenship; physical and social environment and action competence. The second part of the chapter explores some of the theories and principles of practice that underpin the successful introduction of innovations into the setting of the school, namely, management of change and diffusion of innovation. The chapter concludes with a case study of good practice in the development of the health promoting school in the Republic of Ireland, which illuminates the practical application of the concept in the context of one school.

The concept of the health promoting school

The health promoting school can be described as a broad-based concept with a variety of definitions (Tones and Tilford, 1994). One established and universally-used definition (Stewart-Burgher *et al*., 1999) provides the following insight:

> The health promoting school aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment.
>
> (WHO, 1993)

It is interesting to compare this comprehensive yet wide-ranging definition with a more recent definition of a healthy school:

> A healthy school is one that is successful in helping pupils to do their best and build on their achievements. It is committed to on-going improvement and development. It promotes physical and emotional health by providing accessible and relevant information and equipping pupils with the skills and attitudes to make informed decisions about their health. A healthy school understands the importance of investing in health to assist in the process of raising levels of pupil achievement and improving standards. It also recognises the need to provide both a physical and social environment that is conducive to learning.
>
> (DfEE, 1999a, p. 2)

The latter, which appears in the guidance document for the English National Healthy School Standard (NHSS), is more specific in highlighting the potential health gain and academic attainment of pupils achievable through implementing the health promoting school. There is compatibility, however, between the definitions as the latter states that a healthy school 'also recognises the need to provide both a physical and social environment that is conducive to learning' (DfEE, 1999a, p. 2).

Development of the concept of the health promoting school

The origins of the health promoting school concept can be traced back to specific initiatives aimed at improving health in schools during the 1980s. These initiatives were reviewed in Chapter 1, for example the development of the Schools Council Health Education 13–18 Project and Personal, Social and Health Education (PSHE). Both these initiatives recognised the importance of involving the whole school and wider community in the promotion of young people's health. Simultaneously, health educationists were starting to publish visionary work on the potential of the health promoting school (Tones, 1987; Williams, 1987). However, it has been the recognition of a holistic concept of health (Ewles and Simnett, 1985), referred to as 'modern health education' (Downie *et al.*, 1990, p. 35), and the defining of health promotion as an ecological concept (Ottawa Charter, 1986) that have provided an ideological foundation to the health promoting school movement.

The health promoting school has been described as a 'total environment' which provides more than just learning and teaching about health issues in the classroom (Beattie, 1996). The health promoting school also encapsulates the notion of developing a safe social and physical environment for the 'total population' of the school (WHO, CE, CEC, 1993). The descriptors 'total environment' and 'total population' can be used to analyse objectives of the health promoting school (see Table 2.1).

Table 2.1 Application of descriptors to the ENHPS objectives of the health promoting school

Objectives	*Descriptor*
provide a health promoting environment for working and learning through its buildings, play areas, catering facilities, safety measures, etc.	total environment
promote individual, family and community responsibility for health	total population
encourage healthy lifestyles and present a realistic and attractive range of health choices for schoolchildren and staff	total population
enable all pupils to fulfil their physical, psychological and social potential and promote their self esteem	total population
set out clear aims for the promotion of health and safety for the whole school community (schoolchildren and adults)	total population
foster good staff–pupil–pupil relationships and good links between the school, the home and the community	total environment & total population
exploit the availability of community resources to support action for the promotion of health	total environment
plan a coherent health education curriculum with educational methods that actively engage pupils	total environment
equip pupils with the knowledge and skills they need to make sound decisions about their personal health and to preserve and improve a safe and healthy physical environment	total environment
take a wide view of school health services as an educational resource that can help pupils become effective health care consumers	total environment

The term 'health promoting school' clearly epitomises a vision of schools as reflective and dynamic institutions. It also helps to authenticate the notions of 'a whole school approach' and 'social inclusion' within education by highlighting an inclusive learning and teaching environment that aims to foster and maximise human potential. In this context it has provided positive ways in which schools can contribute to the health of pupils, teachers, support staff and their local community through the creation of a health enhancing social and physical environment.

The concept also embraces the principle that the health, and by implication the education, of individuals can be advanced by schools providing relevant and appropriately structured and integrated personal, social and health education within the taught curriculum. The principle embodies the notion that healthy choices will become the easy ones for the whole school population when such a curriculum is supported by safe, stimulating and health promoting physical and social environments. It is important to recognise that the school population is greater than just its pupil intake; many adults spend longer periods of time in this setting than pupils. Additionally, through interaction with external environments, and formation of alliances with members of the community, school health promotion can be strengthened and, in turn, positively influence the society in which pupils' health

choices are made. These include partnerships and collaboration between education and health sectors, local authorities, external agencies, national and international policy makers and funding sources. These issues will be discussed in more detail later in the chapter.

Ideology underpinning the concept

The World Health Organization (WHO) has been a major catalyst for change within primary health care (WHO, 1978) and a driving ideological force behind the development of health promotion. The Ottawa Charter (WHO, 1986) signalled the emergence of a new public health, epitomised by a call for social change and political action. It established what is still considered to be the 'contested' (Tones and Tilford, 1994), yet broadly accepted, concept of health promotion. This concept has been applied subsequently to a wide range of institutional and community settings such as health promoting schools, hospitals and universities. A slight change in terminology brought about by political expedience highlights further examples of settings, namely healthy cities, healthy workplaces, and healthy prisons, and, hence, 'healthy schools'. Clearly, to refer to health promoting prisons would be inappropriate and the macro-environment of a city might be too large to associate with a health-promoting label. Internationally, however, hospital and school settings appear to be referred to as health promoting institutions, although in the UK the term 'healthy school' or 'healthy hospital' is used interchangeably with the term 'health promoting school' or 'health promoting hospital'. These settings underpin what has become known as the 'settings approach' to health promotion (Baric, 1992) and have been the focus for the development of European and, in the case of cities and schools, global networks. There are some fundamental differences, however, in the operation and development of health promotion in different settings, even though they share the same conceptual principles and each has a European network.

For example, WHO established the first Healthy City project in 1987, resulting in over 300 local initiatives currently operating in Europe. The project has provided an opportunity to test the potential of health promotion and its underpinning principles that have been sparked into life by the Ottawa Charter for Health Promotion. The early development of the Healthy Cities Project has been well documented (Morris, 1987; Fryer, 1988; Kickbusch, 1989). However, the Healthy City is an example of a macro-setting in comparison with the health promoting school. It leans heavily upon the creation of intersectoral collaboration for individual city projects to move forward, and has direct links with the targets set for 'Health for All by the Year 2000' (WHO, 1985). It is suggested that the Healthy City project is one practical attempt to interpret the theory of HFA 2000 and break it down to a workable package by accepting the HFA principles of equity, empowerment, participation, multi-agency

inter-disciplinary working and an emphasis on primary health care (Kemm and Close, 1995). Although health promoting schools might also need to demonstrate alignment with some of these principles, they do not necessarily need the same degree of intersectoral involvement to establish a health promoting setting as that associated with a Healthy City project.

Health Promoting Hospitals provide another example of the settings approach to health promotion in action. Again, developments have been spurred on by international co-operation steered by WHO (WHO, 1991b) and, in the case of England, supported by national health strategies (DoH, 1992). In many ways the Health Promoting Hospital synthesises the institutional and operational tasks involved in utilising a settings approach to health promotion. The sheer size and departmental complexity of many hospitals provides a major challenge to those attempting to co-ordinate such an initiative. Nonetheless, this particular setting has become an important focus for the creation of health promoting health care organisations, evidence based health promotion, and health governance (Harrison, 1999).

Healthy Prisons are part of a Europe-wide initiative that focuses upon health development in a specific setting. This initiative is also part of a European network of pilot institutions. Certainly in the UK this setting has been taken seriously by the Home Office Prison Service and a Healthy Prison Award Scheme has been implemented. The prison as a setting for health promotion is not only a challenge but to some people a contradiction. Health care in UK prisons has been largely influenced by traditional attitudes whereby security has been emphasised over health improvement (Joint Prison Service and NHS Executive Working Committee 1999, *The Future Organisation of Prison Health Care*). In common with health promoting schools and hospitals, the healthy prison is a total population and environmental approach to health care and health promotion. In addition to inmates, prison staff and visitors also form part of the population of these institutions.

The Ottawa Charter for Health Promotion and, more recently, the Jakarta Declaration on Leading Health Promotion into the Twenty-First Century (WHO, 1997b), indicate clear movement away from the traditional disease-focused, top-down medical model of health education towards what Tones and Tilford (1994) identify as a radical or an 'up-stream' model. The radical model acknowledges the importance of social and environmental influences on health, a need for a social-structural focus and a collectivist approach to influence health and social policy.

The ideological basis of the Ottawa Charter has been summarised by Tones (1996, p. 3) as:

- The pursuit of equity and the reduction of associated inequalities in health experience.
- A positive and holistic definition of health and a healthy society.
- An emphasis on active, participating communities, and self-

empowerment. Empowerment is a desirable health goal in its own right; it is also the most effective means of dealing with the problems of premature and avoidable death and disease.
- Determination to achieve de-medicalisation: health is too important to leave to health professionals; the medical model tends to ignore the social and environmental determinants of health and traditional medical hegemony militates against empowerment.

The Jakarta Declaration (WHO, 1997b) re-emphasises the importance of the strategies set out in the Ottawa Charter for Health Promotion. It makes reference to the clear evidence of particular settings, including schools, offering practical opportunities for the implementation of comprehensive strategies. In particular, priorities for health promotion in the twenty-first century are introduced. The five priorities listed are relevant and applicable to the ideology underpinning the concept of health promoting schools:

- promotion of social responsibility for health;
- increased investments for health development;
- consolidation and expansion of partnerships for health;
- increased community capacity and empowerment of individuals;
- securing an infrastructure for health promotion.

Theoretical perspectives on health promotion applied to the health promoting school

The health promoting school is congruent with established models of health promotion and health education in general. Such models are useful in terms of unpacking the theoretical components and practical developments of the health promoting school. For example Tannahill's model of health promotion (Downie *et al*., Chapters 4 and 6, 1996) provides a practical framework for planning and action that reflects the wide-ranging concepts of the health promoting school; it systematically encourages attention not only to health education but also to preventive services and amenities and to 'health protection' policies. This framework also encourages explicit attention to the positive dimensions of health, such as well-being and fitness, as well as to the prevention of ill health.

Two further models, Beattie's (1991) matrix of strategies for health promotion and Caplan and Holland's (1990) Matrix of Perspectives of Health Education, provide ways of analysing the structural and socio-political basis of the health promoting school.

Beattie's matrix of strategies for health promotion (Figure 2.1) offers a structural analysis of a range of health promotion approaches. It highlights different dimensions that provide theoretical positioning of health promotion strategies. Based on an analysis of the objectives of the health promoting school (WHO, CE, CEC, 1993), it is possible to identify movement

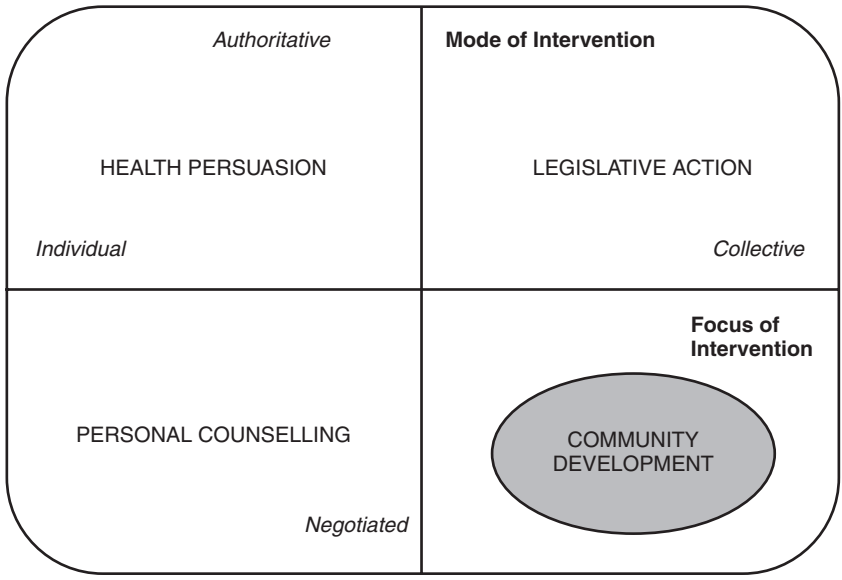


Figure 2.1 Matrix of strategies for health promotion (Beattie, 1991)

towards a 'collective' focus of intervention and a 'negotiated' mode of intervention, positioning health promotion, and thus the ideology supporting the health promoting school, within the 'community development' quadrant of the matrix.

The notion of 'community' in this context reflects the total population of the school, which includes all who attend, work in and visit the institution on a regular basis. The school community will be different in its composition, tasks and way of life from other settings, for example a university or further education college. Indeed there may be identifiable characteristics of particular schools which shape their communities, such as whether they are day schools or boarding schools. However, the importance of the analysis of the health promoting school using Beattie's matrix of health promoting strategies is that it enables clarification of the intervention. The community development approach to the health promoting school, epitomised by bottom-up and negotiated strategies, can be clearly identified within the 'game plan' of both international and national initiatives. For example, the ENHPS has supported the national and local devolution of responsibility for developing health promoting schools through a negotiated framework with schools. Similarly, in England the National Healthy School Standard (NHSS) was created with local health promoting school initiatives in mind. The NHSS is a development of the health promoting school concept that provides a balance between setting national standards of performance for healthy schools and recognising the achievement of individual school-based

criteria. It engages evidence-based practice, and encourages a bottom-up and negotiated approach to the development of health promoting schools while recognising the importance of community development.

The modified version of Caplan and Holland's matrix of perspectives on health education, which incorporates other authors' perspectives on the nature of society and knowledge (Whittington and Holland, 1985; Taylor, 1990), serves to highlight the potential radical re-positioning of health promotion and, by association, the ideology underpinning the health promoting school. Caplan and Holland use Nature of Society and Nature of Knowledge as the two dimensions for their matrix (see Figure 2.2).

The influence of the Ottawa Charter and the settings approach to health promotion has seen a movement away from the 'traditional' perspective on health towards more radical humanist perspectives based upon subjective forms of knowledge. One might argue, however, that national initiatives such as the NHSS in England, which highlights set criteria for healthy schools, might be based on an objective nature of knowledge and thus suggest movement towards a more radical structuralist approach to health promotion.

The dimensions of mode/focus of intervention (Figure 2.1) and nature of society/knowledge (Figure 2.2) within the two matrices are useful in that they not only provide a means of theoretically positioning health promotion but they highlight potential areas of conflict. For example, some policy

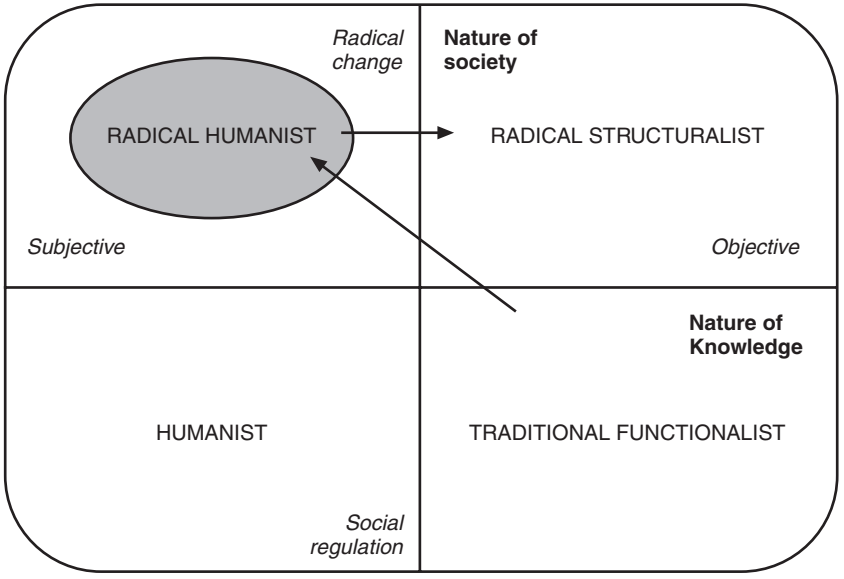


Figure 2.2 Matrix of perspectives for health promotion (adapted from Caplan and Holland, 1990)

makers, medical personnel and politicians might see the health promoting school as an expert-led vehicle for dealing with the eradication of specific diseases and unwanted states, with a focus on individual behaviour and objective knowledge. Educationalists and social scientists on the other hand might view it as representing a holistic view of health, with a negotiated environment and a collective focus.

The ideology underpinning the health promoting school, as perceived from the literature on its development within Europe (NIGZ, 1995; Beattie, 1996; Tones, 1996; WHO, CE, CEC, 1997), would suggest alignment with the latter viewpoint. In reality, however, ideology is always controlled by elements of professional power and the need for public accountability.

Potential areas of conflict surrounding the ideology and therefore the concept of the health promoting school are important as they will have considerable influence upon the criteria against which health promoting schools are evaluated. This point will be discussed further later in this book. The limitation of both Beattie's and Caplan and Holland's models when applied to the health promoting school is that they use only two axes, which focus on the nature of knowledge, nature of society, mode and focus of the intervention respectively. This may be limiting when attempting to analyse something as complex as a health promoting school setting. To this end it is perhaps necessary to investigate the potential of a multi-dimensional model that is based on an inclusive concept of the health promoting school. This can be broadly interpreted by delineating the influences that shape a health promoting school at three levels: international, national and local.

Parsons *et al*. (1996) have developed a multi-dimensional model of the health promoting school which highlights its ecological and holistic concept. The eco-holistic model of the health promoting school highlights the existence of, and demonstrates the relationship between, factors or elements, external and internal, that influence the structure, development and scope of health promotion in school settings (see Figure 2.3).

These areas of influence form a useful structural framework for enquiry, measurement and 'valuation' of health promotion. For example, in the context of European schools, *external factors* are international influences such as the ENHPS and national legislation and guidance on health education in schools. Within England and Wales, these include legislation and guidance on sex and drugs education, regional education and health policies and initiatives, and local health and education initiatives such as health promoting school schemes. *Internal factors* might include management and allocation of health education and promotion roles within the school, health promotion links with the outside community, the formal and contextual health education curriculum, the model of health promotion which has been adopted by the school, and outcomes such as feelings, attitudes, values, competencies and health/illness behaviours of the school community.

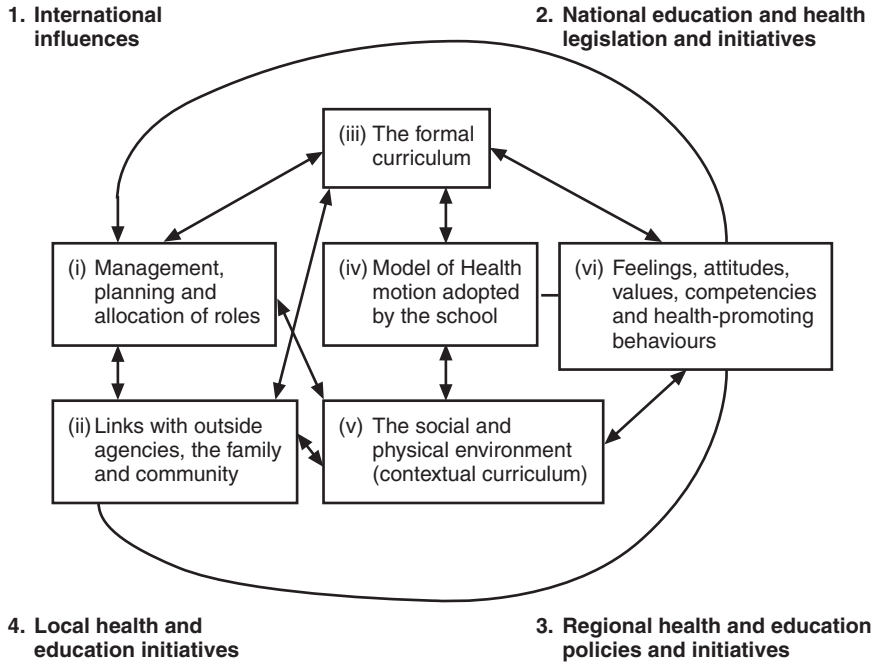


Figure 2.3 An eco-holistic model of the health promoting school (Parsons *et al*., 1996)

Analysis of key issues within the eco-holistic model of the health promoting school

There are five key issues that are central to the concept of the health promoting school and arise from the elements of the eco-holistic model. These issues are shown in Table 2.2 and then discussed briefly.

1 Professional roles and training

The responsibility for creating and sustaining individual health promoting schools and, by implication, the broader movement, is an important issue that is clearly related to professional boundaries, and initial and in-service education and training. For example, the roles of teachers and health professionals in the development of a health promoting school need to be clarified and understood. Senior management and teachers within schools may be recognised as the key players. However, certain health professionals, e.g. school nurses, health visitors, have a legitimate claim to be involved in the development of health promoting schools.

Table 2.2 Issues within the eco-holistic model of the health promoting school

Key issues	*Locating the issue in the eco-holistic model of the health promoting school*
1 Professional roles and training: teachers, health promotion advisers and school nurses	Management and roles, planning and the allocation of roles
2 Partnerships	Links with outside agencies, families and the community
3 Personal, Social and Health Education, and Citizenship	The formal curriculum
4 Safe and welcoming learning and working milieu	The social and physical environment
5 Action competence	Feelings, attitudes, values, competencies and health promoting behaviours

In the UK, school nurses already play an important role with respect to ill health prevention and the health education of young people, although their potential role in the development of the health promoting school is not always recognised. Much of the problem has been the conflict between their ill health prevention role, which is governed by Department of Health targets, and their less well defined, but broader, health promotion remit in schools. Their training and education as community nurses provide them with wide-ranging knowledge and understanding of sensitive health issues, which should be recognised as a positive asset for schools. They are not trained as teachers however.

The role of health promotion specialists (see Chapter 1) has been largely a co-ordinating and facilitating one with local education authorities and schools. Their future role in this capacity and within a new vision of public health for the twenty-first century will be determined by government policy.

The role of teachers and senior management in schools is central both to the implementation and sustainability of the health promoting school. They are best placed professionally to initiate and develop the concept. The degree of teacher involvement and commitment, however, is dependent on their knowledge and understanding of health promotion and education in general and the concept of the health promoting school. The scarcity of initial teacher training in these areas will seriously affect teacher readiness to embrace this concept. Successive research since the mid 1980s in England and Wales has revealed the weakness of teacher education and training in health related areas (Williams and Roberts, 1985; South *et al*., 1998; Stears *et al*., 1999). In-service training compensates to some degree, although much relies on health service provision and teachers being released from school to train in what, for many, is a low status area. Clarity of roles and

the availability of appropriate training for education and health professionals are clearly central issues for the future development of the health promoting school.

2 Partnerships

The development of partnerships, both within schools, for example between education and health, and externally between the school and its local community, is also important to the operational success and local credibility of health promoting schools. The importance of the partnership between health and education at all levels is supported by the NHSS in England and the ENHPS. At an international level, the ENHPS is based upon a tripartite management partnership involving the WHO Regional Office for Europe, the European Commission (EC) and the Council of Europe (CE). Education and health divisions of both the EC and CE are linked to the ENHPS through their respective representatives on the International Planning Committee. Through its Technical Secretariat, the ENHPS has encouraged national health promoting school projects to work with a management coalition of their ministries of health and education. Similarly, the NHSS in England is an initiative born out of a joint Department of Health and Department for Education and Employment partnership. A local scheme that is part of the NHSS will not receive Government Standards funding or accreditation unless it has proof of a working partnership between its local health and local education authorities. The NHSS support material on partnerships (DoH, DfEE, 2000a) highlights four standards that local schemes are required to meet at a strategic and operational level. The local programme must:

- be based in an established education and health partnership;
- involve school staff in planning;
- involve young people in planning;
- involve statutory and non-statutory agencies and community groups in the planning, delivery and evaluation of activities.

Further aspects of partnerships are included in these standards relating to 'management of healthy school programmes' and 'working with schools'.

The publication emphasises that local healthy school programmes in England 'are required to work in partnership at a strategic and operational level' (Section 1). The materials add: 'The formal expression of local strategic partnerships will be the inclusion of healthy school programmes with health improvement programmes and educational development plans' (Section 1).

Partnerships between health promoting schools and local community agencies epitomise the wider public health ideal of the concept. In parallel with the Government's directives on developing a new structure of public

health practice for England (DoH, 1999), partnerships and inter-agency working are seen as important aspects of the health promoting school in action. The NHSS in England requires that 'the level of support available to schools must be communicated to them and a service level agreement negotiated' (NHSS Standard 3.7a, DfEE 1999a).

The notion of schools working in partnerships with local communities and with national health-related programmes has been linked to the enhancement of educational and social well-being, not only of pupils but of families and whole communities (Whitty *et al.*, in Rivers *et al.*, 2000). Partnerships underpin a school's interactions with its local community and, where service level agreements exist, help to clarify roles contributing to the development of the health promoting school.

Finally, the partnership between home and school is crucial. It has long been recognised that schools are more likely to be effective if good relationships are fostered with parents and carers and there is active co-operation and parental involvement in school education. The home provides differential learning experiences for children based on material, cultural and social factors. Partnerships with parents will help to enhance equality of opportunity for children and increase the possibility of parents reinforcing or, sometimes, taking on for themselves the health messages that have been taught in school. Practical examples may include messages about smoking and healthy eating.

Official guidance in the area of school–parent links is lacking but the diversity and complexity of family life calls for a range of strategies for involving parents in their children's health education. These may include family support and the active involvement of parents in health policy development and in health education lessons and activities. This will address not only parents' expressed needs for information about health and health education but may help them to become more effective health educators themselves.

3 Personal, Social and Health Education, and Citizenship

The International Planning Committee of the ENHPS has identified the school curriculum as one of the areas in which development work is required in order to further the advancement of health promoting schools in Europe during the twenty-first century (ENHPS report, 2000). There is likely to be considerable debate about the way in which this happens within different national health promoting school programmes. Such programmes will be shaped by the current state of health education and health promotion in each country, and will reflect different cultural, political and historical developments. These developments might result in a predominantly biomedical, psychological or social approach to health education and health promotion within the school curriculum (Stears, 1998).

In both England and the Republic of Ireland, however, Personal, Social

and Health Education (PSHE) has been identified as the main curriculum area for development in all schools. In the Republic of Ireland it is referred to as Social, Personal and Health Education (SPHE), although the context of the subject area is broadly the same. Both countries have recently developed new national frameworks for this area of the school curriculum, the dissemination of which has been closely associated with the development of health promoting schools.

The NHSS has been carefully designed to support and complement the PSHE framework in England (DfEE, 1999b) and highlights its contents in its guidance documents as key areas for the development of young people. PSHE and Citizenship are two of the eight themes that have been incorporated into the NHSS, the others being drugs, alcohol and tobacco; emotional health and well-being; healthy eating; physical activity; safety; and sex and relationships education. The impact of school life on pupils in the form of consistent and positive experience is identified as a cornerstone to sound personal and social behaviour, and citizenship. The inclusion of PSHE in the curriculum, the way it is integrated, and the teaching and learning methods used, are all significant factors in the development of health promoting schools. It is important that PSHE is not seen as a separate subject and the responsibility of a single teacher but rather as based upon a partnership between staff, pupils and parents. The concept of a health promoting school reflects a whole school approach; therefore PSHE should be integrated into subjects across the curriculum and part of everyday life associated with the school. 'What happens in assembly, on the hockey pitch, on work placement, on the school bus, has as much or more impact on how pupils grow socially and personally, as what they learn in the classroom' (DfEE, 1999a, p. 8).

In practice this may well be easier to achieve in primary rather than secondary schools, where teachers tend to be more subject orientated. Much, however, will depend on the management and thrust of any change process to modify the curriculum, diffuse the health promoting individuals, make sure their needs are recognised and respected and their contributions acknowledged and utilised – all fundamental principles for health promoting schools.

Similarly, the physical environment is very important to the underpinning concept of the health promoting school. This is probably the single most visible aspect of the health promoting school and will be reflected in, and mutually supported by, the ethos and social environment of a school. Such physical aspects as ventilation, lighting and heating, state of buildings, cleanliness of toilets, smoking and nutrition policies and practice, availability of fresh drinking water throughout the day, and its siting, all contribute to the health and well-being of all those in schools. For example, a pupil undertaking an interview for a healthy school audit in the Medway Towns in Kent was reported to have stated 'Why do we have to have our only drinking fountain in the toilets?' Why indeed? This example of pupil enquiry highlights the importance of a whole school approach and the future need

for school architects and planners to be involved in the development of the broader health promoting school movement.

An example of a health promoting school in the south-east of England is also pertinent. This school, with its deprived inner city location, old dilapidated Victorian building and small playground, was impressive as a consequence of its social environment. All age groups of pupils would welcome visitors, offer directions and hold the door open as a minimum welcoming gesture. The atmosphere of the old building reflected the warmth of the ethos produced by happy, healthy staff and pupils. The two aspects of environment, physical and social, should not be seen therefore as mutually exclusive but, often, complementary. Health messages conveyed to children through both will enable them to put into practice the healthy behaviours they have been encouraged to adopt through the taught curriculum.

5 Pupil involvement and action competence

The involvement of pupils in the development of health promoting schools is a key issue and one that should rank among the main objectives in realising the concept in schools. The United Nations Convention on the Rights of the Child provides a clear lead for involving young people in the dissemination of information and discussions about health promoting schools. Article 17 draws attention to: 'The child's right of access to appropriate information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health' (UN Convention on the Rights of the Child, 1991). In many European countries, legislation and clear guidelines have been produced that ensure pupils are involved in school decision-making. Research has indicated that England and Wales 'seem out of line with the rest of Europe in the way that young people have no legislated and government-supported ways to participate in decisions about their education' (Davies and Kirkpatrick, 2000). However, through the joint Department of Health and Department for Education and Employment supported National Healthy Schools Standard, pupil involvement has been placed high on the agenda. Recent guidance for healthy schools in England has summarised pupil involvement in these terms:

> Giving pupils an opportunity to be involved in and consulted about personal, social and health needs is an important part of the process in becoming a healthy school. The National Healthy School Standard therefore emphasises the importance of local healthy schools programmes' involving pupils at both programme and school level.
>
> (DfEE, 2000b, p. 2)

Decision-making and action competence will be the outcomes of the health promotion process where the learning methodology used in PSHE is pupil-

centred, active and participatory. In practice pupils, staff and parents will participate in the development and maintenance of health promoting schools to varying degrees. Arnstein (1971) provides a 'ladder of participation' which can be used as an instrument to analyse the scope of a community's participation, ranging from non-participation through degrees of tokenism to actual power. This is useful in recognising different stages that potential participants can operate at within a particular community. Given that pupils are central to the community of schools it is important that their involvement goes beyond the stage of mere tokenism to a situation where they are given devolved power within the decision-making processes of the health promoting school. A clear case has been made for stronger and positive pupil participation in schools (Cohen and Emanuel, 1999).

Pupils are already beginning to participate in the day-to-day running of health promoting schools, for example through the democratic process of decision-making through pupil orientated 'school councils', involvement in the auditing process of health promoting schools and pupil consultation with reference to the needs of local healthy school programmes (Parsons *et al*., 1997; Stears *et al*., 1999; DoH and DfEE, 2000b).

Probably the most profound development of pupil participation within the health promoting school movement has taken place in Denmark. The concept of 'action competence' has been championed by educationists (Jensen and Schnack, 1994) and has become a cornerstone for Danish health promoting schools (Jensen, 1997). This concept takes the notion of democracy that underpins the health promoting school and focuses it upon developing pupils' confidence and skills to take responsibility for bringing about positive changes within school. In a critical analysis of pupil participation and action competence Paul Hart, Venka Simovska, Derek Colquhoun, Karsten Schnack and Bjarne Bruun Jensen have presented a comprehensive overview of both concepts in the context of health and environmental education (Jensen, 2000). The international commitment to action competence has grown in recent years and it became part of the Conference Resolution at the first international conference of the ENHPS in 1997:

> The health promoting school improves young people's abilities to take action and generate change. It provides a setting within which they, working together with their teachers and others, can gain a sense of achievement. Young people's empowerment, linked to their vision and ideas, enable them to influence their lives and living conditions. This is achieved through quality educational policies and practices, which provide opportunities for participation in critical decision making.
>
> (WHO, 1998c, p. 35)

This statement raises further issues related to the management of change in schools and the way the health promoting school as an 'innovation' radiates out from concept to action.

Management of change, diffusion of innovation and sustainability

Managing change, innovation and sustainability are key challenges for those working to develop the health promoting school. In order to highlight the innovation and direction of change it is useful to refer to the 'settings' approach to health promotion outlined in Chapter 1. It has been suggested that, for a settings approach, it is necessary to modify the traditional conceptual blueprint of health promotion to include organisational as well as medical concepts. Baric (1993) gives the following examples:

- organisations as systems – their structure and size, their mechanisms and processes, effectiveness, technology, power structure, productivity, relationship to the environment;
- people in organisations – management theories, responsibilities and goals, motivation, status and role, group dynamic, leadership, conflict and change, consumerism;
- accountability – the concept of self-assessment and evaluation, the concept of auditing and social responsibility, health gain as an indicator, control over negative or undesirable side-effects.

This kind of reconceptualisation of health promotion in school is vital if the concept of the health promoting school is to become a reality. Management and systems theories, of course, are not new to education but their adoption as part of an integrated health policy may well be. Therein lies the challenge for most schools and the health and education systems that support them. The inclusion of the occasional health education lesson is insufficient. To become health promoting settings, schools may have to re-examine their very ethos, philosophy and purpose and accept the fundamental principles associated with the management of change. Whitehead and Tones (1990) have posed five key questions that help test the peculiar characteristics, benefits and disadvantages of particular settings, and therefore are relevant to schools:

- Access – What kind of target group may be accessed through a given setting? How many people will be reached and to what extent is their state of learning-readiness compatible with the programme aim?
- Philosophy and purpose – To what extent is the overall goal and philosophy of the setting compatible with the programme's philosophy and purpose?
- Commitment – How committed is the organisation and its members to the programme goals?
- Credibility – How credible is the institution and those within it who will be expected to act as health promoters? How will the public respond to them?

- Competence – Irrespective of commitment and credibility, do the potential health educators and health promoters posses the knowledge and skills needed to communicate with and educate clients within the setting?

The Communication of Innovation or Diffusion of Innovation Theory (Rogers and Shoemaker 1979; Rogers 1983) can be applied to the health promoting school. It was developed to illuminate the factors that affect the dissemination of ideas, practices or products, perceived as new, within a community and over time. The health promoting school can be identified as an innovation in health promotion that includes new ideas and practices and possibly new products, for example new resources for use in schools.

Innovation diffusion consists of four essential elements: the *innovation*; the *communication channel*, which may be interpersonal or mass media; the *rate of adoption* and the *individual or social system* that is receiving the innovation. By scrutinising research on adoption and diffusion, Rogers and Shoemaker produced an adoption model based on four stages:

- knowledge – the building of awareness, use of further information and a consideration of possible usage;
- persuasion – the attempt to form favourable or unfavourable attitudes towards the innovation;
- decision – testing the acceptability of the idea; and
- adoption or rejection of the innovation.

Rogers and Shoemaker also identified certain attributes of innovations that are essential for success. They suggested that the innovation has to be easy to understand and perceived as being easy to use. It has to offer advantages over the ideas and products currently in use, and fit in with the values and norms of potential users. Additionally, it should be simple to try out before making a substantial investment or commitment, and the results should be clearly visible to others (Rogers and Shoemaker, 1979).

Interest in the health promoting school, as an innovation, has expanded internationally and within countries as a consequence of widespread acceptance of its underpinning values and its credibility in terms of meeting perceived health and education needs. It is clear, however, that where national co-ordinators of health promoting school programmes have had ministry support expressed through legislation and guidance sympathetic to the innovation, their job of dissemination has been made easier. Many advantages can flow from top-level, official commitment including allocation of funding, documented support and inter-departmental collaboration. Personnel in Health, Education and sometimes other departments such as Youth and Leisure, can contribute to the expansion of the innovation at the local level by, for example, running activities and supporting curricular and extra-curricular health promotion schemes. Public esteem and high public profile

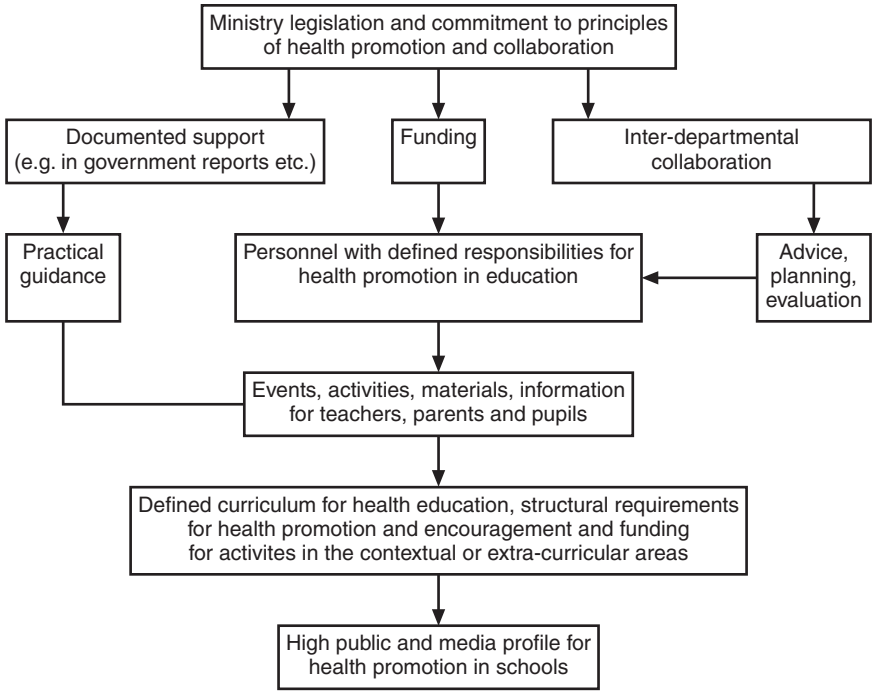


Figure 2.4 Support for the diffusion of innovation

in schools and at local levels can consolidate support at top levels (see Figure 2.4).

The process of innovation diffusion may be recognised within the NHSS in England and many of the national ENHPS projects in other European countries. National and regional co-ordinators of health promoting school schemes have played a major part in communicating the innovation and ensuring, in many cases, successful diffusion within contained pilot projects. However, the ultimate test will be the successful management of change, and diffusion of the innovation, in large numbers of schools in any one country. For example, in England the NHSS has provided substantial resources and many of the supportive elements required to overcome the barriers to successful adoption of the innovation; however, in reality schools will weigh this provision against the numerous educational initiatives that they are continually expected to adopt. Successful adoption of the innovation and the necessary management of the change in schools will depend on the perceived relevance of the concept of the health promoting school to the overall mission of individual schools.

The issues of management of change and diffusion of innovation are central to the sustainability of health promoting schools. Much of the theory

underpinning these issues provides a blueprint for examining the acceptance of the health promoting school concept in practice. Even an initial adoption of the health promoting school concept and its development does not necessarily guarantee a long term investment in this innovation. Changes in school personnel can dramatically affect the continuity of initiatives such as the health promoting school. This highlights the importance of initial and in-service education and training for teachers on the concept and its potential as a major health and education innovation. Sustainability of health promoting schools and the concept that underpins them is, of course, closely connected to the capacity building that has taken place within individual institutions. The capacity of individuals and a school to engage in, and sustain, the development of a health promoting school is important. The following case study will help to illuminate some of the theoretical issues raised here and throughout this chapter by providing an insight into practice within one school.

CASE STUDY

This case study of a school in the Republic of Ireland provides an observation of a health promoting school in action. It attempts to highlight manifestations of practice that reflect many of the theoretical issues discussed within this chapter.

Background to the school, management and roles

Secondary School 1 was one of the first ENHPS pilot project schools in the Republic of Ireland. It serves a socially-deprived district of Dublin, which has few recreation facilities for its school-aged population of 3,500 and an unemployment rate that has reached 78 per cent in recent years. The school receives additional support from the Department of Education because of the deprivation.

At the time of this study, the school buildings were modern and well maintained, with clean and tidy toilets, classrooms and staff rooms. There was a meeting room for parents and a large poster in the main entrance hall advertised the latest course on stress management for parents. Examples of pupils' art and project work were displayed in corridors and the teachers' common room was comfortably furnished with armchairs and coffee tables and had its own kitchen area. The school grounds were laid to green fields and covered approximately six acres. The 'backdrop' behind the school consisted of hundreds of white, semi-detached, municipal houses and beyond them the soft flowing hills of the Irish countryside.

The school reflected visually the views expressed by several of its staff – 'a place which is set aside, both environmentally and socially, from the community which it serves'. The contrast between the school and its

surroundings was stark and served as a reminder of the ever-expanding gap between the perceived middle-class status of a school and its staff, and the lower social class values and expectations of the majority of the local community. Teaching staff gave vivid examples of how unemployment and disempowerment in the area had resulted in parents becoming separated socially from their children. The large majority of parents were between thirty and forty years of age and had experienced periods of long-term unemployment. They were unskilled and some were almost illiterate. By contrast, their children were educated and, therefore, employable. This had led to a situation where some parents could see no reason to get up in the morning, leaving their children to get themselves up and out to school with no support whatsoever.

Secondary School 1, in the staff's own words, was a 'tough school to teach in'. Most teachers were in the age range of between twenties and early forties; few were over fifty. 'You have to be fairly lively to teach in a school like this', was one teacher's comment. Turnover of staff at the school was small, however, with those that had gone having left because of promotion. Teachers were referred to by pupils as 'Sir' or 'Miss', and the majority were shown respect by pupils and, in turn, respected them. Not only was morale high but staff respected one another for who they were and what they offered the institution.

School uniform was compulsory. There were uniform checks every morning and staff felt that uniforms were remarkably well kept, with pupils enjoying the sense of order this gave to their lives. In terms of personal, social and health education, the school was the envy of many schools in Ireland, with its senior managers having a national reputation as prominent educationalists. Secondary School 1 exemplifies how an institution can provide a positive, healthy environment that can compensate for what exists outside the school gates. Both the physical and social environment within the school had contributed to the well-being of its pupils and staff and to their functions of learning and teaching within the school.

Social, personal, and health education and citizenship

At the time of this observation, Secondary School 1 had two vice principals, one of whom had been responsible for developing a comprehensive programme of social, personal and health education. She had a reputation throughout the Republic of Ireland for in-service training in this area of education. The school's social education programme had provided the incentive for the school to become one of the pilot health promoting schools within the ENHPS project.

The school's health education policy had become integrated into the Developmental Social Studies programme (DSS). This programme had been formulated to meet the particular needs of local young people, where the high unemployment, an acute local drug abuse problem and a recent rapid

increase in teenage pregnancies had forced staff to make certain modifications to the DSS programme. Health education, incorporating group work, was integrated into the whole programme, in which the development of self-esteem was a core aim. Drug education, education in sexuality, communication skills, nutrition and eating disorders, and exercise and leisure formed key components. A special Drug Task Force had been set up to address the escalating problem of drug and alcohol misuse. The DSS teaching team continually reviewed and monitored the programme and those teaching it in order to ensure relevance to pupils' immediate health and social needs. Sometimes it became necessary to offer new training for revised programmes and re-establish contacts with outside speakers because of new staff and role changes within the school. The vice principal made the point 'there is no such thing as having a permanent and trained team; it's a dynamic situation'.

The school had developed and tested a sex education curriculum which became linked to the relationships and sexuality programme disseminated by the Department of Education. Poor indoor physical education facilities, however, restricted the teaching of the 'exercise and leisure' component at the time of the observation. Plans for a new sports complex were seen as having the potential to provide a great boost to the promotion of physical health within the school.

In the same way, a pastoral care system was integrated across the whole curriculum so that pupils were able to understand that every member of staff in the school was interested in their welfare. One teacher paid tribute to the successful tutorial system that had been established in the school in which each pupil identifies with a personal tutor with whom they spend forty minutes a day and who remains with them right through the school.

Health education is integrated into the DSS as a spiral curriculum taught for eighty minutes a week in years 1 to 3 and provided as one of two options within the Standard Leaving Certificate course, a vocational preparation and training programme and a course for the transition year in years 4 and 5. Thematic weeks are used to emphasise specific topics which involve a cross curricular approach, for example communication skills, good manners.

All staff did not necessarily wish to teach DSS, but every teacher appeared to support the programme in other ways. For example, subject teachers were happy to let the DSS team overlap their timetabled lessons in order to allow workshops run by outside speakers to take place.

The school researched every outside speaker thoroughly as part of the principal's policy. Visiting speakers were told how their session was to fit into the DSS programme and teachers usually remained with classes so that they could follow-up the talk with the pupils at a later date.

This curriculum development had taken place in the school long before national guidelines for social, personal and health education had been introduced in Ireland because of the genuine interest and commitment to SPHE of one of the school's vice principals. The case study demonstrates the

importance of commitment from senior management of schools to the successful establishment and sustainability of a relevant health-enhancing curriculum within a health promoting school. Staff training and preparation were key issues. The curriculum in Secondary School 1 was both dynamic and flexible – dynamic in the sense that it had to be continually reviewed and adapted, and flexible enough to meet the needs of young people and address negative health problems in the local community.

Active links with the local community

Most parents at the school, particularly fathers, initially wanted nothing to do with supporting activities in what they saw as 'an alien place'. However, the vice principal suggested that this situation was changing gradually and reported that 'parents, mostly mothers, were starting to attend meetings. The school had had a great breakthrough with the formation of a parents' Health Promotion Group'.

This group was formed as a result of funding provided by the Department of Education in Ireland to establish a Home–School Liaison Project. Further monies drawn from the Irish health promoting school pilot project had enabled eleven parents, who called themselves the Health Promotion Group, to be trained as facilitators of health promotion. There is little doubt that the success of the Home–School Liaison Project at this school was due to the enthusiasm and commitment of the project co-ordinator, a teacher at the school. She had made remarkable progress in forging links between school, parents and the local community.

The parent group from Secondary School 1 subsequently joined parents from other health promoting pilot schools at a summer school and at special training weekends run by the national co-ordinator of the Irish Network of Health Promoting Schools and staff from the Department of Education. Such had been the motivation of this group of parents that all eleven undertook and successfully completed a participatory learning facilitator course at Maynooth University.

At the time of the observation, the Health Promotion Group had run courses on drug education, assertiveness training and parenting, working with both the sixth form and parents from the local community. They had also been involved in establishing a primary drug prevention programme and a community helpline in a local primary school.

Secondary School 1 provides a good example of a school, its pupils, local community and external agencies working together to capitalise on the inclusive and empowering nature of the health promoting school. While attending an adult literacy course at the school, a parent had learnt about and joined the Health Promotion Group. Eighteen months later that same parent stood before 500 delegates at the First International Conference of the ENHPS in Thessaloniki-Halkidiki, Greece and presented the views of the parents on the health promoting school movement across Europe. Such

is the potential of the health promoting school to empower all who share the common aims of the initiative.

Supportive social and physical environment

The school had introduced an incentive programme to reward and encourage effort and achievement by pupils at all levels. It had also established an educational and behavioural support unit within the school, with the aim of providing a safe, secure environment for behaviourally-disruptive students where they could learn to react differently to individual and group situations. Support for pupils and staff also came from the school chaplain. One member of the DSS team summed-up his support role: '[The chaplain] is a very strong link between school and the community and a mine of information. He lives in the parish and even the toughest students identify with him. He doesn't preach the gospel to pupils, he just treats them like a friend.' The same chaplain had formed a club for troublesome pupils which consisted of the 'most difficult pupil' in each year group. The club met on Friday afternoons when pupils participated in extra-curricular activities such as horse riding, bowling and swimming. It provided a supportive social environment and the kinds of challenges that these pupils enjoyed. It also required self discipline and certain rules of behaviour. The chaplain was well aware and supportive of the health promoting ethos of the school.

The school placed emphasis on creating a positive physical environment. Walls were decorated with examples of pupils' written and art work, playing fields were well-maintained and classrooms were bright and welcoming areas. Visitors remarked on the cleanliness of the school and its well-maintained buildings. Caretakers removed graffiti from walls as soon as it appeared and although they did not appear to fully appreciate that the school was a national pilot health promoting school, they had a very positive relationship with senior management and a clear role within the school. For example, one described why it was so important for them to keep the school clean and free from graffiti: 'It is important the young people from this neighbourhood can experience conditions that are different from what most of them are used to in the neighbourhood, as soon as the walls are marked the school becomes just another dirty building to work and live in! That's why we remove any sign of damage to walls and buildings as soon as possible.'

Secondary School 1 epitomises the concept of the health promoting school. Some might argue that this case study merely highlights a 'good school' and what schools should be striving to achieve as educational institutions. The difference is that the concept of the health promoting school provides a holistic health approach and ecological focus to this challenge. Even within socially deprived areas like this one, health promoting schools have displayed outstanding progress in the development of health-promoting and learning-enhancing environments.

Conclusion

The success of the health promoting school and health promotion in schools is affected by the power of the messages and their acceptance locally, nationally and internationally. The national context has numerous components which can be constraining or enabling. Undoubtedly, the school and its immediate environment are where health is experienced and promoted. This chapter has pinpointed the need for clarity and a shared vision of what the health promoting or healthy school is attempting to epitomise and provide. There is no place for confusion or ambiguity if the concepts underpinning the health promoting school are to signal a serious movement to manage change in schools effectively. Such change is not only driven by a quest for better health but for schools that will better enable young people and their mentors to maximise their true potential as human beings. With this goal in mind it is appropriate to move on to consider the political, policy and strategic issues that currently fuel the development of health promoting schools.

3 Politics, policies and the health promoting school

Introduction

Chapters 6, 7, and 8 explore the capacity of schools to meet the demands for change; the present chapter addresses a source of those demands, *policy*. Policies for schools can be initiated at many levels: government, local authority or school. They can originate from a variety of sources: administrators, teachers, parents and, on rare occasions, children. Whatever their source, most are probably formulated with the intention of bringing about change. Since the mid 1980s, there has been an increase in policy writing for schools by central and local government departments and a corresponding rise in the number of policies that schools are required to have in place.

This chapter examines the place of policy as a force in the development of school health promotion. After defining the term 'policy', the chapter considers a number of theoretical perspectives for explaining and analysing the policy-making process. Conflicting values and changes in the ideology of education and health are explored with respect to their impact on school health promotion. Selected examples from the field of school health are used to illustrate how there may be a mismatch between the intended aims of a policy and its implementation. The second part of the chapter considers the importance of policy formulated at the level of the school in the development of health education and the health promoting school. Trends in written policy and other management and organisational features of schools are reviewed to cast light on the awareness of schools of the concept of the health promoting school and its processes.

Policy

There is no agreed definition for the term 'policy'. As many as eight working definitions are in use, which indicates the difficulty that academics have in encapsulating the meaning of the term (Guba, 1984). At its simplest level, 'policy' means 'plan of action', its roots originating from the Greek and Latin words for government and citizenship (Crump, 1993). In his seminal work on policy and the policy-making process, David Easton describes

policy as a 'web of decisions and actions . . . that allocate values (Easton, 1953)'. The term 'values' is used in Easton's definition in the broadest sense to mean all the rewards that can be bestowed, or withheld, by those in positions of authority. This raises the issue of power and control in policy making.

Easton stresses that a decision is not sufficient to constitute a policy. Indeed, a mismatch may exist between what the policy makers intend to happen and what actually happens. Equal opportunities policies, for example, are often criticised for being a 'paper exercise', creating the illusion that something is being done, whilst, in reality, the reverse is true (Cosin, 1986). Similarly, although governing bodies have been required by law to formulate sex education policies for their schools, some have failed to discharge their duties (Green, 1994, 1997). Gaps like these demonstrate the importance of considering how policies are put into effect as well as their content and how they are made.

Policy is the result of a complex series of decisions, not just a single decision. In the case of the health promoting school, which cuts across government departments as a concern, the 'web of decisions' is even more complex. To avoid policy emerging as fragmented and contradictory, and the risk of it being abandoned, good communication is essential. The DES's ten-point plan for health education, announced to Parliament in 1989, failed to be implemented because it was superseded by the high-profile national public health strategy for England, the Health of the Nation (DoH, 1992). The strategy identified the school as a key setting for the achievement of targets in disease reduction but failed to specify how they could make a contribution. This represented a missed opportunity in raising awareness among health service managers of the health promoting school and the scope of its actions.

A further important observation is that the people involved in formulating policies are not usually the people who will be responsible for their implementation. It has been argued, for example, that the difficulties experienced in the implementation of the 1988 Education Reform Act, in England and Wales, which channelled so much effort away from health education, stemmed, in part at least, from the failure to consult with teacher practitioners (Fletcher, 1994). More specifically, the concept of the health promoting school, described in Chapter 2, was formulated by national and international bodies and not by those ultimately responsible for putting the principles into practice – the teachers themselves. This raises important issues concerning ownership and the building of commitment to the policy implementation process.

This is not to suggest, however, that teachers are totally powerless in the national policy arena. As implementers of policy they can exploit the gaps and contradictions that exist in policy to better meet the needs of their schools and communities (Crump, 1992). They can, of course, also subvert it. We have already seen in Chapter 1 an extreme example of the room that teachers have to manoeuvre in influencing policy. The health promoting

school was not on the national policy agenda in the late 1980s to early 1990s, yet the absence of policy did not prevent teachers and local health-promotion practitioners from investing resources and effort in development work in the area.

It is also important to acknowledge that policies can change in light of feedback and pressure. As previously stated in Chapter 1, the National Healthy School Standard (NHSS) started its life as a very different project. It was based on an award-bearing structure, the appropriateness and lack of practicality of which raised concerns among health promotion practitioners. These concerns were addressed and the project structure was modified to meet them.

The fluid nature of policy is also exemplified by the current position of PSHE, formerly PSE, in national policy. Despite including aims related to personal and social development that must be reflected in the curriculum of all pupils, the 1988 Education Act made no reference to PSE, and health education was only mentioned in relation to Biology. In response to pressure from outside bodies, the National Curriculum Council eventually included PSE as a 'dimension' and health education as a cross-curriculum 'theme' (NCC, 1990b). Neither measure accorded the two subjects the necessary status to maintain their foothold in the curriculum, but nevertheless their importance received some degree of recognition. It is interesting, given this background, that a working party was set up by the Labour Government to produce a new curriculum framework for PSHE and Citizenship (QCA, 2000). The working party was separate to that which was considering the way forward in the health promoting school. This is surprising given that, as the previous chapters have highlighted, PSHE is not only an important component of the health promoting school but is the foundation of it. It remains to be seen if policy will be 'joined up' sufficiently for it to be integrated into the health promoting school in a seamless way.

The above observations point to the importance of taking a bottom-up perspective as well as a top-down perspective in policy analysis. They also highlight the need to consider how policies are put into effect alongside a consideration of their content and how they are made. Bowe and colleagues propose a useful structure for policy analysis which takes into account the different levels, from formulation to implementation. These are: the policy that the various interest groups want, or intended policy; the actual written report, document or legislation; and the reaction to the policy by schools and local authorities (Bowe, Ball and Gold, 1990). Policy will be in a constant state of flux, with decisions taken at the various levels and fed back into the policy-making process, shaping policy along the way.

The policy-making process

Theories of policy making represent polarised positions on the process of policy making. According to the 'rational' model of policy making, policy

makers work systematically through clearly defined stages in the policy process. They start by identifying the problem, then move on to the development and appraisal of options, and finally to decision making and evaluation (Jones, 1997). Opponents of this model argue that in most cases it is not possible to take a logical and sequential approach. The reason is that policies do not generally deal with single issues in isolation but are more likely to tackle multiple issues and build on other policies already in place. Pressures emanating from political imperatives or ideological considerations may affect the process and determine the options chosen and those cast aside. Powerful vested interests and organisational barriers can also create barriers against successful implementation. It seems therefore that governments have power to set agendas through policy but they are constrained by political pressures and the complex nature of the policy making process itself.

These difficulties give rise to policy making that is disjointed, a phenomenon which Lindblom calls incrementalism, although, as the above account suggests, is much more complex (Lindblom, 1975). For illustration, we turn again to sex education, a topic that represents a rich example for policy study in non-rational policy making. Governors were given powers, in 1987, to exclude sex education from the curriculum, despite HMI considering it a crucial element. To compound the confusion that followed this policy measure, teaching about HIV and AIDS was included in Science, a mandatory subject, only to be removed under the new arrangements introduced by the 1993 Education Act. The situation, since 1994, is that sex education is discretionary in maintained primary schools but compulsory in secondary schools, with all parents having the right, by law, to withdraw their children from lessons. In the past these seemingly irrational and conflicting policies have denied children access to crucial information on how to safeguard their health, as specified by the United Nations Charter on the Rights of the Child (Defence for Children International and UNICEF, 1989) and in all probability damaged locally sensitive arrangements negotiated with parents to meet their wishes on the provision of sex education. The effect of these policies has been to generate widespread confusion, both within schools and local education authorities, on the place of sex education in the national curriculum, and high levels of anxiety concerning the teaching of the topic (Sex Education Forum, 1992). The publication of new guidance in July 2000 (DfEE, 2000) is likely to clarify the situation with regard to sex education and reduce these anxieties.

Influencing the policy-making process

Power and control are important considerations in the policy making process. In the UK the central policy making machinery is the political system, with ministers, the Cabinet, Parliament and civil servants at the core of the policy-making community (Ham, 1993). Jones' overview of access and influence in policy making highlights two generalisations. The

'pluralist' view maintains that there is freedom of access for those seeking to influence the process. Thus, although some groups are located outside the central policy making community, they have some power in making and changing agendas. This is certainly true of some pressure groups in health promotion, which have been very effective in getting their voices heard. Organisations such as the Society of Health Education and Promotion Specialists (SHEPS) have lobbied the Government on issues such as the need to address inequities in health and have striven to be represented at debates so that the views of their professional members are fed into policy on public health and health promotion functions. SHEPS has taken steps to raise awareness of the settings approach in health promotion, which was in danger of being lost in the reorganisation of health promotion from centralised structures within districts to community level.

It is also important to consider the position of international bodies such as WHO and UNICEF, which have a high status but low power in influencing national governments in policy making. Nevertheless, as we have seen in Chapters 1 and 2, they can, over time, considerably influence the ideologies underpinning policy and practice. Through the Ottawa and Jakarta resolutions, WHO has set challenging goals for health promotion and legitimised holistic definitions of health. The Thessaloniki resolution on the health promoting school is expressed in strong language as aspirational, high ideals with the notions of democracy, equity and empowerment central goals of the movement (WHO, 1998c, p. 35). However, the fate of these ideas relies on assent, the co-operation of national and local disseminators and implementers and, ultimately, on national resources.

Diametrically opposed to the pluralist view is the 'conflict' view of policy making. This perspective maintains that there is an imbalance in access to the policy making process with some groups lacking the opportunity or the wherewithal to make a contribution. Depressingly, the group that is often excluded from providing an input into policy, even in matters directly relevant to it, is that of children and young people.

In addition to those on the fringes of the policy-making community, we must also consider the potent influence of those on the inside of the policy making community. Politicians may take up office with particular interests and agendas they want to pursue. They may be susceptible to public and media pressures or possess certain values that influence the policy demands and decisions they make. The lack of coherent policy making in sex education described above has been ascribed to the values and prejudices of politicians, brought to the fore by sensationalist press coverage accusing schools of morally corrupting their pupils (Stears and Clift, 1995). Civil servants, a group thought to have extensive influence and powers in the policy making arena, can also place demands on the system. Moreover, decisions may be taken ostensibly to rationalise the structures and functions of organisations, whereas the real reason for introducing change is to curtail their growing influence and power. This was the case in the demise of the HEC, a

QUANGO, which was disbanded in 1986 – officially to better manage the growing crisis in HIV and AIDS, but in reality to curtail its radicalism. It became deeply involved in the political debate on the need to tackle health inequities, which had been resisted by the Government since its initiation by Sir Douglas Black in 1980.

Little is known about how policy decisions are actually made as governments are imbued with secrecy. One account of the evolution of education policy in the 1980s and 1990s suggests a picture of power struggles and compromises among politicians, bureaucrats and working groups (Timmins, 1995). Biographies and interviews provide useful insights but these are usually published some years after key informants have left office, probably to avoid the possible ramifications of their disclosures. School health education and the health promoting school are not rich in knowledge in this area and existing analyses are largely confined to the content of policies as opposed to the processes by which they are formulated.

We now turn from the above exploration of theory and brief illustrative examples to an in-depth case study, that of national policy in the health promoting school in England.

Policy in health education and the health promoting school in England

By far the greatest influence, in the United Kingdom, on the development of school health education, the 'building block' of the health promoting school, has been the change in the ideology of education since the early 1990s. To understand the present status of the subject, it is useful to compare two quite distinct periods in its history: the 1970s and the 1980s. As stated in Chapter 1, the former is viewed by policy analysts as the 'golden age' and the latter the era of marginalisation and erosion in the recent history of health education (Lewis, 1993).

In the 1960s and 1970s, education was firmly rooted in the ideologies of egalitarianism, progressivism, democracy and social engineering (Ball, 1990). A manifestation of these ideologies was the trend towards the inclusion of social subjects in the curriculum. Policies across the government departments of education, health and welfare were consistent in stressing the importance of school health education, the inclusion of such a subject in the curriculum and the use of appropriate and effective teaching methods (McCafferty, 1979). Teachers enjoyed a considerable degree of autonomy and the relationship between teachers, local education authorities and the former DES was, at least in comparison with the 1990s, a partnership (Boaden, 1986). The overall effect on health education was a considerable growth in the quality and quantity of provision (Whitehead, 1989).

In the 1980s, the drive to cut public spending and a concern for raising educational standards gained momentum, fuelled by the debate, driven by the 'New Right', on the purpose of education and the structure and function

of schools (Quicke, 1989). These pressures culminated in the Education Reform Act of 1988, which led to the imposition of radical changes on schools. These changes were: the delegation of financial budgets to schools; open enrolment; new powers for school managers; greater powers for parents; a centralised curriculum with formal assessments, staff appraisals and regular school inspections. A policy of persistent government intervention, coupled with an increase in centralised decision making, enabled these changes to be realised, whilst simultaneously eroding the autonomy of teachers and local education authorities (Boaden, 1986; Fletcher, 1994). The cumulative effect of these forceful policy shifts has been a total change in the culture of schools (Crump, 1992).

The decline of health education during this period can be attributed to a number of factors, the most significant of which was the marginalisation of health education in the curriculum. The curriculum that emerged in the wake of the Education Reform Act was highly prescribed, overcrowded and academic. Health education was not identified as a subject worthy of its own niche but was relegated to the status of a cross curriculum theme. Adding to the diminishing status of the subject was the lack of intertextuality between policies. Policy for health education was labelled as 'guidance' as opposed to 'statutory orders' (NCC, 1990). Still the only official document in place to which schools can refer, *Curriculum Guidance 5: Health Education* uses language that is less formal and more discursive than that of the statutory orders. This may convey the message to teachers that the subject holds less priority for schools. It also concentrates heavily on individual lifestyle factors, is ambiguous in its objectives and overemphasises awareness raising at the expense of skill and attitude development (CEDC, 1990). The limited perspective of health education that this represents has been compounded by OFSTED's remit for the inspection of PSHE (OFSTED, 1995). Although the inclusion of PSHE in the brief of OFSTED was a positive development, the criterion of assessment is limited to a spiral curriculum with a focus on knowledge gain.

In their analysis of the position of social subjects within the national curriculum, Stears and Clift (1995) accuse the governments of the 1980s and 1990s of actively pursuing a strategy intended to weaken the position of the subjects, by both sidelining them and reducing the critical social perspective of the national curriculum. Given that the opportunity to rectify the situation was not grasped in the recommendations of Dearing (1993), which proposed a reduction in the prescribed curriculum, it was concluded by many observers in the field that health education held little value for key decision-makers. In suggesting possible uses that could be made of the extra curriculum time gained, the Dearing report only mentioned sex education and omitted health education completely from its recommendations.

Further barriers to the development of the subject were presented by a reduction in the training budgets for schools and the prioritisation of national curriculum subjects. In the absence of adequate provisions at initial

teacher training level, in-service training remained the only mechanism by which knowledge and skill development could be fostered among professionals, yet this too was placed under threat.

Health education has a longer history than the health promoting school; therefore the effect of the changing ideologies on provision is easier to discern. Timetabled provision for the subject was squeezed and teachers experienced difficulties in gaining release to attend in-service training events, a problem that continues to this day (NFER 1993; Denman *et al.*, 1999). Some progress was made in orientating practice towards the concept of the health promoting school but not in the area of school, parent and community links. Again, the prevailing educational ideology may have played a part, as the roles of parents as consumers of education and partners in education are, in effect, contradictory.

It is also important to consider, in this example, how policy can directly and indirectly influence provision and how the effect of diminishing political support in education has shifted interest and responsibility to the health sector. The level of support provided for schools within localities is known to have varied across the country. Little is known about how the health service priorities and approaches have affected the pace and nature of development of the health promoting school but it is likely that the lack of synchronicity between the two will have had an impact (St Leger, 1999).

The National Healthy School Standard

Turning to the present, the health promoting school, or the healthy school as the Government prefers to call it, is now strongly reflected in policy and has dedicated resources to support its development. The National Healthy School Standard (NHSS) has already been referred to in Chapters 1 and 2, but its importance in present policy is such that it merits further consideration. In essence, it represents a remarkable turnaround in political commitment and has involved the taking of extraordinary measures in an attempt to mainstream school health promotion, a feat which has not been managed in the past. To achieve better integration, at least on an ideological level, the NHSS has taken on the mantle of mainstream concerns in school; quality standards, assessment, and targets, all of which continue to persist in educational policy.

In direct contrast with the bottom up or empowerment models adopted by local projects in the past, a compliance model of project delivery has been adopted. Various incentives and pressures are brought to bear at the local level for the implementation of the national agenda and to control the speed of implementation. Thus, for example, to promote partnerships, the accessing of funds is dependent on the requirement that joint project proposals are prepared by LEAs and Departments of Public Health. To achieve accredited status, local projects have to demonstrate that they have achieved specified quality standards in the way in which they operate. Similarly, schools are

required to work to standards, identified in action plans and prioritised to meet their needs, as such in keeping with the development planning culture prevalent in schools today.

Assessors then decide, on the basis of the evidence available, whether or not the local project or school has succeeded or failed. The principal questions surrounding the health promoting school now are how it can contribute to an effective learning environment and, indeed, how it correlates with the effective school movement (Hopkins, 1995). Interestingly, the term 'healthy school' implies that there is an absolute healthy state that can be achieved by schools. This contrasts with the term 'health promoting school', which implies a dynamic state and process orientated goals.

Even allowing for the consultation mechanisms built in at school, local and national levels, the project delivery in the NHSS is essentially based on a model of compliance and as such contradicts the notion of empowerment, which is a central goal in the health promoting school. It has to be acknowledged, however, that the NHSS has served to successfully spread project activity across the country and brought the idea of the health promoting school into the consciousness of politicians and professionals, if not yet parents and children. It has also placed demands on local projects to reach all schools – a considerable challenge given that traditionally many projects have not targeted schools but have operated a system of working with interested schools. To observers, the tension is between the extent to which a national agenda can be steered for progress and change, and the degree to which the principles of the health promoting school can be adhered to at a local level by accommodating the processes needed to build ownership and commitment.

More generally, seed changes in education and health policies are also providing new opportunities and challenges for projects, schools and their communities. After many years of political disregard for the need to tackle health inequities, the priority now is to tackle disadvantage on all fronts. Communities have been designated as Education Action Zones (EAZ) and Health Action Zones (HAZ) to channel resources to the communities in greatest need. In parallel with these developments in policy is the major shift towards giving strategic responsibility for health improvement to primary-care professionals, thus bringing national public health strategy closer to the principles of the Ottawa Charter.

These policies have implications for the development work of schools and projects. The focus now is the *community,* and interventions will have to look beyond artificial service boundaries and to creative solutions in bringing about health improvement. The school represents one opportunity among many for achieving objectives, and its contribution will have to be harnessed in a co-ordinated approach to practice. Evaluation will be a considerable challenge as multiple interventions will be running in communities, the effects of which will be difficult, if not impossible, to separate. Knowledge and skills are thus needed in small area evaluations using methods such as

action research, which does not involve the academic separation of research and development. Part 2 of the book will examine these issues in greater detail. The emphasis on the role of primary care will require capacity building, with primary care professionals developing new understandings, skills and partnerships to meet the health promotion agenda of their communities. An important target group will be that of children and young people and a key setting for achieving the strategy will be the school.

An ambitious public health agenda based on the priority of tackling social exclusion requires a reorientation in the way in which we tackle health improvement with social, as opposed to individual, approaches to interventions pointing to the most promising ways forward. Major research is currently underway into the construct of social capital and its relationship with health (Ford, 1999). Social capital is the collective social resources to which the family, neighbourhood or community has access (Gillies, 1999). People in communities with high levels of social capital are more likely to experience good health than those in which levels are low (Cooper *et al.*, 1993). Most schools are in the heart, at least geographically, of the communities they serve. The concept of the health promoting school, with its notions of empowerment and community, places the school in a key role in building social capital. This is an area of research and development that requires further exploration, particularly as the element of the concept pertaining to community is the least well defined and most likely to be illusory in practice.

Policies formulated by schools

We now turn from the pivotal role of governmental policy in determining the pace of school health education to policies initiated by schools themselves. Policies formulated at the level of the school are highlighted, by the literature on school effectiveness and school improvement, as essential components of strategies seeking to improve educational performance (Sammons, 1994; Rutter *et al.*, 1979; Mortimore *et al.*, 1998). Such policies can help to match practice with aims, contribute to more effective co-ordination and provide a means of sharing information (Hargreaves and Hopkins, 1991). They can be especially important in matters concerning whole-school issues, which require the building of consensus and commitment (Boyd, 1985). The health promoting school presents a particularly strong case for policy formulation. Here, a policy can help to specify the rights and responsibilities of children, school staff, parents and the wider community. It can also raise awareness and boost the credibility of the concept of the health promoting school (Griffiths, 1991).

The absence of a policy in a particular area of school life does necessarily mean that a school will be totally inactive in that area. In health education, for example, schools without a policy have been found to provide teaching in the subject, but provision is likely to be haphazard and left to the discretion

of individual teachers (HEA, 1989). Conversely, schools with health education policies are more likely to structure and monitor their courses (HEA, 1989; Denman *et al*., 1999), use their resources and training opportunities more effectively and achieve co-ordination in their activities (HEA, 1989). Written policies have also been shown to contribute to the quality of interventions seeking to develop the health promoting school (McBride *et al*., 1995; NFER,1998; Moon *et al*., 1999a). Although the above findings clearly point to the beneficial effects of policy, an association between written policies and health outcomes has yet to be found.

Policy consultation

Policies formulated by schools are as likely to founder as those originated by outside agencies. Incorporating consultation in the policy making process can minimise the risk of failure. Although time consuming, consultation is essential in building common understandings, a shared vision and commitment to the implementation process (Newton and Tarrant, 1992).

With the exception of sex education, schools in the UK are not required by law to formulate policies in health-related matters. Nevertheless the importance of policy in the development of the health promoting school has been given new impetus by the NHSS (DfEE, 1999a). The NHSS requires policy formulation and consultation at all levels. With regard to school it specifies that:

- the school develops all policies in line with legal requirements and non-statutory guidance;
- the school has established mechanisms for involving the whole school community in policy development and implementation;
- the roles and responsibilities of the whole school community are clearly defined in all policies.

Pockets of enlightened good practice exist in the way in which schools and local projects engage in consultation, two examples of which follow. Orchard Primary School launched its membership of the Leicestershire Healthy School Award Scheme with a survey of parents to gauge the priorities of parents in the work of the school. A healthy school working group was convened, which includes representation by parents, pupils and non-teaching staff. The working group oversaw the production of a folder containing the evidence of the school's activities in the areas of community links, policy, curriculum and ethos, thus reflecting the full breadth of activities undertaken in improving its health promoting status. The school's action plan mirrored the further development of these concerns. The school newsletter and the annual governors' report are used to inform all children and parents of initiatives undertaken in the health promoting school and to keep its profile high.

A major opportunity for pupil involvement within the school arose by the creation of the schools' Eco Committee, which actively involves pupil representatives from each year group to take forward initiatives to improve the school environment. The Eco Committee has been behind several improvements to the school grounds including the building of a pagoda to create a shaded area in the playground, the decoration of which all pupils contributed to by painting stones. The most notable achievement of the Eco Committee is the creation of a wildlife garden. All the children within the school were encouraged to put forward their designs for the garden. A final plan, incorporating their ideas, was developed with the help of a representative from Environ, an outside agency which assists schools in improving their grounds. The plan was then used to create the garden with the help of staff, parents and pupils. Recycling is also a major priority area in policy. The Eco Committee has produced signs for the recycling bins that are located in the grounds of the school. The caretaker has worked closely with the teachers and children to organise systems for the storage and collection of recyclable materials.

At project level, the Derbyshire Health Promoting School Award provides a case study of good practice in partnership work, involving the health and education authorities. Teachers, school nurses and young people are consulted on the development of the award. There is a long standing tradition of involving teachers at project steering group level. School nurses are identified as the key point of contact for schools and are involved in school recruitment and support. Their support work commences with a review of their schools' action plans and identification of priorities. Subsequently, they help schools in meeting their objectives, and assess their progress. Training is provided for the school nurses to undertake this work. Once they have acquired skills, they, in turn, run workshops at the Award events and conferences attended by young people, teachers and other partner agencies.

The Derbyshire project has also run successful consultation days for children and young people to elicit their ideas on how the project can develop. Teacher mentors from schools already involved in the Award help in the recruitment of new schools. Similarly, the nurses already trained and using skills to promote the adoption of the healthy school approach are involved in encouraging their colleagues to participate. Using these cascade and peer support methods the Award has built up strong partnerships, commitment and sense of ownership of the initiative at the local level.

Research on school policy in health

Research on school initiated policies has a recent history, just over ten years in the UK. A number of factors pose serious challenges for research in this area. The term 'policy' is often confused, by practitioners, with the terms 'goals', 'needs', 'objectives' and 'procedures', all of which can be explicit or implicit in policy (Caldwell and Spinks, 1988). Policy is also often used

interchangeably with 'development plan'. The latter involves the specification, often on a yearly basis, of priorities for development and detailed plans to achieve those priorities (Hopkins, 1994). This is distinct from policy, which is essentially a general statement of intent and which, depending on the educational issue under consideration, can provide the framework for development planning. Differences in interpretation will lead to marked variations in the content and detail of policies formulated by schools. These differences are further magnified by the unique needs of schools and the degree to which they adopt external policies, with little or no modification.

The second area to pose a challenge for policy research relates to the evolving nature of school health from a narrow concept centring on the health education curriculum to the wider concept of the health promoting school. This widening in scope has increased the potential number of policy issues for consideration in policy research to such an extent that a selection is needed to make the task manageable. Schools also vary greatly in the extent to which they cover health issues with separate policies or opt for an all encompassing policy. These factors make it difficult to establish trends in policy.

There is no model health promoting school policy. Projects that have sought to guide policy development, implementation and review have attempted to delineate the main content areas that could be expected to appear in such a document, whilst acknowledging the flexibility needed to account for the differences between schools and their communities. Table 3.1 shows a framework derived from a selection of these projects (TACADE, 1996; Joyce and Binstead, 1989; Griffiths, 1991). This is not to suggest that policies should always be lengthy documents. They can be powerful if reduced to easily remembered statements or rules. Whatever their depth and complexity, it is important that they are not confined to a shelf to gather dust but are in use, guiding and improving practice.

The third factor to consider is that the policy making process is not composed of discrete stages. It is possible to distinguish between schools

Table 3.1 Components of a health promoting school policy

Health needs of the school
Description of the policy formulation and consultation process
Aims and objectives of the health promoting school
Content and organisation of the school's health education programme
School ethos and the physical environment
Partnerships with parents and the wider community
Dissemination of the policy
Procedures for reviewing policy and practice
Key advisers and documents consulted

planning to write a policy, revising an existing one and at the stage of developing a new one. However, even this expansion of groupings has been found to be insufficient as, in reality, the boundaries between these stages can often be blurred (Jamison, 1993).

Notwithstanding the problems posed by definitions and the dynamic nature of policy development, the study of policy can provide invaluable insights into the management and organisation of school health promotion and the extent to which schools are aware of the broad concept of the health promoting school. Such data can be used by advocates of school health in strategic planning and the targeting of resources.

Structured surveys that have employed questionnaire tools with predetermined codeable items have had the advantage of enabling the content of policies to be subjected to systematic analysis but do not reveal the detail or quality of individual policies. Complementary qualitative methods are needed to ascertain the quality of policies as some school policies offer little more than accounts of existing practice (Green, 1994, 1997). To detect a mismatch between policy content and the implementation of policy, as previously highlighted, it is essential to include a scrutiny of practice in the enquiry. The inclusion of development plans in research will help to identify the school's priority areas for development and the place of the health promoting school in those priorities.

Surveys conducted over the past ten years have shown that secondary schools are much more likely to possess a written policy for health education and health promotion than primary schools. Within the primary sector, smaller primaries are the least likely to have policies in place. Across all school types the presence of a named teacher in charge is associated with the existence of a policy but, interestingly, it is not always the teacher in charge of health education who drafts the document. Teachers are the most common group to be consulted in policy, with non-teaching staff rarely involved in the process. Parents and children are the least likely groups to be involved, even in those schools reporting the active development of their health promoting status (HEA, 1989; NFER, 1993; Denman *et al*., 1999).

Finally, given that we have argued that policies have an important role in the development of the health promoting school, it is useful to consider the influences that prompt schools to embark on formulating them. Schools appear to be prompted by a wide range of factors, of which national policy is but one. Primary schools, particularly those in middle class areas, are more likely to report responding to pressure from parents and governors but, as noted above, this does not extend to an active involvement in the policy process itself (NFER, 1993).

In summary, policy is a complex web of decisions, which can be subverted, amended, ignored or changed down the line towards implementation. It is always in a state of flux, vulnerable to the waxing and waning support of powerful influences as exemplified by the development of the health promoting school. Policy needs to be morally legitimated, politically

supported and materially enabled. The contribution of policy to the development of the health promoting school lies as much in the opportunities presented by processes of consultation in empowering individuals and groups, as in the framework it provides for guiding practice. Research in this area is complex but provides useful opportunities for gauging progress towards the ideology of the health promoting school.

4 Examining the evidence base for the health promoting school

Introduction

Evaluating the health promoting school (HPS) and its effectiveness is crucial to its future development and sustainability. The research needs to be sound, relevant, to respond to the full array of elements that constitute the HPS, and to satisfy the criterion of utility. An examination of a range of research into the HPS reveals a variety of methodologies, focuses and decisions about what are to count as 'results'. It is instructive to consider the research within a hierarchy of evidence in terms of the certainty it can be expected to give: about an initiative being the cause of change; about whether the results can be generalised (i.e. confirming that it will bring about the changes elsewhere); about whether it responds to the complexity of a holistic development like the HPS; and whether it is useful and informative to those working in the field.

The first part of this chapter explores the polarised debates between the biomedical positivist and the humanistic social scientist. It looks for a way beyond the paradigm war to present a continuum of research approaches and a continuum of HPS goals. The chapter continues with a discussion of the outcomes of focused approaches and examines the arguments for the place of process studies. It also examines a range of research studies in order to illustrate the evidence base for health promotion, considers the kinds of studies that are both feasible and useful for policy makers and professionals, and proposes approaches deemed most usefully provocative and cost-effective. It concludes with advice on research and evaluation of the HPS.

Hierarchies of research approaches, focuses and evidence

The physical science methodologies, positivist, empiricist approaches and experiments have a simplicity of purpose and can communicate hypothesis-testing results. Interpretative studies examining processes, decision making and contexts respond to the diversity of settings and purposes but report less definitively. The order within a hierarchy of evidence can have more to do

with the power of professional sub groups to define what is more and what is less important than with 'science' or utility. There is a dynamic and a tension evident in debates about paradigms, models and methods, and movement in the credibility given to evidence at the different levels in the hierarchy. Figure 4.1 is an extension of the model produced by Long (1998) and presents an ordered framework from the most to least positivist approaches.

Levels 1–4 in the hierarchy are those that approximate to the experimental method. Levels 5–8 are more interpretative and often qualitative in nature. Levels 9–10 are more exploratory and speculative approaches. The hierarchy exists only in the sense of moving further and further from a highly simplified but captivating notion of physical science. The top of the hierarchy is also concerned with raw causality, rather than understanding, and for this purpose the hierarchy is sound. However, approaches at the top of the hierarchy apply to research into HPS only partially and only for particular elements of a complex set of interventions and outcomes. This may include smoking reduction, exercise or diet initiatives.

While a properly designed RCT at the top of the hierarchy, applied to the right sort of area, will give sound evidence about whether an intervention has or has not led to an improved outcome, approximations to the RCT (2, 3 and 4) will always be compromised and deficient. It is the randomisation that is so important to this design. A comparison group of some sort is

1 – Properly-designed randomised controlled trials – RCTs

2 – Well-designed controlled trials without randomisation

3 – Well-designed cohort or case control analytical studies

4 – Comparisons between times or places with or without the intervention

5 – Opinions of respected authorities based on clinical experience, descriptive studies or reports of expert committees

6 – Surveys of experience, perception and reported impact

7 – Self-report through structured inteviews, semi-structured interviews and questionnaires; action research

8 – Observation of practice; case studies

9 – Life histories

10 – 'Fictional' accounts composed from scattered and relatively unsystematised information

Figure 4.1 HPS hierarchy of evidence (based on Long, 1998)

better than none, provided the reader is aware of the quality and reliability of the research design.

Other approaches are more theory-oriented and sensitive to the nature and quality of the implementation. Such approaches (5–10) can provide insights, offer explanations of causality and communicate well to practitioners and policy makers. The obvious way forward is to use several methods – and this is what Chapter 5 will advocate.

Figure 4.2 sets out another hierarchy, that of HP goals and processes, with the more amorphous and challenging at the bottom of the pyramid and the specific, obvious and measurable at the top. The pinnacle is marked by those rare opportunities to design studies of an experimental kind which will determine whether particular teaching inputs result in the intended knowledge gain, attitudinal states and those ultimate triumphs, behaviour change and better health.

The two hierarchies roughly correspond with each other; those who have a view of health promotion that is associated with narrow goals will see greatest importance attached to the top of the hierarchy of evidence. Those who see health promotion as a broad and system-wide set of interventions will have an affinity with the methods further down the hierarchy in Figure 4.1. Theory and experience indicate strongly that acceptance of, and domination by, either of these hierarchies is not a fruitful way forward in health

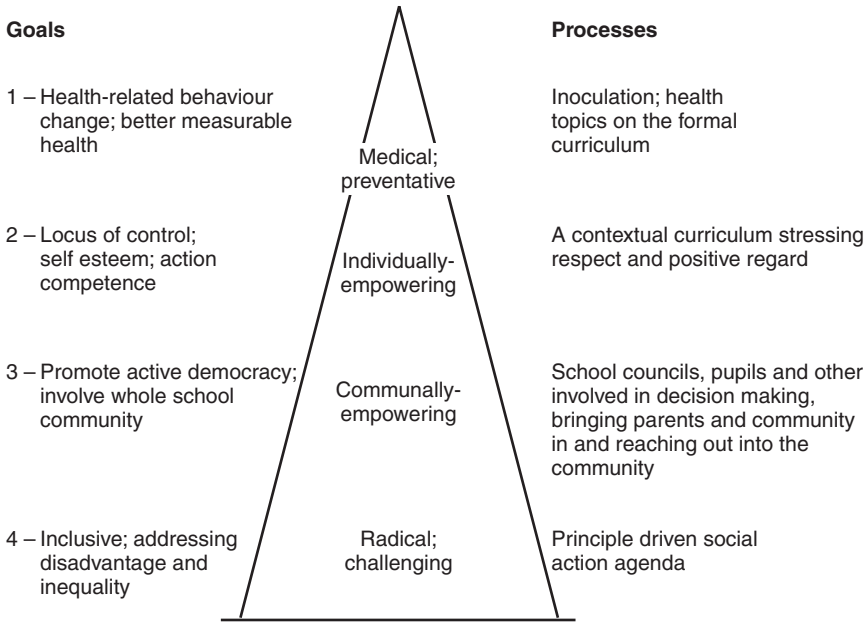


Figure 4.2 HPS hierarchy of goals and processes

promotion or its evaluation. Chapters 1 and 2 have demonstrated the state of knowledge and thinking about health promotion and Chapter 3 has pointed to policies, how they are made and the extent to which expert or informed voices are heard in that process. It is clear from these chapters that the HPS is a complex innovation even if national policy makers may want simple biomedical data showing improvement. Descending the pyramid in Figure 4.2 invites more qualitative research and attention to such natural experiments as may occur. Many valuable studies focus on the context, inputs and processes of the HPS by gathering perceptions, observing, and bringing together other reports, tests or evidence on performance or outcomes.

Public services, as well as private business, need to be evaluated and quality assured. It is necessary to make sure that the best is being done within cost limits and that mistakes are avoided. It is important to ensure that blind alleys are not pursued and that waste does not result through poorly informed policy and practice. The evaluation needs to aspire to appropriate high levels of scientific design which suit the nature and goals of the phenomenon under study. The challenge is to ensure that the approaches chosen are appropriate to the complexity and aspirations of the interventions. Health promotion operates in an environment where evidence based practice is called for. When implemented methodically, as in illustrations in Perkins *et al*. (1999), research and evaluation styles and findings can function as a support in the development, elaboration and dissemination of the health promoting school.

Outcome focuses in health promotion evaluation

Practice in the full range of professions should be informed by evidence. For health promotion this means examining contexts, practices, projects, interventions and outcomes. The focus of evaluation effort should be spread across the full panorama of interventions made to achieve the desired healthy outcomes, however widely these are defined. Oakley (1998), Peersman *et al*. (1999) and Fitz-Gibbon (1999) demand that there is a significant focus upon outcomes and that studies informing practice need to be as well structured as possible. For these authors, this means Randomised Control Trials (RCTs) where this is possible. The gold standard is, indeed, the RCT where, from a sufficiently large sample, schools or individuals are allocated by random methods to either the experimental or the control group. 'Evaluating an intervention by comparing outcomes for a group of people who receive it and one or more similar groups of people who do not, offers the most reliable way of identifying intervention effects' (Oakley, 1998, p. 73). The challenge is to locate those sorts of studies for which experimental research is most appropriate. Sadly these are few in educational research and still fewer in the complex, multi-disciplinary environment of the HPS. While the gold standard is to be respected, researchers must recognise its limitations.

Oakley is scornful of what she sees as a rejection of quantitative methods by social scientists in favour of 'interpretative' methods. She perceives 'a battle' between social scientists aligning themselves with 'democratic' values opposed to the authoritarianism of experimentalists. Whilst advocating 'demilitarisation', Oakley compounds the unpleasantness by promulgating the views expressed by Ebrahim and Davey Smith (1997) that the anti-experimentation position may have more to do with establishing professional identity than with science or understanding and later pointing out that good studies of HP interventions find few examples of significant levels of effectiveness in terms of outcome measures. Both these factors, it is said, motivate health promoters to take up the qualitative approaches. The counter-argument can be made about the advocates of RCTs seeking professional advancement, individually and collectively, by promoting their approach!

Professional in-fighting aside, the problems with the positivist, outcome measurement studies outside carefully-controlled environments are many. Key questions with regard to the generalisability of any evaluation study are: Will the initiative work in other similar locations, with similar professional staff and with similar young people and communities? How similar must other dissemination locations be? Is there enough information on processes in trial sites to know exactly what was implemented, the preparation leading up to implementation and the support for the new scheme once begun? Answers to these questions tend to be vague and what emerges is a strong message that others must both examine evaluation evidence and their own context, and exercise professional judgement in deciding if, how and when to implement a new scheme about which there is positive (even negative) evaluation evidence.

Health promotion in any setting is value driven and theory driven. Whilst it must take account of health behaviour outcomes, it is also the case that much of the intervention is to do with the improvement in context and developments in process. These developments and improvements are deemed to lead in the medium and long term to better health. Indicators of health promotion effectiveness need to accommodate the full range of changes that the health promoting school idea generates. Thus, WHO's 'ENHPS indicators for a health promoting school' (WHO, 1999a) relate to all of the changes that might occur. These include changes which span management, relationships, outside professional and community links, developments in the curriculum as well as such outcomes as reduction in smoking and an understanding of safe sex. The document also presents indicators at international, national and school level.

RCTs have their place in studies where the intervention is narrowly defined and easily contained. For example, the administration of a drug to two separate samples can show conclusively, even with relatively small sample sizes, the degree of effectiveness of the drug. Interventions that have a singular or a finite number of precisely-definable goals can be evaluated by

RCTs; introducing fluoride into water systems and monitoring caries (tooth decay) can show whether a general measure has had a significantly different outcome in a precisely measurable area. There comes a point when the complexity of the potential experimental situation means that samples must be very large or control of the intervention must narrow its range of variability or the time-scale must be so long that the study becomes prohibitively expensive. Added to this is the fact that over any time scale, even as short as two or three years, there are changes in the social environment that effect the outcomes from an intervention some years earlier. Drug education may have some impact but also this may be swamped by the sudden emergence of cheap drugs, or a culture switch making drugs more acceptable to youth, or raised youth unemployment.

This is not to reject RCTs, but to acknowledge that, as the International Union of Health Promotion and Education (IUHPE) points out, 'the health promotion community is conscious that there is further to go in improving the quality and range of the evidence available to guide decision making' (IUHPE, 1999, p. 10). Part of the process is to select and refine the appropriate method or methods.

Nutbeam and Smith (1991) stated a limited view, one which was perhaps consonant with the times, that evaluation had two fundamental tasks – to determine outcomes and to understand the process of change. They suggested at that time that, ideally, youth health evaluations should follow a basic randomised control, experimental design: pre-test studies to establish baseline measurements; use of a representative sample of the target population; random assignment of subjects to intervention and control groups; use of a clearly designed intervention; post-test studies to identify change from baseline measurements. They acknowledged that it is impractical, and possibly unethical, to allocate children to control and intervention groups and recognised that school-based research can be very difficult. There are so many other influences on the health of young people which cannot always be accounted for. Although they spend a considerable part of their time in school, they spend much more within their own home background with family, friends and others. Even carefully matched schools that are close together can be contaminated, for example where groups from each school mix with each other socially and share what is happening in the intervention. As already noted, there is also the difficulty of recruiting sufficient schools into a sample to give the results statistical power when randomisation and analysis is at the school level and not the pupil level.

As Tones comments, the simple application of the *Who* did *What* with *Whom? Where* did it happen and *Why? How* did it work? checklist may be all that is required. Even where there are lots of process measures of effectiveness, little was done to find which parts actually worked and how. It is very hard to isolate *input, process change* and *outcome* as three different areas for examination when there are multiple inputs, diversity in methods and experiences, and multiple outputs and outcomes.

Nutbeam and Smith concurred with the call for more rigorous, systematic process evaluation but concluded that only empirical, experimental research is perceived as having high status – the value of process-related research, so called 'soft' research, is devalued. 'The paucity of literature on process evaluation in health education research is testimony to the fact that it is not yet taken seriously by researchers.' That picture is changing, as much because RCTs cannot 'deliver' as because of the better organisation and reporting of process studies. Campbell *et al*. (2000) acknowledge in the *British Medical Journal* the limitations of the RCT in evaluations beyond single interventions such as testing the effectiveness of a drug. Researchers and evaluators in this field should note that the very expensive HEA/NFER evaluation of the English ENHPS project was a quasi-experimental study (Study 15 discussed later in the chapter), which concluded on the comparisons between the pilot schools, reference 1 and reference 2 schools that:

> There was no single unambiguous pattern of difference between the groups of schools at the aggregate level. In particular there was little evidence of measurable positive change over time in learning gains amongst pupils in pilot schools as distinct from those in Reference 1 or 2 schools.
>
> (HEA/NFER, 1998, pp. 189–90)

Since Nutbeam and Smith wrote in 1991, there has been a growing recognition of process evaluation, as well as outcome measures, as particularly suited to school settings (Denman, 1994; Parsons *et al*., 1996). Any extensive and worthwhile evaluative study of school-based health promotion, particularly of the health promoting school and its effectiveness in changing school management, policy and practice and pupil behaviours, is likely to include a range of approaches.

Process focuses in health promotion research and evaluation

As long ago as 1978, Kreuter and Green recommended that evaluation should be carried out at three levels: process evaluation, precursor evaluation and then, where appropriate, outcome evaluation – a model that is particularly useful in the context of the health promoting school. The holistic nature of the HPS, which touches on every aspect of school life, including ethos and environment, demands that evaluation should be multifaceted. Process or formative evaluation, which measures the activities of the programme, its quality and whom it is reaching, is vital because without it, it is impossible to identify which parts of a programme contributed towards the successful outcomes. In Kreuter and Green's terms, precursor evaluation refers to the evaluation of criteria which theoretically, or by previous empirical study, have a high probability of affecting health outcomes. These might

include cost-effectiveness studies and evaluation of the immediate impact of the intervention on specific knowledge and skills. They caution that, unless steps are taken to clarify the specific immediate function of school health education, programmes might be judged on outcome measures that are inappropriate and unrealistic. The state of health education in the school, for example, and the degree of support given to it must be considered.

Tones (1996) states that the health promoting school 'should be judged primarily by its contribution to such health promotion goals as equity and empowerment – or by the success of initiatives in contributing to such long term goals'. He then goes on to argue that, rather than focusing on outcome measures to assess output following an intervention, intermediate measures of effectiveness and efficiency are needed. These might include the acquisition of knowledge and understanding, evidence of successful values clarification, the efficient performance of health skills, the enhancement of self-esteem and changes in self-efficacy beliefs.

Errors arise in such research if process is not taken into account. Type I and Type II errors have been common in school-based research (Tones *et al.*, 1990; Hansen, 1992). Type I occurs when unjustifiable claims for the success of a programme are made. Type II errors are in the failure to show the existence of a genuine programme effect.

Tones (2000) has subsequently drawn attention to the dangers of Type III errors, particularly when evaluating a health promoting school, with its many activities and interventions in different spheres. He states that a Type III error occurs when a health promotion intervention is judged to be ineffective when it is actually the management and implementation of the intervention that is deficient. He emphasises the need to pay attention to research findings that indicate the components of an effective intervention. Building on this, it can be argued that there are at least six ways in which the Type III error can occur where the quality of the intervention has not accorded with the proposed scheme. This elaboration of Type III is as follows:

IIIa prerequisites are not satisfied, in terms of accommodation, equipment or teacher development;
IIIb the project is partially implemented with only some of the objectives pursued and experiences provided;
IIIc there is 'poor practice' where, though the scheme is being followed, there is too little skill deployed to effectively implement the scheme;
IIId the project is 'contained' and is not pervasive practice;
IIIe the project is under resourced;
IIIf the project is not consonant with other principles by which the school is run.

Thus, experimental, outcome focused studies will be misleading if they do not examine process also and therefore address the issue of various Type III errors.

Connell (1984) and Allensworth (1994) list specific conditions that should be satisfied for successful implementation, and to these Bremberg (1991) adds: time given to the intervention; teaching and learning methods; the size of groups; a focus on the individual and his or her needs; personal skills development; family and community support and well-defined behaviour targets.

So, a multi-factorial whole school approach to teaching and learning about health, which targets behavioural, environmental and social change and has been identified as essential in school-based health promotion, demands the use of multiple interventions, a variety of different methodologies and the involvement of inter-disciplinary and inter-agency personnel through community involvement and support (Elder, 1991). Research and evaluation in this field must respond to that.

Reviewing selections of evaluation studies

Two sets of evaluations studies are considered below both to elicit the messages for the management and development of the HPS and to derive guidance on effective and useful research and evaluation approaches. The systematic review of research by Lister-Sharp and colleagues (1998) was carried out as part of the NHS R&D Health Technology Assessment programme while Moon's (1999) review was part of her PhD and has been extended in its presentation here.

Lister-Sharp *et al*. (1998), in their reviews of the health promoting schools approach and the effectiveness of health promotion in schools, adopt a position on reviewing closely tied with the Cochrane Conventions. To be included in the review, studies had to meet three criteria:

- the intervention dealt with areas of ethos, the curriculum and family or community links;
- controlled studies with a comparison group or a before/after design;
- include and report health-related outcomes.

In their draft report they found only six studies that met these criteria. Twelve studies were eventually found following a slightly more generous interpretation of the criteria, six in the USA, four in the UK and two in Denmark. These extended in time over the period 1979–97. It is interesting to note that the overlap between the 12 studies discussed in the Lister-Sharpe study with the 18 (extended to 23) in the Moon review is small.

A number of the 12 studies listed, acceptable because of their experimental design, have weaknesses that undermine their status as experimental studies. The English evaluation of the European Network of Health Promoting Schools (ENHPS) focused on 18 experimental schools and two groups of reference schools of the same number. The sample size is too small to

accommodate the vast range of variables on which the schools will differ. The evaluation of the Wessex Healthy Schools Award scheme contained a different number of schools matched to the project schools and these were not randomly allocated (acknowledged in Chapter 6 of this volume). The evaluation of the healthy eating policy (Young, 1993) involved three schools, one intervention and two controls (because the matching of characteristics proved difficult) and data were collected post hoc. A very large study of the American *Health Promotion Schools of Excellence* (Sobczyk *et al*., 1995), also in Moon's review, involved over 11,000 pupils in 15 schools in before-after testing. The reviewers comment on the messages that can be drawn from the project evaluation that, 'no baseline information was given. Lack of information about the projects in each school limit the conclusions that can be drawn about effectiveness' (Lister-Sharpe *et al*., 1998, p. 28).

This review required there to be an experimental design. It is noteworthy that so many of the studies were flawed and that the conclusions reached on the effectiveness of the HPS approach, while expressed encouragingly, are speculative and provisional.

> Taken together the studies . . . show that a health promoting school approach can impact on the social and physical environment of the school in terms of staff development, school lunch provision, exercise programmes and social atmosphere. Although failing to demonstrate change on all measures in all studies, the approach could be successful in improving aspects of health-related behaviour such as dietary intake and physical fitness. The programmes which targeted healthy eating or cardiovascular disease prevention were more successful in achieving these ends than those with more general health goals.
>
> (Lister-Sharpe *et al*., 1998, p. 23)

Elsewhere they write of the HPS as 'can have a positive effect . . . suggestive evidence' (Lister-Sharpe *et al*., 1998, p. 24) and that it is 'promising . . . would be likely to improve overall effectiveness' (Lister-Sharpe *et al*., 1998, p. iv). The conclusion to be drawn is that the selection criteria for studies were too narrow, that the experimental studies are not concluding convincingly and helpfully about the impact of the HPS (note all the 'can', 'could' and 'would be likely' statements) and that studies from lower down the hierarchy of evidence need to be included.

Moon's review covers many more recent studies – only two were reported prior to 1990. It is important to note that her review was only systematic in so far as it met her criteria for the PhD and that a number of the studies she includes have not been published. The discussion of this review is in three parts: a general overview of the complexities of the HPS or comprehensive health education programme; two comprehensive school health programmes from the USA; other evaluations of HPS or other schemes.

There have been few detailed evaluations of healthy schools awards or health promoting schools in the UK. The move towards a whole-school approach to health – comprehensive health education – which has been taking place over many years in the United States has led to a proliferation of American studies. Comprehensive health education programmes were first introduced in US schools early in the 1980s and, as their focus and methods have developed and changed over the years, the term 'comprehensive' in this context has become largely synonymous with the concept of the health promoting school. School health education and promotion have long since become integral parts of the public health agenda in the US (Kolbe and Gilbert, 1984) and the comprehensive approach is now generally accepted as the most effective in the face of increasing behavioural health problems and limited classroom time and resources (Schall, 1994). Schall defined it as including 'an organised and co-ordinated set of policies, procedures and activities to protect and promote the health and well-being of students and staff'. Interestingly, the 'community' is not mentioned in this definition.

Allensworth and Kolbe (1987) identified eight components of comprehensive health education – the curriculum, health services, environment, school food service, health promotion programmes for pupils and staff, counselling and psychology provision, physical activities and integration with the wider community. Their model forms the basis for many interventions, but is recognised as an 'ideal' which is not always possible because of lack of expertise, personnel and resources. The concept of comprehensive school health education, based on these eight components, is now widely accepted as the way forward for the future in the US. The eco-holistic model is similar.

The literature search results are listed in Appendix 1 and set out more schematically in Table 4.1. The original literature search used reference in the title, or content of the evaluation, to the HPS concept or a whole-school approach to HP, and publication or conference presentation as the main criteria for inclusion. Only a small number had been published as papers in peer-reviewed journals. As in the Lister-Sharpe *et al*. review, several of the studies demonstrate considerable weaknesses of design, methodology and reporting: for example, there was inadequate sample size, lack of a control group, sample numbers not given. None were excluded for these reasons because of the small number available in published form or presented as papers at conferences. Other studies were then added (19–23), which were largely humanist/qualitative focusing on process and contrasting with (possibly complementing) the 'scientific' studies. The total set is still only illustrative of the range of studies of the HPS that can be informative, whether based on an experimental design or more humanistic approaches.

The studies are referred to in the text by the number given in Table 4.1. A key, initial reaction to a literature search based on the Cochrane criteria is that only a limited number of studies are identified and these, arguably, do not cover all the useful and, indeed, rigorous findings on the HPS. Extending

this, there is no convincing evidence that such studies are genuinely generalisable or contribute valuably to evidence-based practice. Appendix 1 displays the differences in purpose and aims of the studies, the samples involved, the processes and methodologies used, the main findings and the recommendations arising from the research. The majority of recommendations, however, are intended for wider application.

It is interesting to note that only one evaluation, Sobczyk (9), sought to evaluate the impact of the health education initiative on the personal health-related behaviours of staff, as well as pupils, although the ENHPS project (15) and McBride (11) looked at the effects on teachers' knowledge and some attitudes.

Two comprehensive school health programme evaluations

Two major evaluations from the US are worthy of further detailed comment. Connell and his team (1) evaluated four well-established comprehensive health education programmes. The programmes, two of which were much more popular than the others, were taught by a variety of teachers, some trained and others untrained, in a variety of ways. Some used and completed a whole programme; others selected parts of a programme in a 'pick and mix' fashion. Researchers tried to take account of these variables and also looked at the impact of the programmes on pupils' lifestyles and noted if any health-related changes were made. They reported significant increases in knowledge in the intervention sample compared to the controls and also found smaller, but still significant, increases for attitudes and self-reported practices. However, they found that teachers appeared to have little difficulty in completing the knowledge components of the materials but were less faithful in implementing the attitude and behaviour programmes. The researchers were unable to explore the many other influences on the health behaviour of young people, for example the impact of local or national media campaigns.

In an assessment of the findings by a number of health education specialists (Newman *et al*., 1985) some remarkable claims were made. While recognising some of the problems with school-based research, for example random assignment of students to groups and 'equal' presentation of the different learning materials by different teachers being almost impossible, and, therefore, the limitations of the study, the results are seen as 'impressive' and as showing that 'health attitudes and behaviours, as well as knowledge, can be influenced through educational approaches'. The researchers themselves claim, 'health education works; that it works better when there is more of it; and that it works best when it is implemented with broad scale administrative and pedagogic support for teacher training, integrated materials and continuity across grades' (Newman, 1985).

While there were clear gains in health-related knowledge through the use of the four programmes, there were few changes in attitude and behaviour

Table 4.1 Studies of comprehensive school health education or the health promoting school

No.	*Authors*	*Date*	*Publication*	*Country*
1	Connell, D.B., Turner, R.R., Mason, E.F.	1985	'Summary of the findings of SHEE: Health promotion effectiveness, implementation and costs', *Journal of School Health 55*, 8: 317–21	America
2	Nutbeam, D., Clarkson, J., Phillips, K., Everett, V., Hill, A. and Catford, J.	1987	'The health promoting school: Organisation and policy development in Welsh secondary schools', *Health Education Journal 46,* 3: 109–15	Wales
3	Smith, C., Roberts, C., Nutbeam, D. and MacDonald, G.	1992	'The health promoting schools: progress and future challenges in Welsh secondary schools', *Health Promotion International* 7, 3: 171–9	Wales
4	Moon, A.	1995	'The Health Promoting Primary Schools Project in Wandsworth: Final Report', Salford: TACADE/Sir John Cass's Foundation	England
5	Allensworth, D.D.	1994	'The Research Base for Innovative Practices in School Health Education at the Secondary Level' *Journal of School Health 64*, 5: 180–7	USA
6	Coggans, N. and McKellar, S.	1996	*Health Promoting Schools: An investigation into the wider context of health education in schools*, Glasgow: Department of Pharmaceutical Sciences, University of Strathclyde	Scotland
7	MacGregor, A. and Currie, C.	1995	*The Health Promoting School in Lothian: A Project Report,* Edinburgh: Research Unit in Health and Behavioural Change, University of Edinburgh	Scotland
8	Wilmot, H	1996	'Health Promoting Schools: An evaluation of a pilot project in North Cambridgeshire', *North West Anglia Health Authority*	England
9	Sobczyk, W., Hazel, N., Reed, C.D., Ciarroccki, B., Cohen, S. and Varga, D.	1995	'Health Promotion Schools of Excellence: A Model Programme for Kentucky and the Nation', *The Journal of Kentucky Medical Association* 93: 142–7	USA
10	Nic Gabhainn, S. and Kellegher, C.	1997	*The Irish Network of Health Promoting Schools – A Collaborative Report*, Centre for Health Promotion, NUI., Galway and the Steering Committee of the Irish Network of Health Promoting Schools	Eire
11	McBride, N., Cameron, I.,	1995	'Facilitating Health Promotion in Western Australian Schools: Key Factors for	Australia

	Midford, R. and James, R.		Success', *Health Promotion Journal of Australia 5*, 1: 11–16	
12	Morgan, M.	1997	*Evaluation Report of the North Eastern Health Board Healthy Schools Project*, North Eastern Health Board	Eire
13	Lanarkshire CC	1997	Evaluation of the health promoting school project	Scotland
14	Loggie, J.	1997	*Happy Children is a Healthy School: An evaluation of the Northern Regional Healthy School Award*, Gateshead and South Tyneside Health Promotion Service	England
15	NFER/HEA	1998	*The Final Report of the Evaluation of the ENHPS Project in England*, London: HEA	England
16	Barkholtz, U. and Paulus, P.	1998	*Gesundheitsfördernde Schulen: Konzept Projektergebnisse Möglichkeiten der Beteiligung*, Werbach-Gamburg: Conrad, Verlag für Gesundheitsforderung	Germany
17	Lewis, D.	1998	*Staffordshire Health Promoting Schools Award Scheme: Evaluation Report*, Staffordshire Health Promotion	England
18	Thomas, M., Benton, D., Keirle, K. and Pearsall, R.	1998	'A review of the Health Promoting Status of Secondary Schools in England and Wales', *Health Promotion International 13*, 2: 121–9	England and Wales
19	Parsons, C., Stears, D., Thomas, C., Thomas, L. and Holland, J	1997	*The Implementation of the European Network of Health Promoting Schools in Different National Contexts,* Copenhagen: World Health Organisation	Europe
20	Stears, D., Holland, J. and Parsons, C.	1999	*Investment opportunities for Health Promotion in Schools in Wales: A Valuation of Assets*, Cardiff: Health Promotion Wales	Wales
21	Moon, A., Mullee, M.A., Thompson, R.S., Speller, V., and Roderick, P.	1999	'Helping Schools to become Health Promoting Environments: an evaluation of the Wessex Healthy School Award', *Health Promotion International 14*, 2: 111–12	England
22	Denman, S., Pearson, J., Hopkins, D., Wallbanks, C. and Skuriat, V.	1999	'The Management and Organisation of Health Promotion: a survey of school policies in Nottingham', *Health Education Journal 58:* 165–76	England
23	Rivers, K., Aggleton, P., Chase, E., Downie, A., Mulvhill, C. Sinkler, P., Tyrer, P. and Warwick, I.	2000	*Setting the Standard: Research Linked to the Development of the National Healthy School Standard (NHSS),* London: Department of Health	England

domains. None the less, these were better than the results of many other studies and support the research findings that cognitive-based programmes are not likely to have an effect on health practices. All the reviewers advise treating some of the results with caution and some identify flaws in the research construction and design.

A number of important recommendations came out of the study. Reviewers identified the support for a 'comprehensive (healthy school) approach' to school health education/promotion, involving the whole school community. As Parcel and his colleagues (1989) commented:

> In many cases, school health education presents tremendous conflicts for children and youth; what is being taught in the classroom is inconsistent with what is being modelled and reinforced in the community and social environment. . . . There needs to be more consistency between what is being done in the school . . . and what is being done in the classroom. The classic example is teaching children healthy nutrition practices in the classroom and then allowing [them] to go into a school lunch programme that provides no clear alternatives for choosing food that is consistent with the dietary goals for health promotion and disease prevention.

In the second American study (5), Allensworth (1994) reported on a large scale secondary school controlled evaluation of a comprehensive school programme called Teenage Health Teaching Modules (THTM). The results indicated that a self-reported reduction in drug use, alcohol consumption and cigarette smoking could be achieved in schools using a comprehensive school health education curriculum.

Arising from the results, Allensworth identified ten characteristics of a health promoting school approach that she saw as essential to ensure effectiveness in school health education and promotion.

1 Use of multiple theories and models when planning health-related interventions
2 A focus on priority health behaviours
3 An expanded curriculum to include food services, community, worksite health promotion, etc.
4 Use of multiple strategies in addressing 'problem' behaviours
5 Co-ordinated school and community health promotion activities
6 Co-ordination of a whole-school health programme through all disciplines
7 Promotion of active student participation in lessons and methodologies, e.g. experiential approaches, peer group learning
8 A focus on the development of life skills appropriate for prevention
9 A wider view of all aspects of school life, e.g. developing a caring, nurturing school environment

10 Work closely with parents, carers and, where possible, with whole families.

Other evaluations of HPS initiatives or HSA schemes

The remaining studies in the table are mostly of those that have taken place in the British Isles, apart from Sobczyk *et al*. (9) (United States), Nic Gabhainn and Kelleher (10) (Eire), Morgan (12) (Eire), Barkholz and Paulus (16) (Germany), and McBride (11) (Western Australia). One study by McGregor and Currie (7) (1995), was at the stage of developing and testing criteria and tools for evaluation, and the remainder either explored the concept of a health promoting school and what helps and hinders its development or sought to evaluate the effectiveness of a healthy schools award scheme.

Some studies, for example Connell (1), Allensworth (5) and McGregor and Currie (7), used a quasi-experimental, controlled design with large numbers of schools and pupils. Others did not use a control group and based their evaluations on small samples, e.g. one (Loggie (14) or two schools (the Lanarkshire study (13)). There are four studies in which random selection of the sample took place, Nutbeam *et al*., (2); Smith *et al*., (3); Morgan (12) and Thomas *et al*., (18). The NFER/HEA study (15) involved random allocation of forty-eight schools in matched triads to pilot, reference 1 and reference 2 status. It is encouraging to note the number of studies in which a variety of research tools, both quantitative and qualitative, were used and that only five used one investigative technique exclusively – Connell (1), Nutbeam (2), Smith (3), McGregor and Currie (7) and Thomas (18). This is despite the fact that both Connell (1) and Nutbeam (2) recommend the development and use of a wider range of research tools in schools. Apart from the American studies and those of Nutbeam and Smith, none was completed before 1995.

The researches of Parsons (19), Stears *et al*. (20), Moon *et al*. (21) and Denman (22) are the basis for Chapters 6–9 and will not be discussed here. The Rivers *et al*. study (23) is an audit of Healthy Schools Award schemes, an evaluation of pilot site activities and follow-up case studies of impact. As with the NFER/HEA study (15), this set of investigations gives many useful suggestions for the management of change and the support needed if the HP goals and processes are to be taken forward. Here there is considerable utility, and it does not derive from RCTs or other experimental arrangements.

Main findings from the studies

There were many similarities in the findings and recommendations from these studies. Key themes and major recommendations to emerge included:

- support for a whole school approach;
- active involvement of support and non-teaching staff (it is interesting to note that the ENHPS project did not involve support staff in the

evaluation; studies 6 and 11 involved support staff but do not include them in their recommendations);
- the need for a partnership with parents in school health education;
- the need for high quality health education training for school staff, especially co-ordinators;
- a focus on raising the status of PSHE and of the co-ordinators;
- the crucial role of senior management in the success of health promotion projects;
- the importance of needs assessment in planning health promotion projects;
- the need to involve pupils actively in planning and implementation of health initiatives;
- the importance of clear, detailed health-related policies which support and match curriculum content and which are reviewed and implemented;
- policies that should involve non-teaching staff, parents and other adults in school in their development;
- future work with teachers on the meaning and components of a health promoting school;
- the need to develop good community links;
- the need for funding to enable projects and award schemes to continue and to pay for training, cover for teachers, resources and support;
- the need for schools to tackle the area of nutrition and healthy eating;
- the urgent need for further research into influences on behaviour change, links between behaviour and health outcomes, costs of programmes – short- and long-term – effective class room approaches, what does and does not work, key factors in involving parents, and more;
- the development of a range of practical research tools to facilitate evaluation of the programmes.

Most of the studies have tried to assess the effectiveness of a healthy school award or health promoting school scheme in changing health-related practice in schools and, occasionally, knowledge, attitudes and behaviour of pupils. The strongest recommendations coming from the largest number of schools relate to research and evaluation in school settings. The importance of future research in schools, the use of a variety of methodologies and the development of tried and tested tools are all highlighted. Yet school-based evaluation of health education and promotion initiatives remains difficult.

Challenges in the evaluation of school-based health education and promotion

There are difficulties in evaluating school health education and promotion interventions and their effectiveness, particularly when programmes encompass a whole-school approach and are not focused and behaviour spe-

cific (Moon, 1999). If the aim of evaluation is simply to assess the success of an intervention in changing knowledge, attitudes and behaviour, then it will be almost impossible to do so unless the many informal, 'external' health-related influences experienced by the participants are recognised and taken into account by using a controlled, experimental research design.

As mentioned at the start of this chapter, randomised control trials are still thought by many to be the best research design because they avoid selection bias and randomly distribute confounders. The complex nature of schools, however, means that randomised controlled trials are not always appropriate or manageable, logistically and ethically, in school settings. Much depends on the purpose of the evaluation and what is being evaluated. Random allocation is not always possible, particularly where schools can volunteer to take part in an intervention. The fact that intervention schools are volunteers introduces a bias and indicates an immediate difference between them and any controls before the study starts. Where randomisation is not possible, an experimental, non-randomised controlled design is likely to be the best alternative. But the use of controls can also be problematic if they are volunteers, introducing a form of selection bias. Randomisation can control for extraneous influences but feasibility is a major problem.

When it is not possible to allocate individual students to intervention or control groups, the unit of analysis becomes the school. Randomisation of schools, however, requires large samples and this may be difficult to achieve. Cluster methods of analysis are needed (Black *et al*., 1998) and, as Goldstein *et al*. (1998) state, carrying out an analysis that does not recognise the existence of clustering, e.g. pupils within schools, creates serious technical problems. For example, ignored clustering will generally result in underestimated standard errors.

The move to broaden the concept of health from a focus on specific individual behaviours in a personal and social vacuum to a holistic one that incorporates lifestyle and the influences of home, school, the media, the community and the workplace, has meant that there need to be multiple interventions when trying to bring about behavioural, environmental or social health-related change. Each intervention and its implementation should then be researched and evaluated separately and variables excluded where possible. Where community-based health education interventions are employed, whether in school or in the wider community, it would be impossible to record every individual's experiences and so the results in terms of an intervention need to be regarded with some caution. The media, for example, may be responsible for having a powerful impact on attitudes through a programme screened at the time of the intervention. These may then be reinforced by the intervention but cannot be said to be a specific outcome of the intervention. The need for a control group is vital in these circumstances if causality is to be argued convincingly on the basis of data.

The diverse nature of many of the health education/promotion interventions seen in schools cannot always be evaluated by looking only at

outcomes. The elaboration of Type III errors already corroborates the requirement to examine process. Additionally, some initiatives will not have measurable outcomes. The focus on behavioural change as a measure of effectiveness, which is so often required by funding bodies – usually over a period that is too short term – demonstrates a misunderstanding of what is involved in school-based health promotion and of the difficulties of changing behaviour through one, or even many, interventions. Short-term follow-up is inadequate to detect medium- to long-term behaviour change that is sustained.

Recommendations for effective research

The recommendations recorded below are in three groups: those that relate to experimental studies; those concerning more interpretative and qualitative studies; recommendations about the democratic and participative character of evaluations which might have additional benefits.

It is difficult to better the advice of Flay (1985) in relation to experimental studies. He carried out a review of twenty-seven school-based evaluations of smoking prevention and made the following recommendations, based on the flaws he detected in the research designs of the studies of this sort:

- future studies need to reach the highest level of internal validity, with random assignment of schools and classrooms, experimental conditions, tracking of individuals over time, minimally-reactive measures and measurement procedures, use of placebo control groups;
- the relationships between methodological and theoretical issues need to be explored further, e.g. relationships between classroom and school characteristics and variation in smoking onset;
- the question of whether programmes change social norms needs to be explored and rates of attrition predicted;
- there is a need for a comprehensive assessment of presumed mediating variables;
- future studies need to include comprehensive measurement of target audience involvement, characteristics of treated audience and the properties of social environment inhabited by the target audience.

Qualitative, humanistic, interpretative studies need to accord with best practices in these fields and a number of authors are sensibly proposing their use (Green and Britten, 1998). The following pointers are suggested:

- there should be a consideration of the application of the full range of methodologies available, including RCTs to which qualitative approaches could contribute;
- there should be piloted, triangulated approaches agreed with funders, stakeholders or major users of the research;

- the focuses should be made explicit from the outset and the data gathering determined as sufficient, feasible and scheduled over time;
- explicit effort should be made to check for bias (especially undue support) in the collection, interpretation and reporting of data;
- reports should allow access by interested parties to the data and an examination of the quality of the study;
- researchers should make explicit the features of complex interventions to which they are attending and make clear the extent to which their studies are not comprehensive evaluations of a scheme;
- ensure, in relation to the HPS, that there is recognition of the complexity of the concept overall and the variability of its manifestation in different school and community contexts.

A WHO European Working Group on Health Promotion Evaluation, composed of distinguished, international health-promotion specialists, met in April 1998. They identified four core features of approaches appropriate for the evaluation of health-promotion initiatives: active participation of all key players; the use of multiple methods; evaluations that should enhance the capacity of individuals, communities, organisations and governments to address health promotion concerns; and evaluations that accommodate the complex nature of health promotion interventions and their long-term impact. Their recommendations for policy makers, also applicable to schools, need to be heeded if a balanced approach is to be pursued:

- encourage the adoption of participatory approaches to evaluation that provide meaningful opportunities for involvement by all of those with a direct interest in health-promotion initiatives;
- require that a minimum of 10 per cent of the total financial resources for a health-promotion initiative be allocated to evaluation;
- ensure that a mixture of process and outcome information is used to evaluate all health-promotion initiatives;
- support the use of multiple methods to evaluate health-promotion initiatives;
- support further research into the development of appropriate approaches to evaluating health-promotion initiatives;
- support the establishment of a training and education infrastructure to develop expertise in the evaluation of health-promotion initiatives;
- create and support opportunities for sharing information on evaluation methods used in health promotion through conferences, workshops, networks and other means.

A major concern for the future is the funding of health-promotion evaluations. It is all very well being aware of what is needed to help make an intervention effective and of the necessity for a range of research methods and approaches, particularly when evaluating issues surrounding the health

promoting school. Without adequate funding, however, practitioners will remain uncertain as to what works or does not and how best to move forward. Inadequate and inappropriate interventions, unsupported by research, will continue to be used and there will be many more lost opportunities to influence positively the health and well-being of all members of the school community, including those in its environs.

The analysis in this chapter is relevant to HP researchers and evaluators at many different levels, from school-based evaluations, through national studies, to international investigations. Chapter 5 goes on to deal in greater detail with how this advice might be implemented in the evaluation of the HPS.

Part II

Evaluating the Health Promoting School in Action

5 Evaluating policy and practice in the health promoting school

Introduction

Approaches to researching and evaluating the health promoting school (HPS) require a panoramic conception at the planning stage. Health promotion can take diverse forms, involve many agencies and be enacted in varied ways within both the formal and 'contextual' curricula of schools and in the broader community. It is also important to see the workings of health promotion conditioned by the wider and immediate institutional context, management and the processes used, which may then lead on to sought-after outcomes. An ecological and holistic view of the HPS demands both this breadth of vision and a dynamism that accepts changes over time. The full range of methodologies may be used in studying the HPS but it is important that outcomes are sought in terms of that full eco-holistic panorama of context, management, processes and relationships as well as competences and health-related behaviour changes in young people.

In the midst of league tables, standards and demands for effectiveness in education, there remains a place for nurturing, facilitating growth, allowing exploration and taking a long-term holistic view of the development of young people, as well as the more direct promotion of their learning. The committed promotion of subject-based learning can co-exist with personal and social learning and with goals concerning mental and emotional health. It is important within this complexity that professionals who seek a degree of autonomy and self government in their vocation enquire and reflect in a selective, targeted and useful way.

This chapter defines evaluation and indicates the variety of approaches and techniques that can be used. It offers guidance on specific techniques but refers the reader to the Christ Church University College Centre for Health Education and Research (CHER) website www.cant.ac.uk/depts/units/cher/cher.htm and to numerous texts offering evaluation support. Central to the discussion in this chapter are the purposes of evaluation and ensuring the utility of evaluation and research findings.

Defining evaluation and related terms

Evaluation in the context of education can be defined as the *purposeful gathering*, *analysis* and *discussion* of evidence from *relevant sources* about the *merit*, *quality of provision* and *impact* of courses and experiences on pupils. Evaluation a) collates useful, relevant information; b) collects it in reliable and systematic ways; c) sorts, analyses and presents data with rigour and clarity; d) reports into decision-making forums and e) supports planning, development and accountability. Other procedures akin to evaluation are set out in Table 5.1.

Evaluation can be precursive, formative or summative. *Precursor evaluation* establishes benchmarks or baselines; it can be a valuation or audit (Stears *et al*., 1999) of health promotion assets. *Formative evaluation* is an ongoing activity where the evaluation can feed in to alter the course of the innovation or interventions. *Summative evaluation* is usually retrospective. It can look back at, and judge, what has worked well, what has worked less well and even at what cost. Well-designed summative evaluations can contribute to evidence-based practice and inform those in other locations about what might work, likely pitfalls, pre-requisites and costs.

Generalising from studies can be indicative or affirmative. A reader of an evaluation report may infer that a proposed project, which has similar characteristics, will operate in similar circumstances and that implementing the evaluation report's recommendations will lead to similar reported satisfaction. This inferential or indicative response is different from the rarer affirmative stance based on measured positive experience that asserts that this initiative, carried out in this way, in these circumstances *will* have these outcomes. The level of confident transferability is hard to achieve and one must usually manage with softer 'evidence bases'.

Table 5.1 Terms and processes overlapping with evaluation

Accountability	checks that monies are deployed appropriately and that the job is done according to agreed procedures and to set standards
Quality assurance	is the totality of features and characteristics of a product or service that bear on its ability to satisfy stated or implied needs
Valuation	investigates the assets in place to support planned development
Monitoring	is routine collecting and organising factual data: how money was spent; number of person in-service days; attendance rates; reports of bullying
Audit	is a count or check of resources, activities or outcomes
Assessment	is of pupils to determine what has been learnt
Appraisal	is of teachers to review quality of work, consider staff development needs and set future targets
Review	is the process of examining and discussing all available evidence on initiatives, interventions or strategies. Evaluation, along with information from audit, monitoring and assessment, may feed into review.

Reasons for evaluation

There is a number of reasons why valuable professional time should be devoted to evaluation. Ascertaining 'where we are now' is often an important starting point in the planning of any change; precursive evaluation will serve this benchmarking function. Evaluation can address the question 'does it work?' and provide answers about the effectiveness and cost-effectiveness of an intervention or set of interventions. Reflecting on what we do, how and why, can itself lead to clarification of goals, as well as questions of effectiveness and efficiency, value-added and what performance indicators should apply. In a production-oriented, resource-limited, professional environment this is important. Evaluation can function to maximise information about the quality and impact of the provision made, the form it takes and the way it is organised, and thereby contribute to evidence-based or evidence-informed practice and improve provision. In a formative role it can be developmental. Evaluation can also motivate school staff, and other health professionals and stakeholders, and encourage team-work. It can motivate pupils, and others asked to provide information, who might feel valued by the special attention. It can enhance relationships between young people and adults. Where parents and others, for example visiting performance groups, health professionals, members of the community, are part of an evaluation, the process itself can improve communication and commitment to the school. Evaluation can serve accountability demands from parents, the community, those who provide funding and those who inspect. To that extent it is politically expedient at a time when teachers and other professionals are under pressure to give evidence of being effective and adaptable.

Evaluation may be self-evaluation carried out by the individual teacher or other professional, usually focusing on how the teaching situation is being managed. It may be carried out by outsiders but more and more it is becoming the insiders' responsibility. Most benefit will be derived when evaluation is part of an agreed activity amongst colleagues with common professional concerns.

Few evaluations are fully comprehensive. Evaluation is always selective in focus. It needs to be realistically costed in terms of personnel time and finance, and feasible within the constraints of doing the job. It needs to serve identified audiences on a time-scale appropriate to their decision-making and in a form easily accessible to them.

The evaluation panorama

To put the focus of an evaluation and the techniques used in perspective, the notion of an evaluation panorama is helpful. It responds to the holistic and complex reality of the HPS. Stufflebeam (1971), in general educational evaluation work, has presented his Context, Input, Process, Product (CIPP) scheme to encourage evaluators to take a broad focus. Stake (1967), in his

Table 5.2 The evaluation panorama – from specification to product

Intrinsic and value analysis	*International, national, regional and local context*	*Institutional context*	*Processes*	*Product*
Is project based on best research evidence? Is it informed by consideration of ethics and the social good? Is it feasible with available resources?	Influence of international organisations; national curriculum; national policies and priorities; funding at national and local levels; local efforts and initiatives.	Policy and mission; roles; physical environment; resources.	Interactions; experiences; relationships; school and community inputs.	Knowledge; attitudes; values; competences; dispositions; behaviours.

classic work, used the term 'panorama' and advocates that we examine very closely the match between what was proposed in a project and what was actually implemented. This separates out the different contexts of professional work in education, from the national, through institutional context and process, to the product or outcomes, in terms of what the children have learnt. These ideas can be broadened and adapted further and are represented in Table 5.2, which sets out a more extensive spectrum.

Intrinsic and value analysis

The form that health promotion takes, the sites in which it occurs and the investment in it are moral and political issues as much as technical and scientific ones. Intrinsic and value analysis involves examining the theoretical and evidence base for the projects or practices and the values that inform them. It is not just about the quality-assurance maxim of 'do it right first time', but rather 'do the right thing'. Seedhouse (1997) rightly separates out the empirical evidence base for a profession from its 'theories of purpose' (p. 5). Health promoters need to know, and to be able to communicate, why they do what they do and not just debate which methods are best. He suggests that health promotion does not have a developed set of philosophies.

Contexts

The international, national, regional and local context refers to influences from international bodies like the World Health Organization (WHO), Organisation for Economic and Cultural Development (OECD) and the European Commission (EC), and requirements laid down in national law as well as regulations that may apply locally. It also covers the political and cultural context in which the innovation takes place. It includes public opinion, support and finance being directed towards the topic. It includes

competing claims and factors that might reduce the receptivity of teachers or schools to an innovation or development. It is not all about restrictions, however. There are projects and funding opportunities available, locally or regionally, that may benefit the school. There may be supportive links established and consortium arrangements of which the school can become part.

The institutional context is the totality of provision in terms of school policies, visions, missions and commitments. It includes the allocation of roles, the physical environment, the teaching accommodation and resources available.

Processes

Process refers to all that takes place in encounters with children, young people and others. It is all the interactions and experiences, it is all the contacts with staff and the teaching and learning activities that take place. These are experiential factors, which are concerned with the operation of the explicit, formal curriculum *and* the contextual or hidden curriculum. It includes the care of the building and how welcoming the institution is both to pupils and to parents and the community. It concerns messages given by the ethos of the school.

Product

Product concerns outcomes. It is all the knowledge, attitudes, values, competences, dispositions and behaviours that the child acquires as a result of the processes within the contexts provided. There are changes that can be measured in the short term. Experience has shown us that many of these are the trivial knowledge elements that are conveniently amenable to measurement and to short-term change. Long term outcomes are more difficult to gauge, more expensive to follow-up and more difficult to associate with earlier interventions. In respect of this last point, it is important that professionals develop a confidence to set their goals, in terms of pupil learning, as widely as they judge appropriate. There is a sound value basis for not being satisfied as educators with the immediately testable.

In the English Healthy Schools guidance, the generic and specific are mixed in the eight thematic areas for action. Thus, there are 'healthy eating' and 'physical activity' mixed in with 'citizenship' and 'emotional health'. Table 5.3 lists generic and specific outcome areas that need to be seen as largely distinct and evaluators should recognise the different character of the two lists. They cannot be evaluated in the same way.

The focus points, within the full panorama of evaluation focus points, extend in the same way from the context of the intervention or innovation

Table 5.3 Generic and specific outcomes

Generic outcomes	*Specific outcomes (knowledge, attitudes and values and behaviours)*
Communication skills	Drugs
Emotional intelligence	Smoking
Self esteem	Alcohol
Self confidence	Diet
Self valuing	Oral health
Action competence	Exercise
Mental health	Hygiene
Democratic participation	Safe sex
Refusal or resistance skills	Safe behaviour
Liking for school and teachers	Sun protection
Citizenship	Road safety
Empowerment	

through process to short- and long-term outcomes. The 'output' of an initiative may be at any level: changed policy, developed teaching approaches, established community involvement or enriched pupils' experiences.

In devising schemes for health promotion interventions, it is necessary to consider the theoretical base that supports the proposals. Theories can be mere guesses, speculations or beliefs unsupported by empirical evidence. They can be propositions drawing on what is known about learning. The theory base needs to be examined and monitored with regard to its application in practice, including whether it supports a changed context, the necessary processes and leads to desired outcomes. There is a demand from health and education authorities that developments are supported by evidence-based and theory-informed practice. Health promotion is in general a more speculative area than many of those that officially and legitimately intervene in the learning and development of the young.

Issues in the evaluation of the health promoting school

Like many social and educational initiatives, the HPS is complex, broad, multi-sectoral and long-term. It is important that evaluations must mirror these characteristics, if health promotion takes its lead from the Ottawa Charter. Giddens (1984) is one of many social scientists who point to that confounding, intervening variable of human agency, which itself makes a difference to the implementation and course of any project. It cannot be likened to a specific treatment to achieve a given result over a short time-

scale. The many different levels on which health promotion operates, and the value factors inherent in it, make for a particularly complex evaluation challenge. Nutbeam (1990) expressed disappointment at the state of health-promotion evaluation some years ago, and the International Union for Health Promotion and Education (IUHPE) stated somewhat later that, 'the definition and measurement of intermediate health outcomes such as health behaviours and healthy environments, and the health promotion outcomes which may influence them, has taxed the skills of researchers for decades' (IUHPE, 1999, p. 7). There is little surprise, then, that health-promotion evaluation has set itself goals that are too ambitious.

Speller and colleagues have made the point that, despite the breadth of effort that characterises HPS, 'many research studies are still seeking such simple results with little consideration of the effect of other influences, or use costly designs to attempt to control them' (Speller *et al*., 1997, p. 361). WHO, in producing its *ENHPS Indicators for a Health Promoting School* (WHO, 1999a), has studiously avoided the temptation to highlight simple health and health behaviour outcome changes and focuses sensibly 'upstream'. It pays attention to the international, national, school and community based dimensions of the health-promotion effort while at the same time trying to give a logic and tightness to the focus and the intended outputs of evaluation reporting. It has suggested that national projects, and indeed individual schools, taking note of the objectives, the indicators and criteria for success, can produce evidence that reflects back the advances they have made and the quality of their own performance, as well as demonstrating to others the nature and quality of work and achievement that has taken place.

Unavoidably, the HPS is entwined with value considerations. Springett, in line with the principles of the Ottawa Charter, suggests,

> the primary criterion for determining whether or not a particular initiative should be considered to be health promoting ought to be the extent to which health promotion activities involve the process of enabling or empowering individuals or communities.
>
> (Springett, 1998, p. 11)

This approach questions the medical model and is less amenable to experimental designs. Qualitative research has some merits but Rogers and colleagues have set out demanding standards if studies are 'to meet the criteria of adequacy at the level of knowledge, subjective meaning and context' (Rogers, 1997, p. 51). The approaches set out in Table 5.4 span the range of techniques and their characteristics. Used judiciously they can yield data and interpretations helpful for judgement and development.

Evaluation techniques

There are thirteen main approaches to gathering data for evaluation purposes, which are dealt with here. Others may well segment the field differently. It is important that those engaging in evaluation at any scale choose approaches that suit their style, workload and audience. It is worth noting that a multi-method approach is best and this may involve enriching quantitative questionnaire data with interviews, or funnelling the enquiry to focus on particular aspects that more general data have signified as critical. In this way associated factors may be examined for the extent to which they are causal factors and the mechanisms through which they operate. The methods are set out briefly in Table 5.4.

These thirteen approaches are dealt with specifically on the CHER website (www.cant.ac.uk/depts/units/cher/cher.htm). Like a dramatic production, evaluation can be played out at the level of Shakespeare at the National Theatre or The Little Brown Hen at the front of the class. Evaluation should be an activity designed for its context and purpose in the knowledge of the options available and their limitations. Evaluators should know the standards current in the field.

Many texts will help teachers, evaluators and researchers to conduct enquiries into the HPS. General social science research texts exist to prompt thinking about theory, data collection methods and the management of the research endeavour. Layder (1993) and Burns (2000) offer fairly demanding advice on 'professional' research. Layder (1997) draws attention to the notion of 'domains of social life'; these are, in increasing levels of scale, the personal face-to-face, the interaction of role figures, the group locations of social type (e.g. employment groups) and macro-sociological factors such as the distribution and ownership of resources. Studies of HPS can be at any one of these levels but will often visit other levels. For example, a study of pupil/teacher interaction will focus on performance within the social context of the classroom. It will also involve consideration of the role defined for teachers and current training for teachers as a work group. The HPS is a broad based social intervention that requires broad approaches to research and evaluation.

Practical texts on research include Robson's *Real World Research* (1993); he wants to take the mystique out of research, give confidence and 'generate a degree of informed enthusiasm' (p. 2). Numerous books have been produced to guide teachers and others keen to investigate the educational world. Nisbet and Entwistle (1970), Cohen and Manion (1997) and Anderson (1998) are mainstream examples. Davidson *et al*. (1991) and Parsons *et al*. (1994) offer practical examples and workshop ideas on data gathering in educational institutions.

There are four recent texts specifically on health promotion evaluation: Scott and Weston (1998), Warwick *et al*. (1998), Springett (1998) and Thorogood and Coombes (2000). These give advice with examples to

Table 5.4 Evaluation techniques and their main characteristics

Technique	*Characteristics*	*Examples*
Experimental study	provides hard, scientific evidence; convincing evidence-based implications; can be expensive, long-term and face difficulties in controlling for relevant factors	HEA/NFER (1998) see Chapter 6
Standardised tests and attitude inventories	often valid and reliable measures of a situation at one time; allow comparisons between groups or for change in the same group over time	self-esteem tests (Lawrence, 1988); health behaviour surveys (Balding *et al.*, 1999)
Interview	can control the setting in which data are gathered; can ensure questions are understood; can probe, penetrate and get at underlying feelings; can check more easily that answers are accurate	see Chapters 7 and 8
Questionnaire	can get at large numbers relatively quickly; can get representative samples from which to generalise; can be open 'almost essay style', or highly structured 'box-ticking' variety	health behaviour of school-aged children Chapter 7
Observation	advantage over the above self-report methods is that this involves actually seeing it happen; can involve written record, audio tapes, photographs or videos	Chapter 6
Environment audit	structures the collection of information; simple method to ensure coverage and avoid omissions	see Chapter 6
Examination of official statistics and documents	usually easily accessible background data – test scores, Pandas, examination results, attendance rates, free dinners, etc.; stated objectives of a course, content, policy statements, etc.	annual regional (NHS) health authority public health reports (NHS Executive, 1999); School statistics on absenteeism, attainment, etc.
Field notes, informal and incidental reports of experiences, logs, diaries	can participate and record what happens as it happens, identifying issues only as they arise; exploratory technique; can record events over time; can record inferences, feelings and interpretations alongside a record of events	Burgess (1985)
Case study	records detail and uniqueness; rich, descriptive: of pupils; of institutions; of projects	See Chapter 8
Action research	study of own situation with a view to improvement; enhances professional self-confidence	McNiff (1988) Chapter 6
Team self-review	sharing meanings; pooling experiences and judgements; challenging assumptions; checking common practices; eliciting personal feelings	Parsons (1994)
Stakeholder review	collective judgements of workers, those affected and those paying; offers immediate and shared feedback	Chapter 8 Patton (1986)
Triangulation, multi-method and progressive-focusing approaches	observation + questionnaire + interview is a common combination; progressive focusing commonly involves following up generalised data to answer questions raised	Chapter 6

varying extents and to varying degrees of 'expertness'. In terms of methodology, the first advice must be to draw on the work of others, including their instruments. While suitably acknowledging sources, it saves time to adapt questionnaires and approaches from others who have done work before in the area. It gives 'copying' a good name and is an acknowledgement that there is too little replication in social science research; too few opportunities are taken to consolidate previous research findings.

Experimental design

Experimental design was discussed in Chapter 4. Where this is feasible and in keeping with the project, strategy or initiative and the required timescale and resources, then it is appropriate. A small local group of practitioners may not have the opportunity or capacity to launch a randomised control trial (RCT) but will be able to carry out monitoring, evaluation and quality assurance of use to themselves and to others. The RCT may be seen by many as the gold standard but its application in this context is limited.

Standardised tests

Standardised tests are usually 'off the shelf' products. To achieve high levels of reliability in evaluation instruments requires a lengthy development period. Non-standardised tests, inventories or questionnaires are commonly used, often asking for responses to a series of statements, for instance on how enjoyable school is, or how much was learnt from the PSHE module that was new. Often responses are on a five-point scale and can be aggregated to give the instrument the status of an inventory. MacIntosh and Morrison (1969) is a standard text on objective testing. Heaton's (1990) book is also useful, especially on the writing of curriculum-based assessment items; though focusing on the English curriculum, it gives general advice that is useful to teachers when developing their own tests.

Interviews and questionnaires

Useful texts on interviewing include Powney (1987) and Holstein (1995). The application of questionnaires is well described by Sudman and Bradburn (1982), Sapsford (1999) and in Oppenheim's (1966) classic text. Gilham (2000) provides a useful contemporary text and Hoinville, Jowell and Associates (1979) offer practical tips on sampling, and the management of interview or questionnaire surveys.

Observation

Wragg (1998) gives wise advice on observational styles from the highly-structured to more open methods, and Hammersley (1993) discusses the

issues with a preference for less formal approaches to observation. Participant observation or detached observation is important in providing evidence of what actually happens. The presence of an observer may affect the action and few episodes may be observed because it is time-consuming. However, the importance of observational studies cannot be overstated; in the study of an intervention it is vital to have data on how the intervention was implemented. As pointed out in Chapter 4, Type III errors confound research design and evaluation logic; with a complex set of initiatives, such as HPS, it is vital to record the quality of the implementation. Studies that rely on tests of behaviour change, without an assessment of the processes intended to cause changed outcomes, are distinctly flawed. Furthermore, the first-hand recorded evidence of action arising from observation should be valued above self-report data from interview and questionnaire.

Environmental audit

Environmental audit may be seen as having overtones of public health inspectors and clipboards. As indicated in Chapter 7, there is a list of characteristics, items and practices one might expect to find in the health promoting school or healthy school. The rigorous recording of items as varied as staff using school sports facilities, clean toilets, school councils and regular liaison with other agencies allows monitoring of change over time and comparison across sites.

Examination of official statistics and documents

Examination of official statistics is often underrated as a research element – it seems too obvious. Information may be in filing cabinets, school registers, minutes of meetings, etc. Attendance numbers, discipline problems and staff training are usually logged. Increasingly, extensive data are held on whole school populations but researchers must know and comply with the principles of the Data Protection legislation.

Field notes, logs and diaries

Field notes are also often underrated. They offer the opportunity, like documents, of capturing what is there for everyone to see. Discipline needs to be applied and a focus given to note taking. Research/evaluation is too often dependent on the tarnished recall and self-report of others (interviews and questionnaires) whilst overlooking events and encounters that occur naturally.

Case study

The case study of a school, a consortium of schools, a school-community project, individual events or people, offer insights. Some abbreviated case

studies are given in Chapter 8. Yin (1993) has offered guidance and examples to help practitioners.

Action research

Action research is the antithesis of the experimental study. It is defined by Carr and Kemmis as: 'a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social practices, their understanding of these practices and the situations in which they are carried out' (1986, p. 162).

Action research investigates problems identified by practitioners. McNiff (1988) presents an account, and Hart and Bond (1995) describe action research in health settings and include 'a toolkit' of methods and approaches. Proponents see the method as ideally suited to advanced professional practice, empowering practitioners to improve their practice in their situation. Chapter 7 follows an action research approach, focusing mainly on the management and support for change in a local HPS scheme.

Team self-review

Team self-review draws considerably on the Total Quality Management (TQM) movement. Borrowing from Ishikawa, Deming and other exponents of TQM or TQI (improvement) work, groups gather information that helps them know how they are doing, what the problems are and what are likely to be the best ways forward (see contributions to Parsons, 1994).

Stakeholder reviews

These draw on the work of authors such as Patton (1986) and his ideas of 'utilisation-focused evaluation'. The purpose of involving stakeholders is that they often hold purse strings and are gatekeepers. Involving them in any evaluation from the outset and being receptive to their criteria and their knowledge needs can help the evaluation to be seen as appropriate and useful for informing future practice.

Triangulation, multi-method and progressive-focusing approaches

Triangulation and a multi-method approach to such a complex development as HPS is a desired requirement. The complex nature of the HPS means that no evaluation will be totally comprehensive. It will require different approaches to the gathering of data and its cross checking. The flexibility offered by progressive focusing, or a grounded theory approach, can alert policy makers and practitioners to unanticipated outcomes or problems and help maximise the effectiveness of projects and their investment.

Using all the above methods, research studies and evaluations need to be planned and scheduled following decisions about focus, resources, timescales, audience and desired outcomes.

Managing and communicating evaluation

Springett concludes that 'the planning of the evaluation was considered to be equally important as the data collection phase' (Springett, 1998, p. 27) and Warren urges that 'it is too late to think about communicating the research after the research is done. It should be planned in from the start'.

It is important to determine from the outset who the evaluation is for and its purpose. The answers to these questions can influence choices about the character and methodology of the research. The evaluation outcomes may need to be communicated in different ways to meet the needs of different audiences.

Planning and conducting an evaluation through to the extended period of reporting involves action in doing the work, being selective, organised and decisive, and communicating. Note that in the presentation in Figure 5.1 two of the steps concern action, five are about choices and being selective and eight are about communicating. Evaluation is a social, political and communicative endeavour.

The fifteen steps set out in Figure 5.1 may be of help in planning the evaluation study. The evaluator is not always free to choose the objectives or the foci of the evaluation. The framework may be fairly well set from the beginning with limited room for manoeuvre, but still there are decisions to be made about the nature of the study. Evaluators should be aware of the importance of obtaining the insights and advice of others. This will assist the participatory nature of evaluation by preparing the collaborators as participants. If evidence-based practice is to prosper, people must be willing and able to receive and deal with the evidence that emerges from evaluations.

An evaluation will often be constrained by what is feasible with current skills, personnel and time. It is also important to establish roles and agree responsibilities – even if these vary as the evaluation proceeds. Again it is good to inform and consult with all collaborators as details of method are settled and decisions are made about audiences, the scale and nature of data collection and the time available. The study itself needs to be of a high standard, independent and reported with an alertness to the characteristics of the many different audiences and what is appropriate for them in terms of feedback. It is not always necessary to write a full report and many audiences will not have much time to devote to reading the results. It may be necessary to produce a full report and also a digest or list of recommendations for a wider readership. Advice should be taken from the commissioners of the evaluation on the content, length, balance and tone of the report.

Reporting may be mainly oral, perhaps with some text or tables

Step	Nature of the step	Type
1	select the foci and frame the evaluation	A
2	discuss with colleagues and practitioners	C
3	narrow the focus/be selective	B
4	decide roles and responsibilities	B
5	inform and consult colleagues, practitioners and other stakeholders	C
6	decide which audiences will information be collected	C
7	be strategic about how, and how much, information is to be gathered	B
8	be clear about how much time will be made available	B
9	devise the methodology and collect the data	A
10	know when the results need to be reported	C
11	know to whom, and how, results are to be reported	C
12	decide how results will be shared more widely	C
13	identify who will be involved in decisions and what forum might formally review evaluation findings	C
14	be rigorous and ruthless in analysis and write-up	B
15	report with care over a time period to multiple audiences	C

A = Action; B = Being selective; C = Communicating

Figure 5.1 Managing and scheduling and evaluation

circulated or bullet-pointed issues handed out. It may be helpful to follow a 30:3:30 rule in relation to written reports: a single page or executive summary (a summary read in 30 seconds); a condensed account (for the 3 minute reader); a full report with validation of the information, appendices, etc. (likely to take 30 minutes to digest).

It is important that readers or listeners are assured of the report's reliability, validity and accuracy, whatever form the dissemination takes. People might need to be informed about research elsewhere, examine data and know numbers involved, and the evaluator should be in a position to give this further information if appropriate. Both immediate decision-makers and also the wider community of 'stakeholders' will need to be informed, along with other staff (teachers and other professionals), pupils/students and members of the community.

Pursuing the marketing format, Warren indicates that effective communication can be through direct marketing or through empowering intermediaries. On the latter he writes:

> find out what bureaucrats and policy analysts want and use them as messengers. Almost every major or national initiative has associated advocacy groups; if they are given the information you can be sure the minister will hear about it . . . produce media-friendly materials. Health Sells!!
>
> (Warren, 1998, p. 53)

Making the most of and making use of evaluation

Overall, the exercise of professional care in evaluating policy and practices in the health promoting school will mean there has been consultation with all implicated parties well in advance and they have been given the opportunity to comment and contribute. As the evaluation proceeds everyone, especially the 'decision-makers', is kept informed about the way the evaluation is going. In the conduct of the evaluation it is important not to write or communicate details, negative or positive, that identify any individual during the course of the evaluation.

Permission needs to be sought to identify participants in the final report. An overriding principle is that the focus should be on issues, not people. It is important to include as many commendations as recommendations in the report and to observe the pragmatic criterion of 'palatability' (Parsons, 1990).

Whatever the scale of the evaluation activity, it needs to be seen as a good example of its kind. Whether a large-scale team effort or a local 'rapid appraisal' (Beebe, 1995), and whether experimentally-oriented with before–after measurement or a collection of qualitative perspectives, data need to be seen as gathered reliably and analysed with rigour. Studies may function to inform national decisions in line with Ziglio's (1998) Investment for Health, or be for local consumption as for a school-based study. Some of the arguments about dichotomous paradigms, discussed in Chapter 4, are sterile, but the need for good evidence on which to base policy and practice is ongoing.

It is important that colleagues and other stakeholders discuss the results of an evaluation and make decisions based on the findings about the future development of the project, evaluation strategies to be used and its resourcing. The school or project that evaluates its work in a confident and efficient way can be said to be in charge of itself. Evaluation in its simplest form can help reduce worries that might arise at the prospect of an external evaluation. For insiders, evaluation should be a supportive, collegial experience which celebrates, improves and empowers. Realistically, evaluation should assure outsiders that proper quality assurance and reflectiveness is in place,

that the appropriate processes are implemented and appropriate outcomes sought, and that the enterprise is deserving of continued support.

The next three chapters report evaluations in a necessarily condensed way but offer illustration of the theory, policy and practice of HPS implementation. In reading what has gone before and the empirical chapters to come it appears that truths and certainties are elusive in the world of HPS as in so many other complex developments. Findings are often relevant only to the setting in which the evaluation has taken place and will be of concern to the people involved at that time and in that setting. The key question for all researchers is, 'What do these findings say to us, here, now?'

6 The evaluation of the Wessex Healthy Schools Award Scheme

Introduction

This chapter describes a three-year independent, externally-funded evaluation study of a healthy schools award scheme in Wessex that took place between 1995 and 1998. It outlines the aims and content of the scheme and its implementation, and the purpose of the evaluation. It details the multifaceted nature of the evaluation, the variety of evaluation approaches used and the design and administration of a range of research tools. It highlights some of the difficulties with school-based research, from the recruitment of the sample through to setting up and carrying out the various aspects of the evaluation. It sets out the results of the study, discusses its strengths and weaknesses and draws a number of conclusions relating both to healthy schools award schemes and, more generally, health education and promotion in schools.

The evaluation of the Wessex Healthy Schools Award Scheme

The development of the Wessex Healthy Schools Award (WHSA) scheme in the early 1990s was underpinned by an alliance between health and education specialists that had already been established in the county of Hampshire in the UK. Educationists provided 'inside' knowledge about schools and working with teachers and health promotion officers (HPOs), some of whom had teaching backgrounds, were able to contribute specialist health information, resources and the different perspective that comes from someone working in an outside agency. The award was administered by the Wessex Institute for Health Research and Development, which is part of the University of Southampton.

The award was established as a way of encouraging schools to make school life a health-promoting experience for all children and adults who teach, learn and work in them. It was based upon the need to offer schools a focus and framework for cross-curricular planning and delivery of health education through a whole-school approach. The WHSA scheme was one of the first of its kind in the UK.

The scheme was based on nine key areas that reflect the curriculum, the organisation and management of the school, the environment, the community and staff health (see Table 6.1).

The choice of key areas was dictated by a focus on coronary heart disease prevention, the priority for many health authorities at that time. Areas such as sex and drug education were seen as being part of key area A: the curriculum.

Schools joining the scheme were asked to nominate a co-ordinator, generally the PSHE or health education teacher, to promote, administer, monitor and evaluate the project in school and liaise with the institute. Schools were also supported by a locally-based Healthy Schools Award co-ordinator who could be an LEA advisory teacher for PSHE or a health-promotion officer. The co-ordinator's role was to help schools by facilitating the award process, e.g. complete an audit, set targets with staff, run training sessions, provide advice, establish community links and identify and obtain appropriate resources.

Schools were recruited to the scheme by county and each paid a £30 fee to cover administrative costs and a resource manual containing lesson plans, suggestions for classroom activities and guidance on achieving the award. The progress of the award and the processes involved were monitored by the WHSA co-ordinator and validation was carried out at the end of a mutually-agreed period of time. Each school produced a portfolio of evidence of ways in which the targets had been achieved. This might include reports, minutes of meetings, copies of policies, samples of children's work, etc. Schools did not usually

Table 6.1 The nine key areas of the WHSA

Key areas	*Statements of intent*
A	The school should be working towards the National Curriculum Guidance Document No. 5 (Health Education). Its policies and programmes should be co-ordinated, comprehensive and progressive and be reflected in the School Development Plan.
B	Policies should reflect the school as part of the wider community.
C	The school should be working towards a smoke free environment.
D	Pupils should be educated and encouraged to make healthy food choices.
E	The school should offer a wide range of physical activities which are accessible to all and in which working towards health becomes an important cultural practice within the school (National Curriculum Physical Education Statutory Orders).
F	Schools should encourage young people to take responsibility for their health.
G	The school should be a health promoting workplace for staff.
H	The school should promote a generally stimulating, clean, safe and tidy environment.
J	There should be equal opportunity and access to health education for all who teach, learn and work in the school.

'fail' but were given more time to achieve targets, as necessary. The key factor in the assessment was the degree to which the school had demonstrated positive change and forward movement in reaching the set targets. Schools that had successfully completed the award received a certificate, a Healthy Schools logo for their school notepaper and, in some areas, a tree to plant in the school grounds, all presented at a high-profile annual award ceremony.

Much anecdotal evidence, and that taken from the validations of the award, indicated that the scheme appeared to be effective in bringing about change in school management structures, the curriculum and in the number and scale of health-related activities carried out in school. There had been no systematic, independent evaluation of the scheme, however. Nor was there evidence of evaluations of other similar schemes in the UK. In 1994, a bid for funding in order to carry out a detailed evaluation of the effectiveness of the award was successful.

For a more detailed overview of the scheme see Moon *et al*. (1999a and b) and Moon (1999).

The aims of the WHSA scheme were to:

1 evaluate the impact of the WHSA on levels of health-promotion activity, on the organisation and functioning of participating schools, and on all staff;
2 identify models of good practice;
3 determine effects on pupils' health-related knowledge, attitudes and behaviour.

The more specific objectives were to:

1 determine methods used to implement change in key statement areas including how priorities were set, action plans developed and processes monitored;
2 evaluate the feasibility and acceptability of different approaches and identify critical success and constraining factors;
3 evaluate effects on the organisation and running of schools in terms of curriculum development, delivery of health education, staff time and training, community links and school environment;
4 determine the impact of the award on school staff;
5 determine change in pupils' health-related knowledge, attitudes and behaviour;
6 estimate resource costs of implementing the award;
7 disseminate findings of the evaluation.

Design and recruitment of sample

The design of the research was quasi-experimental, with the intention of matching an award school with a control school. Random allocation was

impossible, however, because of the voluntary nature of the award and the need to actively recruit intervention and control schools into the research. The decision was taken to use secondary schools because the 11–16 year age group is an important one during which early health-related beliefs and attitudes consolidate and dictate future behaviour and the organisation of secondary schools provides the opportunity to follow a group in the same school prospectively over time.

The original aim was to have twelve secondary schools in each group – twenty-four altogether – which were representative of the counties that comprise the Wessex region – Dorset, Hampshire, Wiltshire and the Isle of Wight. Schools on the Isle of Wight could not be part of the main study, however, because of a middle- and high-schools system that does not have years 7–11 together in one school. Eleven intervention schools were recruited from those about to start the award scheme in Autumn 1995 and controls were selected and matched on the basis of area, percentage of free school meals and social status, using figures supplied by the education offices.

Major difficulties in recruitment of control schools occurred. Reasons given included:

- internal pressures, e.g. academic timetables, time constraints, lack of senior management and/or staff support, OFSTED inspections;
- poor status and low priority of health education/promotion in schools;
- lack of monetary or resource incentives available;
- misunderstandings by teachers about the nature and purpose of evaluation in schools.

The final sample consisted of eleven intervention schools and five controls, mostly from Hampshire but with one of each from Dorset and Wiltshire. An intervention school withdrew following baseline because of changes in school senior management. Pupil numbers ranged from 440 to 1486 and percentage of free school meals from 4 to 49 per cent. Staff numbered twenty-seven in the smallest school and ninety-six in the largest. The pupil sample was mostly white, with between 1 and 20 per cent Asian pupils in a school, and 1 and 2 per cent black pupils.

Assessment methods

The design incorporated qualitative and quantitative aspects (see Figure 6.1), using specially-constructed tools, linked to the nine key areas of the award.

Process evaluation involved audit, curriculum and policy review, observation of the environment and a health education lesson, semi-structured interviews with teachers, non-teaching staff, parents and governors and focus group interviews with year 10 pupils.

Pupils' health-related knowledge, attitudes and behaviour were assessed by a self-completion questionnaire that was given to year 7 and 11 pupils at

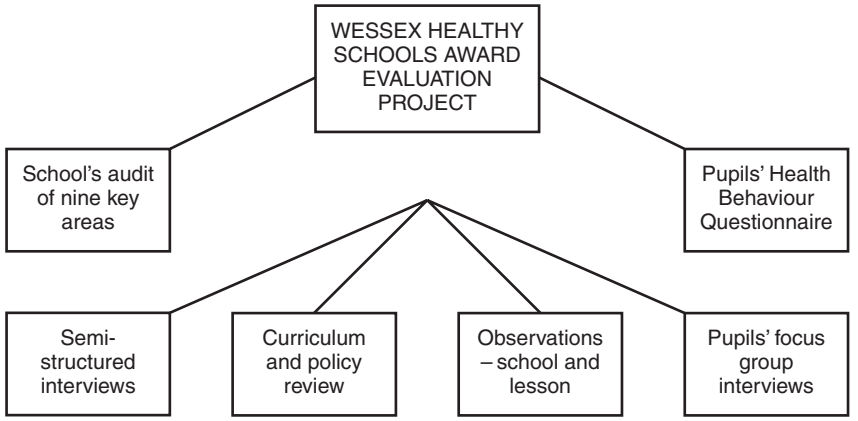


Figure 6.1 Research methods used in the WHSA evaluation project

baseline and year 8 and 11 at follow-up. Audits, observations, curriculum reviews and pupil questionnaires only were used in the control schools. All interviews, apart from focus groups, were carried out by the same researcher to ensure consistency and eliminate bias.

Tools were tested in a pilot study conducted in two schools on the Isle of Wight and a large comprehensive school in Basingstoke. The structure of the assessments is shown in Table 6.2.

Table 6.2 The WHSA evaluation plan

	Intervention	*Control*
	Schools audit	*Schools audit*
At baseline autumn 1995	Pupil health yr 7 pupils Questionnaire yr 11 pupils	Pupil health yr 7 pupils Questionnaire yr 11 pupils
	Semi-structured interviews School observation Lesson observation Curriculum review Policy review Focus groups yr 10 pupils	School observation Curriculum review Policy review
At follow-up spring 1997	Pupil health yr 8 pupils Questionnaire yr 11 pupils	Pupil health yr 8 pupils Questionnaire yr 11 pupils
	Semi-structured interviews School observation Lesson observation Curriculum review Policy review Focus groups yr 10 pupils	School observation Curriculum review Policy review

Audit

The use of an audit reflects the practice for LEA or Health Authority supporters to visit participating schools to assess states of health education and promotion, identify weaknesses, select areas for development within the award and set targets. It is based on the nine key areas of the WHSA but the criteria were expanded and extended by the inclusion of a number of additional questions so that the issues were explored in greater depth.

The tool's content and validity were appraised by an independent group of health education/promotion specialists who also valued each section. Each question was allotted a maximum of five points and sections were given equal weight, enabling scores to be calculated for key areas, and in total.

Three copies were sent to schools for completion by a senior manager and the co-ordinators of Physical Education (PE) and Personal, Social and Health Education (PSHE). The pilot revealed that head teachers were unable to answer all questions without reference to these colleagues and that when they were involved there was sometimes a difference in perception amongst the three. The researcher visited schools approximately a fortnight later to facilitate a discussion and produce an agreed master copy. The same process was followed both at baseline and follow-up.

Semi-structured interviews in intervention schools

Semi-structured interviews (SSI) were developed for use with key staff in intervention schools only – health education co-ordinators, a teacher not involved in health education, a governor, a parent and members of non-teaching staff, e.g. a caretaker, a caterer, a school nurse.

The interview schedule explored:

- perceptions of school health education and what constitutes a healthy school;
- the impact of the WHSA at follow-up on the school's organisation and management;
- knowledge about, and active involvement in, the WHSA process;
- constraining and facilitating factors in achieving the school's objectives;
- the degree of consultation with, and involvement of, support staff and parents in health-related initiatives and policy making.

Schools selected respondents and arranged confidential interviews that lasted approximately half an hour. The researcher used a 'tick box' schedule that had been developed during the pilot. Participants were not shown the schedule. Seventy interviews were carried out at baseline and sixty-seven at follow-up.

Health-related pupil questionnaires

A questionnaire was designed to assess health-related knowledge, attitudes and behaviour. Sections were included on alcohol and drug use and misuse, pupil self-esteem and sources of information relating to health. It included a small number of standard tested questions from other surveys, e.g. Health-related Behaviour Questionnaire (Balding, 1995; Welsh Youth Survey, 1986) and used closed or multiple-choice questions where possible, with Likert type scales to explore attitudes. The questionnaire, which was accompanied by detailed instructions, was administered by teachers in classroom settings and took between thirty and forty-five minutes to complete. Pupils were assured confidentiality and finished scripts were sealed in individual envelopes.

Two samples were studied; a cohort of year 7 pupils aged 11–12 at baseline, who were surveyed again at year 8 at follow-up, and an annual cross-sectional survey of 15–16 year olds, allowing a comparison between baseline and follow-up. All respondents in control schools and a stratified random sample of approximately 1300 pupils from intervention schools, drawn by school year and sex, comprised the research group. Response rates for years 7 and 11 at baseline were 80 per cent and 66 per cent respectively and 76 per cent for both years 8 and 11 at follow-up. A major flu epidemic in autumn 1995 and work experience, summer visits and activities at follow-up accounted for some absences.

Focus group interviews

The focus group schedule was designed to explore perceptions of health and a healthy school and assess change following the award process. Teachers were asked to identify a random, but vocal, sample of 9–10 pupils from year 10 (14–15 years), representing a range of abilities, to take part in a confidential group discussion. Interviews, which lasted about an hour, were taped with participants' agreement.

A random sample of only five interviews was conducted at follow-up because of difficulties with school arrangements, and costs and time involved in transcription and analysis. In the event, only two were playable.

Curriculum and policy review

A curriculum review schedule based on *Curriculum Guidance 5: Health Education* (NCC, 1990b) that had already been developed for the WHSA in Dorset (Lindsay-Clift, 1994) was used. Schools had found it straightforward, and a useful diagnostic tool. The schedule explored the provision, timing and context of health-related topics in the curriculum. Schools were sent copies of the review relating to key stages 3 and 4 to complete at the beginning of the award process. They were encouraged to circulate them to all teaching staff to ensure a full picture.

Policies relating to health education and promotion were requested from schools but obtained with considerable difficulty. Only five health education policies, rising to seven at follow-up, were available from intervention schools and two from controls. Where a policy was under review or awaiting update, schools were unwilling to submit them. Other policy statements seen included bullying, child abuse, sex education, discipline, health and safety, community and environment. All were reviewed briefly for areas covered, guidelines for implementation and resources and support.

Observation

Observation schedules were constructed covering school environment, catering facilities, health and safety standards and health education lessons. Differences in perceptions of cleanliness, stimulating environment, etc. resulted in a guide that enabled observers to tick 'yes' or 'no' or circle one of three graded indicators for each question. The researcher and two assistants observed intervention schools independently at baseline. There was considerable agreement when results were compared. Observations in control schools and at follow-up were performed only by the researcher.

The lesson observation tool used in intervention schools is based on standard OFSTED criteria for effectiveness (DfEE, 1994).

Resources used by supporters

Designated supporters of the WHSA in schools were asked to record time involvement and resources given on a day-to-day basis to all project schools, intervention or control, throughout the period of the research so that costs could be determined.

Data processing and analysis

All data were analysed using SPSS (Norusis, 1993) apart from the focus groups, when Ethnograph (Seidel *et al*., 1995) was used. When analysing the responses to the student questionnaires, the unit of analysis was the school. Thus, for example, the percentage of current smokers (defined as smoking one or more cigarettes a week) was calculated for each individual school. The mean percentage of current smokers for intervention schools, for example, was then calculated as the mean of the percentage of current smokers for the ten intervention schools.

When determining the change from baseline to follow-up, the follow-up measure (be it audit score or student characteristic) was subtracted from the baseline. Mean change in scores was then calculated for the intervention and control schools. Tables 6.3 and 6.4 display baseline and change in measures for audit scores and students' responses, respectively. Figures 6.2 and 6.3 compare the changes from baseline to follow-up between the intervention

Table 6.3 Audit scores at baseline and comparisons of change in audit scores from baseline to follow-up

	Baseline scores				*Change (1997–5)*			
	Intervention (n=10)		*Controls (n=5)*		*Intervention*		*Controls*	
	mean	(SD)	mean	(SD)	mean	(SD)	mean	(SD)
Total score	58.9	(7.5)	58.6	(13.7)	10.8	(7.4)	0.5	(18.6)
Curriculum	59.5	(10.2)	57.0	(23.2)	6.9	(7.5)	−11.5	(28.0)
Wider community	71.2	(12.2)	71.7	(19.2)	2.7	(16.2)	−12.7	(28.4)
Smoke-free environment	38.7	(17.4)	29.7	(9.2)	16.2	(10.4)	8.2	(16.6)
Healthy food choices	35.2	(13.9)	38.1	(17.4)	9.7	(12.4)	−6.5	(18.7)
Physical activities	70.3	(11.6)	70.0	(13.9)	1.6	(20.7)	1.9	(23.2)
Take responsibility for health	85.0	(11.9)	71.4	(22.2)	4.6	(17.2)	8.6	(25.8)
Healthy workplace	57.4	(19.3)	61.9	(12.4)	12.6	(17.9)	5.8	(15.4)
Stimulating, clean, safe, tidy environment	58.6	(15.6)	60.8	(17.8)	16.4	(16.0)	0.0	(17.6)
Equal opportunities and access to health education	54.5	(24.1)	67.0	(23.6)	26.5	(29.2)	11.0	(31.9)

and control schools, for audit scores and students' responses, respectively. They show the mean difference in changes between intervention and control schools, along with a 95 per cent CI (Confidence Interval) for this difference. The position of the mean difference, relative to the vertical line at zero, indicates whether the intervention schools performed better or worse, on average, than the control schools. Thus, for example, Table 6.3 shows that, at baseline, intervention and control schools had similar mean total audit scores (about 59). It also demonstrates that intervention schools increased their total audit scores at follow-up by an average of 10.8, whilst control schools showed an average increase of just 0.5. This provides evidence that intervention schools performed better, on average, than control schools when looking at change in total audit scores (mean difference = 10.3). We cannot be certain that intervention schools did better than control schools, however, because the 95 per cent CI for the mean difference between change in scores includes zero (−12.4 to 32.9). It should also be noted that both groups of schools may have deteriorated from baseline to follow-up, but intervention schools would be considered to have performed better than controls if the deterioration had, on average, been smaller in the intervention schools.

Results

It is not possible to include the detailed results in this chapter but they have been written up separately and are available as papers and reports.

Table 6.4 A selection of pupil results comparing intervention and control schools at baseline and follow-up

	Males 12/13–11/12 years						*Females 12/13–11/12 years*						*Males 15/16 years (1997–1995)*						*Females 15/16 years (1995–1997)*					
	Intervention			*Control*			*Intervention*			*Control*			*Intervention*			*Control*			*Intervention*			*Control*		
	n	*mean*	*(SD)*	*n*	*mean*	*(SD)*	*n*	*mean*	*(SD)*	*n*	*mean*	*(SD)*	*n*	*mean*	*(SD)*	*n*	*mean*	*(SD)*	*n*	*mean*	*(SD)*	*n*	*mean*	*(SD)*
% Current smokers																								
Baseline	16	6.9	(7.5)	18	6.2	(2.2)	7	5.0	(7.8)	9	3.6	(5.1)	66	32.0	(8.3)	81	29.3	(5.1)	81	41.8	(14.2)	100	33.7	(6.2)
Change (1997−1995)		0.8	(7.7)		9.3	(4.9)		8.9	(6.4)		12.8	(3.6)		−4.4	(12.9)		2.6	(8.7)		−5.8	(21.3)		5.5	(6.7)
% Probably/definitely smoke when 20																								
Baseline	17	8.1	(7.7)	19	7.4	(6.8)	9	6.2	(7.8)	14	4.9	(3.8)	29	13.7	(10.8)	33	14.9	(8.4)	35	19.4	(14.2)	37	12.5	(3.3)
Change (1997−1995)		1.9	(11.9)		1.1	(7.5)		5.6	(5.1)		4.9	(7.4)		−3.7	(13.0)		3.1	(4.4)		−2.6	(14.7)		4.2	(5.9)
% Drink alcohol once or > once a week																								
Baseline	20	9.1	(8.3)	49	17.7	(7.9)	11	6.3	(5.2)	17	5.1	(2.1)	80	37.0	(18.6)	120	47.6	(4.9)	55	28.4	(11.7)	81	28.3	(9.8)
Change (1997−1995)		9.1	(9.6)		1.0	(9.6)		3.1	(8.8)		5.7	(2.4)		6.0	(16.5)		2.5	(10.7)		4.1	(21.5)		9.6	(15.0)
% Tried low risk drugs																								
Baseline	3	1.7	(3.0)	9	3.1	(3.3)	3	2.2	(4.6)	5	1.7	(1.1)	94	45.1	(10.9)	108	42.2	(5.8)	77	42.0	(13.8)	102	36.4	(7.8)
Change (1997−1995)		11.4	(9.3)		9.3	(7.7)		2.4	(7.7)		4.5	(3.3)		−0.5	(13.7)		14.1	(10.8)		0.3	(223)		6.0	(117)
% Agreeing using drugs is exciting																								
Baseline	12	5.0	(5.2)	23	8.1	(3.7)	4	2.0	(3.7)	10	4.0	(4.7)	93	44.9	(15.0)	116	43.5	(5.3)	51	31.0	(11.5)	85	30.0	(4.4)
Change (1997−1995)		11.7	(4.0)		12.7	(7.2)		7.1	(8.6)		9.5	(4.9)		−9.4	(16.3)		2.2	(9.7)		−5.7	(13.0)		2.7	(8.3)
% Having less healthy snacks at breaktime																								
Baseline	181	71.3	(10.2)	248	76.2	(10.1)	162	69.9	(11.1)	251	78.1	(8.8)	158	75.6	(6.4)	216	79.1	(11.8)	143	71.6	(10.0)	194	67.9	(13.5)
Change (1997−1995)		14.7	(9.1)		7.0	(11.3)		−0.3	(13.2)		−0.2	(8.4)		−0.7	(10.3)		−2.6	(3.9)		−1.8	(14.5)		4.6	(7.1)

% Agreeing it's easy to buy healthy meals in canteen																					
Baseline	105	43.4	(10.3)	178	55.2	(7.9)	88	43.8	(12.7)	155	48.6	(3.6)	71	34.4	(8.4)	96	36.1	(9.3)	49	25.8	(7.8)	96	32.0	(11.4)
Change (1997−1995)		3.2	(17)		−12.3	(6.4)		−12.4	(9.8)		−8.1	(10.1)		−1.2	(11.9)		−5.5	(7.0)		10.0	(13.2)		1.2	(9.8)
% Chose fruit and vegetables as healthy																					
Baseline	145	58.2	(11.9)	199	59.9	(6.8)	179	79.8	(9.8)	253	77.4	(13.6)	128	59.5	(13.5)	156	58.1	(12.5)	145	72.5	(16.9)	235	81.0	(2.4)
Change (1997−1995)		0.5	(17.8)		1.4	(8.6)		−2.7	(15.6)		3.1	(13.3)		0.5	(15.7)		4.8	(15.4)		11.2	(17.9)		2.8	(5.5)
% Taking part in sports at school once a week or more (not PE)																					
Baseline	157	62.6	(9.5)	159	47.4	(12.7)	113	51.8	(10.3)	162	51.7	(8.4)	99	47.3	(12.4)	143	51.4	(11.3)	46	22.2	(9.9)	61	20.4	(5.2)
Change (1997−1995)		−5.8	(18.3)		13.3	(12.6)		−7.5	(20.9)		−10.7	(11.6)		−4.2	(18.3)		−1.6	(8.6)		4.3	(10.6)		1.1	(7.5)
% Change in mean knowledge scores																					
Baseline	232	7.1	(0.8)	297	7.1	(0.8)	207	7.7	(0.9)	301	7.9	(0.6)	206	8.1	(1.1)	263	8.5	(0.8)	195	8.5	(1.2)	283	8.8	(0.9)
Change (1997−1995)		−0.1	(0.9)		0.1	(0.6)		−0.5	(1.3)		−0.0	(1.1)		0.4	(1.3)		−0.7	(1.4)		1.0	(1.0)		0.5	(0.8)

The audit

A comparison of the audit results between intervention and control schools shows that intervention schools made more progress in all areas apart from physical activities and taking responsibility for health. (See Table 6.3 and Figure 6.2.)

However, intervention and control schools had similar mean scores at baseline in most areas. Control schools had greater variation in total audit scores but it appears that both groups had been well matched with regard to the status and practice of health education and promotion. Table 6.3 shows that, while total mean scores in the control schools changed little (mean difference = 0.5; SD = 18.6), those in intervention schools rose (mean difference = 10.8; SD = 7.4). The difference in mean totals (10.3), however, failed to reach statistical significance (T = 1.19, P = 0.29; 95 per cent CI = −12.4 to 32.9). There was wide variation in scores between the nine key areas for all schools. All intervention schools responded positively to the audit and made progress in most key areas, even those not targeted for the

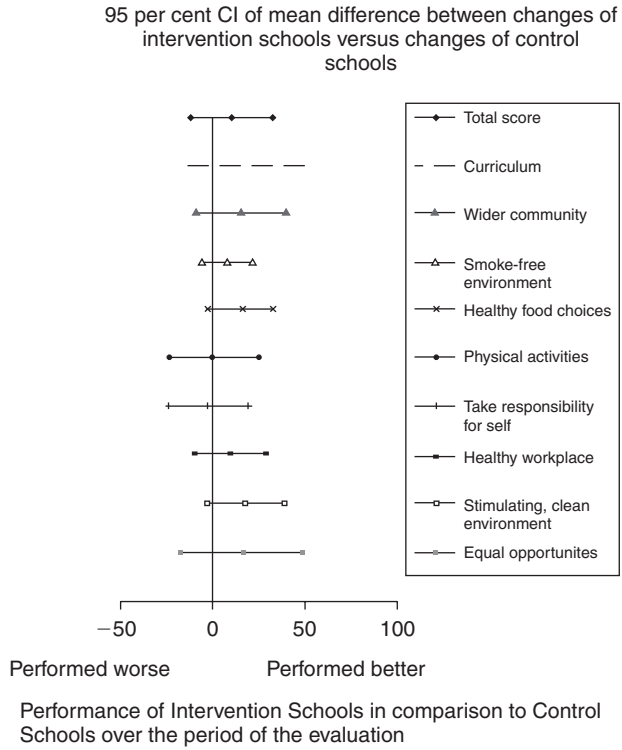


Figure 6.2 Change in audit scores from 1995 to 1997

award. The two areas where, on average, schools scored poorly were 'a smoke free environment' and 'healthy eating'.

Semi-structured interviews (SSIs)

Key findings from the SSIs, which were conducted in intervention schools only, concern the content of school-based health education, consultation and involvement of support staff, parents and governors in health-related initiatives, training opportunities provided by schools and perceptions of a healthy school. Percentages are given as an average of baseline (seventy respondents) and follow up (sixty-seven respondents) scores when appropriate, or in bold for baseline and italics for follow-up.

- Ninety-eight per cent of the sample stated that school health education is a vital part of the curriculum and 97 per cent that, while teaching about health is the parents' responsibility, schools have to compensate for inadequacies of home and ill-informed or reluctant parents. There was no change in scores at follow-up.
- The content of health-education programmes was seen mostly in terms of healthy lifestyles – diet (85 per cent) sex education (84 per cent) drugs (76 per cent) exercise (68 per cent) and smoking (59 per cent). There was a small increase in those including relationships (**36 per cent,** *46 per cent*) at follow-up.
- Few parents, caretakers, caterers or school nurses had been consulted about or involved in school health-related initiatives or policy making. Forty-three per cent, rising to *47 per cent* at follow-up, indicated no involvement. Some teachers (*22 per cent*) and governors (*18 per cent*), with little change at follow-up, contributed through staff and governors meetings. Only *23 per cent* of the respondents felt that they had been well informed about the WHSA scheme at baseline, rising by just 10 per cent to *33 per cent* at follow-up. Thirty-nine per cent stated they knew nothing at baseline, with *11 per cent* claiming the same at follow-up. Opportunities for health-related in-service training are few for support staff, although the provision of drug prevention courses had increased by 15 per cent during the award.
- Main barriers to achieving a healthy schools award were perceived as lack of time (**31 per cent**, *35 per cent*) and resources (**17 per cent**, *20 per cent*), poor facilities (**6 per cent**, *18 per cent*) and catering services (**7 per cent**, *14 per cent*).
- Facilitating factors identified included staff commitment (**70 per cent**, *89 per cent*), senior management support (**41 per cent**, *41 per cent*), concern for pupils' health (**34 per cent**, *59 per cent*) and pupil awareness (**26 per cent**, *27 per cent*). It is encouraging to note the rise in the percentage indicating concern for pupils' health, 25 per cent, at follow-up and it seems likely that this is as a result of the award process.

- The main distinctive features of a healthy school were identified at baseline and follow-up as having a clean environment (71 per cent), caring ethos (51 per cent), healthy eating (56 per cent), health awareness (44 per cent) and good manners on display (39 per cent). There were increases in those identifying positive attitudes (**29 per cent**, *61 per cent*), good relationships (**30 per cent**, *49 per cent*) welcoming environment (**19 per cent**, *24 per cent*) and good role models (**10 per cent**, *27 per cent*) – all reflecting aspects of the WHSA key area criteria.

At follow-up, participants were asked to pinpoint the main benefits to the school from participating in the award. All responses were positive, with the award as a motivator, a focus, a catalyst for change and providing a structure being cited most frequently.

Pupil questionnaire

Overall, the results reveal few changes between intervention and control schools. Table 6.4 and Figure 6.3 illustrate a selection of those that demonstrate some changes in behaviour and attitudes, in particular a significantly smaller increase in the percentage of current smokers in intervention schools compared with control schools. There is little change in pupils' health-related knowledge scores but these were generally high at baseline.

Focus group interviews

Main findings were:

- Health education during the award process had made a positive impact on pupils, particularly in the area of drugs prevention. Teaching methods had improved – no longer a purely didactic approach. Some concern about topics coming 'too late' in the school year.
- Pupils prefer interactive methods, particularly role play.
- Pupil responses concerning empowerment and taking responsibility for health were more positive and affirmative at follow-up.
- Friends were the most important source of information about health for these pupils – teachers were not generally consulted or respected.
- Most pupils were unaware that their school was part of the WHSA, although they thought it a good idea.

Curriculum and policy review

Schools responded well to the curriculum review schedule and stated that they found the process a valuable exercise that helped them to identify gaps and make changes in their health education provision. Every intervention school except one made additions, major in five schools, to their health education cur-

riculum during the award process. The policy review was complicated by inconsistent responses from schools making it hard to draw firm conclusions. It was clear, however, that intervention schools were more aware of the need to produce and monitor health-related policies and changes were made to cover such areas as healthy eating, a good community and bullying prevention.

Observations

The findings from the observations were largely inconclusive. Weather, timing, financial resources and age and deterioration of buildings were major influences on the state of schools and their environs. Constraints of time and resources – both material and human – meant it became impossible to control for all these variables.

Changes in the Health Education lessons observed at follow-up included a greater use of inter-active methods and increased involvement of other subject teachers, e.g. Maths and Science, who expressed the wish to participate in health-related aspects of the curriculum.

Project costs

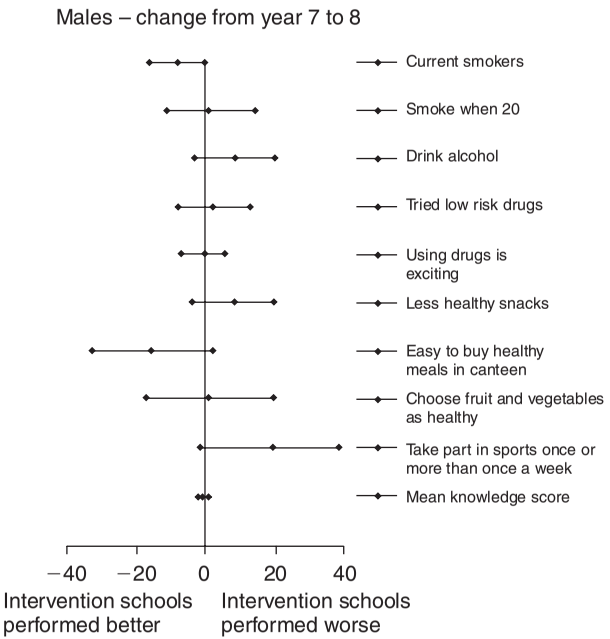
As might be expected, costs varied from school to school according to the LEA or health authority status and the degree of involvement of the supporter. LEA advisers are paid at a higher rate then health promotion officers (HPOs), resulting in higher costs for shorter amounts of time in a school supported by an adviser than in one supported by an HPO.

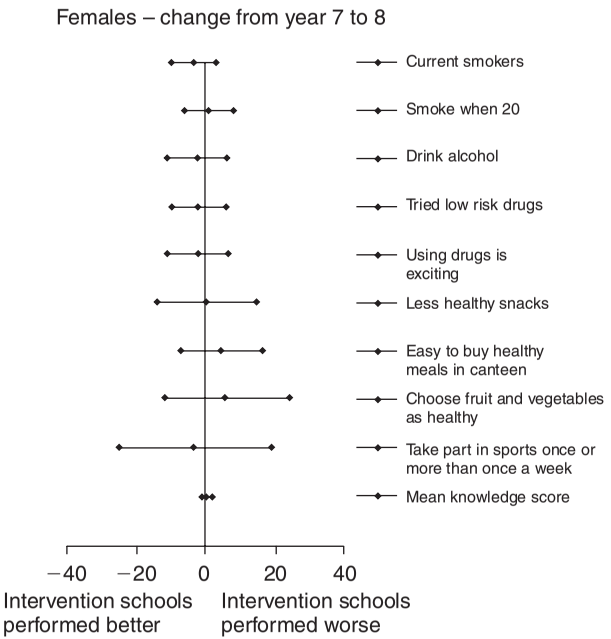
Reflections on the evaluation

Strengths of the study lie in its being an evaluation of an existing, well-established programme that was generally welcomed by schools and fully supported by LEAs and health authorities. A range of qualitative and quantitative methods was employed and tools constructed that involved representatives of the whole school community. Most aspects of school life were explored. Participatory approaches to evaluation were adopted and a mixture of process and outcome measures used as recommended by the WHO European Working Group on Health Promotion Evaluation in 1998.

The evaluation audit, the principle of which is integral to the WHSA scheme, provided an acceptable and practical framework for review and assessment of current health education and promotion practice in school, identification of gaps and goals, target setting and working for change. The audit schedule was very well received by teachers in intervention and control schools and is continuing to be used by project schools following the evaluation.

The SSIs also worked well and have provided a useful overview, possibly unique, of the perceptions of support staff concerning health education and promotion in school settings.


Males – change from year 7 to 8
Current smokers
Smoke when 20
Drink alcohol
Tried low risk drugs
Using drugs is exciting
Less healthy snacks
Easy to buy healthy meals in canteen
Choose fruit and vegetables as healthy
Take part in sports once or more than once a week
Mean knowledge score
−40
−20
0
20
40
Intervention schools performed better
Intervention schools performed worse


Females – change from year 7 to 8
Current smokers
Smoke when 20
Drink alcohol
Tried low risk drugs
Using drugs is exciting
Less healthy snacks
Easy to buy healthy meals in canteen
Choose fruit and vegetables as healthy
Take part in sports once or more than once a week
Mean knowledge score
−40
−20
0
20
40
Intervention schools performed better
Intervention schools performed worse

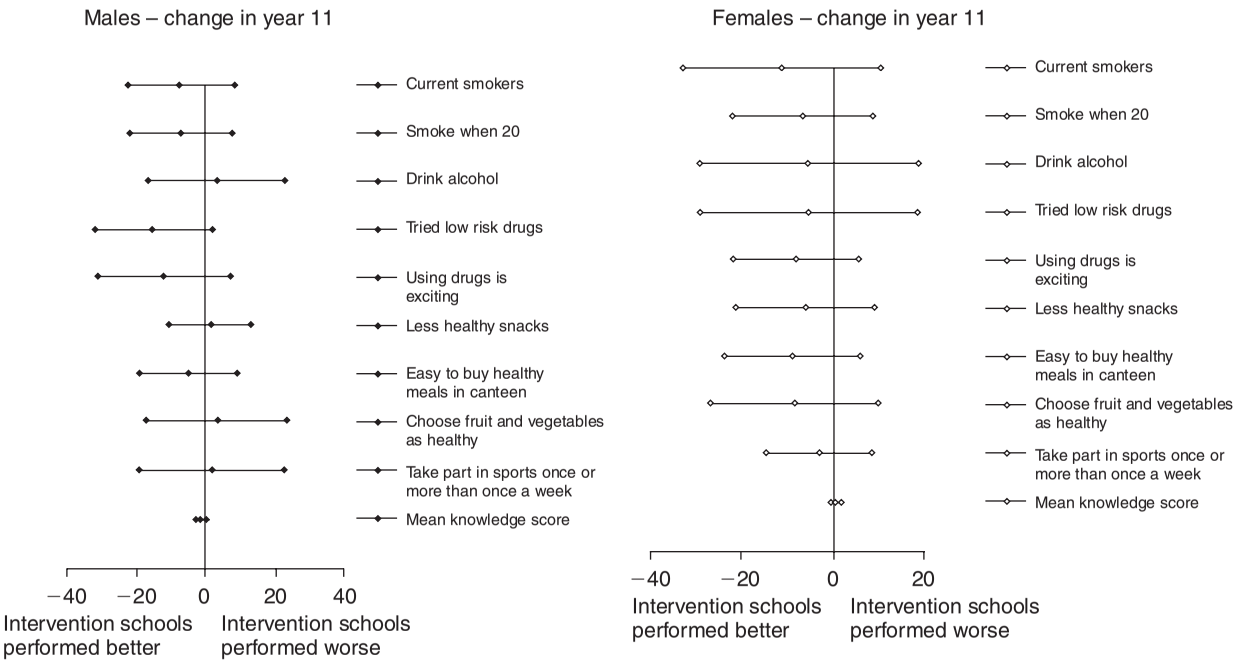


Figure 6.3 A comparison of pupil questionnaire responses in intervention and control schools using ten key marker questions likely to demonstrate change

The questions in the pupil questionnaire and in the lesson observation schedule were standard ones that had been tried and tested. The pupil sample sizes and response rates were good and using the same researcher in the audit, semi-structured interviews and observations largely eliminated observer variability.

The main weaknesses concerned non-randomisation, the small number of participating schools, particularly in the control group, and the resulting low power to detect statistically-significant results. The short time for the award process – four school terms – also made it highly unlikely that sustainable change in pupil health-related behaviour would be detected. There were difficulties in accounting for uncontrollable external influences, e.g. media focus on drugs, and major staff changes, which may have had a differential effect on the results.

A disadvantage of the audit tool lay in its comprehensiveness, which had a mild intervention effect on control schools, resulting in staff identifying gaps and changes needed in PSHE provision and practice.

The project was not able to produce a detailed review of health-related policies in all schools, largely because of problems with obtaining copies from the co-ordinators. Such problems had not been foreseen and tight time schedules and resources limited their procurement. It is clear, however, that participating in the award acted as an incentive to writing, rewriting and updating health education policies. These findings compare with those in the evaluation of the ENHPS project in England (HEA, 1998). Their research showed that only a minority of project schools had developed broad health-promotion policy documents during the period of the project. Instead, schools concentrated on producing individual topic-based policy statements on, for example, sex education. There was also little evidence of schools monitoring or evaluating their policies in terms of implementation and effectiveness, as in the WHSA.

In addition, the study was limited with regard to assessing the impact of the award on the school physical environment. Yet since the Ottawa Charter (WHO, 1986) identified creating supportive environments as an essential component of health promotion in schools, the physical environment as one aspect has been recognised increasingly as a key factor in promoting health and well-being. Constraints within schools, e.g. the existing infrastructure, lack of funds, limited access, and the use of only one researcher, meant that the observation did not prove to be a reliable indicator of change in the school environment. There was no time to restructure the tool and its application because environmental observation played one small part in this large study and had to be fitted into the research day at times dictated by the school. There were similar inconclusive findings regarding the environment in secondary schools in the ENHPS evaluation (Hamilton, 1997).

Conclusions

The conclusions are derived from condensing the totality of the evidence, both qualitative and quantitative, i.e. some of the points are not derivable from any specific set of results. They are based on triangulating a range of evidence from each aspect of the research. It is also important to note that the study was generally under-powered to detect significance because of using the school, of which there were fifteen, as the unit of analysis.

The WHSA scheme provided a structure and focus for health education in secondary schools, which raised awareness of health issues, motivated and facilitated action for change in school management structures and processes and influenced positively some health-related behaviour of pupils.

The evaluation audit, the principle of which is integral to the WHSA scheme, provided an acceptable and practical framework for review and assessment of current health education and promotion practice in school, identification of gaps and goals, target setting and working for change. It appeared to act as an intervention in itself, with teachers immediately identifying areas in which they wished to work, and could provide schools with a useful evaluation tool for the future.

More research and development is needed in the areas of healthy eating and promoting a smoke-free environment in school, the two weakest key areas. Ways of collaborating with school caterers and budget holders to improve school meals and snacks provision need to be explored. LEA edicts about non-smoking schools are not always implemented and how to ensure a smoke-free environment and give support to smokers wishing to give up need investigating.

Being part of the award scheme, with its focus on health education, had an impact on the provision and practice of curriculum-based health education in intervention schools and pupils have benefited from a more participatory and interactive approach to teaching. Subject teachers are willing to teach health education and/or emphasise the health-related aspects of their subjects if they are consulted and involved.

Although pupils were not always aware of the school's participation in the scheme, it appeared to have a positive impact on health-related attitudes and behaviours, particularly in the areas of smoking and use of low risk drugs. Knowledge levels were high at baseline and these showed little change.

Results from the pupil questionnaire in the areas of alcohol consumption and healthy eating were largely inconclusive and may be due to chance in the former. Inconsistencies by sex in the latter are likely to be due to differences in knowledge and perception between males and females although it is interesting to note that these linked with the low audit scores in this area.

Senior managers are key influences and players in health education and promotion in school settings and, without their active involvement and support in health-related initiatives, there are unlikely to be many positive changes in school structures, management processes and practice. The status,

incidence and policy, budget and resource provision for health education in school is largely dependent upon the value accorded it by senior management – also a key factor in achieving a whole-school approach.

The contribution of support staff to the health and well-being of pupils and teachers has been largely underestimated. They are well aware of their potential roles and wish to be consulted on matters relating to health and to be fully involved in health initiatives. It seems likely that their participation is crucial to achieving a whole-school approach and their active involvement might be assured by asking schools to set up WHSA teams, including representatives from each discipline, to monitor the awards progress.

It would seem that the degree to which school-based WHSA co-ordinators inform and involve members of the school population, parents and governors is variable and largely dependent on individuals and the time and commitment available.

Parents see their children's health as primarily their responsibility and health education as an area in which they would like to work in partnership with the school. They are pleased that schools are covering sensitive topics such as sex education but would like to be consulted and involved much more actively. This would seem to be particularly important in areas such as healthy eating, physical activity and smoking, where parental example and practice play such an important part.

Facilitating factors for a healthy schools award included staff commitment, senior management support, concern about pupils' health and pupils' awareness about health. Main barriers were seen as lack of time and resources, poor facilities and the catering service and provision in school. There is a growing recognition of the importance of good relationships and positive attitudes as components of a healthy school.

The lack of active involvement in the majority of schools of parents, support staff, governors and even pupils raises doubts over the achievement of a whole-school approach to health through the project – a concept that is built into the philosophical basis of a health promoting school. Further investigation is needed into whether the concept can become a reality and ways in which it can be achieved.

There appears to be no consistency in the degree of support and resources offered to schools by the HPOs or LEA advisers, with wide variations in time allocation and, therefore, individual costs. While recognising that entry to schools in this case must be by request, a more equitable distribution of support can only benefit schools.

The WHSA appeared to be an effective health intervention in school settings in influencing positively school management structures and processes and health-related behaviours but requires commitment of time and resources from health promotion officers (HPOs) and/or teacher advisers. The difference in salaries makes it more cost effective to involve HPOs, although it is important to maintain close links with the LEA in this successful healthy alliance.

There have been a number of major changes to the administration – and in some counties to the structure – of the WHSA to bring it in to line with government developments relating to a national healthy school scheme – the Healthy School Standard.

Summary

The evaluation of the WHSA scheme was complicated and the findings, to some extent, inconclusive. The study highlighted some of the difficulties with school-based research. There were problems with using a controlled approach and in recruiting a school sample, particularly the control arm. Randomisation proved impossible. The study emphasised that the complex nature of schools means that randomised controlled trials are not always appropriate or manageable, logistically and ethically, in school settings. Much depends on the purpose of the evaluation and what is being evaluated. Random allocation is not always possible, particularly in a study that compares schools and where schools can volunteer to take part in an intervention. Randomisation of schools makes the unit of analysis the school, which could cause problems with lack of power to detect change, unless there is a large number of schools in the sample. The fact that intervention schools are volunteers introduces a bias and indicates an immediate difference between them and any control schools before the study starts. The use of control schools can also be problematic if they too are volunteers, introducing a form of selection bias.

The difficulties in recruiting a sample may have been accentuated because there was a lack of monetary and resource incentive for schools to participate in the research. Some head teachers lost interest in participating when told that there was no money available to support the evaluation. A fine set of worthy but intangible benefits that may accrue from participating are unlikely to prove sufficiently persuasive in busy school settings with a focus on academic achievement.

The evaluation confirmed the need for a variety of research approaches, both qualitative and quantitative, to assess a range of aspects of school life and demonstrated the importance of triangulation of results to strengthen the findings. Some of the research instruments used in this study proved more useful than others and it is worth noting that the observation of buildings and grounds, states of cleanliness, etc. is fraught with difficulties. Unless all schools can be observed at the same time on the same day, the results will be inconclusive. The school and curriculum audits, relating to health and provision of health education, proved particularly useful, especially where representatives from different subject disciplines were able to meet together for discussion. The vital role of non-teaching staff, parents and governors in helping a school to move towards becoming health promoting became very clear – and their wish to be involved actively was expressed frequently. It would seem important for these groups to be

included in the planning and development of health initiatives in schools to help ensure a whole-school approach. The focus group interviews with pupils provided an insight into their perspectives on a healthy school and the factors promoting or mitigating against their school becoming one.

Another major difficulty for the researcher lay in the many daily pressures on schools that resulted in sudden and unexpected changes to routines, plans, meetings, etc., and the apparent lack of understanding of the research process amongst many teachers. Research timetables had to be changed because of changing priorities, and everything seemed to take twice as long in practice than on paper. This highlighted the importance of having a co-ordinator of the project within each school who met regularly with the researcher and liaised with other staff. Regular consultations with senior management and heads of department, as appropriate, proved invaluable.

The concept of a whole-school approach proved difficult to delineate and put into effect. Uni-lateral decisions were made and aspects of the project abandoned when pressures within school became too great, resulting in a lack of consultation with other stakeholders and a halting of progress. Much more work is needed on what a whole-school approach means and how it can best be achieved.

The evaluation highlighted the importance of partnerships between education and health authorities working in schools and the need for their representatives to work closely together to achieve success in healthy school initiatives. Overall, the evaluation demonstrated that the WHSA intervention had a positive impact on schools and resulted in changes in a number of areas of school life, including management styles, curriculum content and pupil health-related behaviours.

7 The evaluation of the Nottinghamshire Towards Health Project

Introduction

This chapter describes the purpose, structure and evaluation of a five-year local health-promoting school project. The chapter starts by outlining the rationale behind the project. It then details the management and organisational features of the three stages of the project: recruitment, development and dissemination.

After giving an overview of the evaluation methods used, within the framework of action research, the chapter focuses on the degree to which change was achieved in the diverse group of twenty schools that participated in the development stage. The chapter concludes with a summary of key factors needed for successful change, from the vantage points of both school and project.

Background

The Nottinghamshire Towards Health Project was conceived in response to the developments and pressures explored in the earlier chapters of this text. Essentially, these developments related to the emergence in the late 1980s of the concept of the health promoting school (Young and Williams, 1989), a growing acceptance that the concept provided the most appropriate and effective framework for guiding public health action in the setting of the school (Rogers *et al*., 1998), and the policy drive by the World Health Organization (WHO) Europe towards its widespread implementation (Parsons *et al*., 1997).

Within the UK, these international developments coincided with mounting pressures to find effective solutions for the promotion of the health of children and young people. Yet, paradoxically, as the case for innovation and investment gathered momentum, the status of health education in schools actually diminished (NFER, 1993). Additionally, the curriculum and professional support services provided by local education authorities were cut back (Denman, 1994). Nationally, a guidance document on health education, espousing the whole-school approach to health promotion, was distributed to

all state schools by the National Curriculum Council (NCC, 1990b). Later, a pilot project was launched under the auspices of the European Network of Health Promoting Schools initiative (WHO, CE, CEC, 1993). Notwithstanding these developments, there was little evidence of leadership or indeed a commitment at the national level to a strategic approach to the development of schools as health-promoting environments. Furthermore, there was a dearth of published materials that schools could use to convert policy to practice.

The Nottinghamshire Towards Health Project was the strategic response of the local health and education services to these pressures and needs. There was a good base on which to build a successful initiative: a co-ordinated approach to the formulation of policy and the provision of training across the services of health and education; the provision, by the health sector, of a relatively well resourced training and consultancy service for the 550 schools in Nottinghamshire; and a history of successful partnership work involving the health promotion specialists, education advisers, school nurses and university staff.

The broad aim of the Towards Health Project was to advance the formulation and implementation of school policies in line with the health promoting school. Four principal objectives were identified:

- to establish the state of development of school policies in health education and health promotion and to determine the extent to which they reflected the content and practices of the health promoting school;
- to recruit twenty diverse state-maintained schools to formulate and successfully implement action plans for the development of the health promoting school;
- to provide the assigned teachers the responsibility of liaising with the project and their schools with an appropriate and effective training and consultancy service for the development of the health promoting school;
- to disseminate exemplars of good practice, including the practical tools needed to convert policy to practice, from the twenty core project schools to all schools in the county of Nottinghamshire.

The theories of management of change (Fullan, 1991) and the diffusion of innovations (Rogers and Shoemaker, 1979; Rogers, 1983) were drawn on to inform the design. Given the early stage at which schools were in developing their health promoting status (NFER 1993, Denman *et al.*, 1999) and the centrality of teachers to successful development (St Leger, 1999), teachers were selected as the principal target group in the intervention. Teacher empowerment and advocacy for school health were chosen as key dimensions to provide a strong basis for development and sound partnerships involving schools, their communities and the project team.

Management and organisation

The Towards Health Project was funded by the Nottingham, North Nottinghamshire and the former Trent Regional Health Authorities. It was implemented by a project team, which consisted of a senior teacher who was seconded from a local secondary school to act as the project co-ordinator; four health promotion specialist practitioners with a remit for schools in the two health promotion specialist units in Nottinghamshire; and the lecturer in health promotion at the University of Nottingham, who directed the project. This team drew on the advice and support of a wider network of professionals but principally the project advisory group, the membership of which was drawn from the health and education sectors.

The Towards Health Project was based on a similar design to other school health promotion initiatives such as Health for Life (HEA, 1989), and Health Skills (Anderson, 1989), both of which used teacher involvement and research in their preparation and involved the dissemination of quality resources. It consisted of three distinct but overlapping stages, namely: recruitment, development and dissemination. (See Figure 7.1 for a summary of the structure of the Project.) The *recruitment stage* commenced with the mailing of project publicity materials to all state-maintained primary and secondary schools in Nottinghamshire (449 schools). Schools interested in joining were sent an application form for completion. A condition of acceptance was that head teachers should sign a written 'working agreement' committing the school to the identification and development of the two priority areas in the health promoting school; assigning a teacher of senior status and influence to liaise with the project; and matching the teacher replacement monies provided by the Towards Health Project in the school's first year of involvement.

The purpose of the recruitment drive was to generate a pool of applicants to the project from which twenty diverse schools could be selected to generate the ideas and materials for wider dissemination. These schools were to be chosen by purposive sampling, for maximum diversity, to increase the likelihood of the project's products having practical use in the wider population of the schools in Nottinghamshire. A full account of the recruitment strategy is given elsewhere (Denman *et al*., 1994).

Ten secondary, eight primary and one of each of infant and middle schools were recruited. The schools varied greatly in terms of their size, geographical location, the stage they were at in developing their health promoting status and their priorities for future development. The majority did not have a policy for health promotion and had not addressed the in-service training needs of their staff in the two years prior to signing up to participate in the Towards Health Project.

During the *development stage*, which was eighteen months long, these twenty schools were engaged in policy formulation and consultation, action planning and the implementation of action plans. The action plans of the

schools spanned a wide range of concerns in the health promoting school and across all the schools reflected the full scope of the concept, as discussed in Chapter 2. They covered: curriculum review and planning in topics such as sex education and mental health; organisation and management; development of partnerships with parents and the wider community; staff training; and whole-school issues related to nutrition, first aid and the physical environment.

The teacher contacts, called for the purposes of the project 'the project link teachers', and their schools were provided with a consultancy service. This was provided by the project team to assist in the review of school policy and practice, the assessment of need, the development of an action plan and the implementation of the action plan. Additionally, a programme of centre-based in-service training was provided for the project link teachers and funding for teacher replacement time to enable teachers to be released from the classroom to undertake administrative tasks, attend meetings and in-service training events, and purchase resources. The profile of the project was kept high during the development stage by using mass-media approaches to publicise the innovative aspects of the schools' work. The rationale behind this strategy was to ensure that the successes of the project schools were visible to all, thereby generating and maintaining interest among the other schools in Nottinghamshire, thus increasing the likelihood of a successful dissemination stage.

The *dissemination stage* commenced with the unsuccessful applicants to the Towards Health Project being invited to attend a training day to preview and comment on the draft practical guidance manual. The final draft of the materials was disseminated to all schools, free of charge, through a programme of consultancy and training. This dissemination stage was time limited and those schools that had not accessed the project were sent a copy of the resource by post. The total length of Towards Health, from the recruitment of the twenty core schools to the dissemination of the resource, was five years.

Evaluation

Towards Health was an action research project. Action research combines research and development to generate knowledge about a social system whilst simultaneously trying to change it (Bowling, 1997; Hart and Bond, 1995). The evaluation was undertaken by the project team members and the project link teachers. The advantage of utilising this model was that it was empowering for the teachers and project personnel. Importantly, it also enabled the project to be adapted to the expressed needs and concerns of the participants.

The principal aim of the project related to policy formulation and implementation. Changes in the state of the development of school policies and guidelines were monitored, using a structured postal questionnaire, at the start and end of the project. However, these survey data were not intended

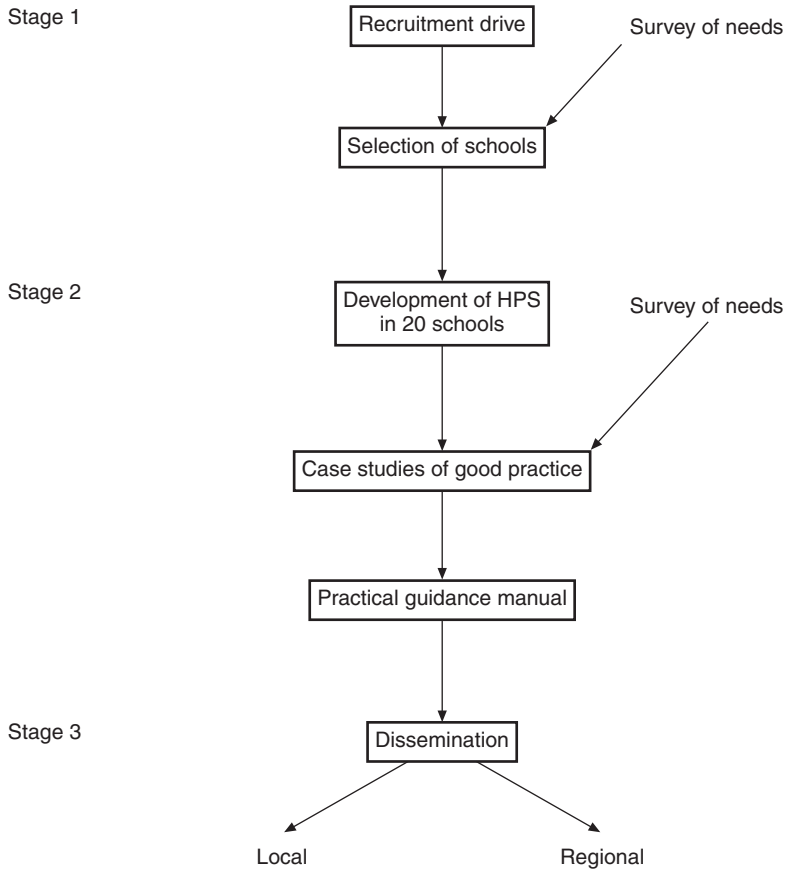


Figure 7.1 Plan of the Nottinghamshire Towards Health Project

as a means of measuring the overall success of the initiative, given the timescale of Towards Health (five years) and the wide range of influences that could have prompted schools to formulate them.

To gauge the success with which project objectives were met, separate evaluations were undertaken on the three stages (see Table 7.1 for an overview of the methods). Quantitative methods were deemed most appropriate to evaluate the *recruitment* and *dissemination* stages. A comprehensive project database was set up to enable the contact of schools with the project to be monitored and to target the resources of the project. Analysis of the information provided by the school applicants on the project application forms and a follow-up of non applicants enabled a thorough assessment to be made of the success with which the objectives of the recruitment drive were met. (For details of the evaluation of the recruitment drive see Denman *et al*., 1994.)

Evaluation of the dissemination stage centred on establishing the method used by schools to access the resource, their perception of its usefulness and the specific use they made of the resource. This component of the evaluation required the provision of information by the team of health-promotion specialists engaged in the dissemination process. It also necessitated the completion, by teachers, of a structured questionnaire, which was distributed with the manual.

Evaluation of the development stage commenced with a baseline review, conducted by the project link teachers with their assigned consultant. A semi-structured schedule was designed to enable the health-promoting status of each school to be assessed, to further identify development needs, to refine objectives and to seek joint solutions to problems. In some schools the review led to further research. One primary school, for example, carried out a survey of the views of parents on school health education. A secondary school surveyed teachers to ascertain their attitudes to, and involvement in, health promotion in order to inform the development of a training programme in the health promoting school.

The subsequent role of the project link teachers in the evaluation centred on assessing the degree of success with which their respective schools achieved the objectives of their action plans. As was expected, given the variation across the schools in the objectives of the action plans and the differences in the speed with which they implemented them, a wide range of evaluation methods were used, with some schools not reaching the stage at which they could evaluate their work within the official time-scale of the project.

The common theme that bound the twenty project schools together was change and the management of change at staff and organisational levels. Qualitative methods were deemed most appropriate to establish the extent to which change had occurred as the schools were characterised by diversity and it was expected that the combination of factors that determined progress will have been unique in each school. This part of the evaluation involved face-to-face semi-structured interviews of project link teachers at end of their official period of participation in the project. The director of the project conducted the majority of the interviews with the assistance of one of the members of the project team. The schedule included some of the questions used in the baseline interview, to enable responses to be compared and to establish the changes that had occurred in school and the factors associated with them. The interviews were tape-recorded and transcribed and the transcriptions were analysed for content.

To validate the data, in five schools, the head teacher and one other teacher were also interviewed. Further validation of the data was provided by the termly accounts of development written by the project link teachers and the reports of the project team members, which drew on their role as participant observers in the project. The interview process had an additional function to evaluating the project. It served as a review for the project link teachers and their schools at the official end of their participation in the project, as the basis of further action planning for the future.

Table 7.1 Evaluation of the Towards Health Project

Timescale	*Stage*	*Purpose*	*Evaluation method*
3 months	Recruitment	To assess the success with which recruitment-drive objectives were met.	Analysis of application-form responses; Structured telephone survey of non applicants.
18 months	Development – Implementation of school action plans	To review the health-promoting status of the project schools and build partnership;	Semi-structured questionnaires completed by project link teacher and consultant;
		To assess progress in the implementation of the action plans;	Various, depending on specific objectives of schools;
		To gather information for project record and for data validation.	Analysis of termly written account of development by project link teachers; Observation of schools.
	Project evaluation	To determine the changes achieved and the influences on change;	End of project semi-structured interviews of project link teachers, head teachers and teachers;
		To ascertain acceptability and appropriateness of training;	Structured questionnaire completed by project link teachers;
		To evaluate overall project mechanisms;	Focus group discussions involving project link teachers;
		To monitor trends in health-promotion policy and identify development needs.	Structured postal questionnaire completed by head teachers and teachers in charge of health education at start of project and 5 years after.
2 years +	Dissemination	To assess the acceptability of the practical-guidance manual and dissemination method;	Structured questionnaire for teachers;
		To assess the number of schools receiving the practical-guidance manual.	Analysis of computer database at university.

The wealth of data collected in the evaluation studies necessitates the selection of data for presentation in this chapter. Therefore key results from the evaluation of the development stage are presented below.

Results of the evaluation of the development stage

Change was assessed in three interrelated areas: the knowledge, skills, role and status of the project link teachers; the professional practice of the school staff; and the management and organisation of health promotion and the health promoting school. As might be expected, the changes reported in the

knowledge and skills of the project link teachers varied according to their prior experience and expertise as teachers and managers. Improved levels of knowledge were reported and observed in the theory and practice of the health promoting school and enhanced skills in teaching and management. Additionally, the status and profile of the project link teachers improved in school as a result of their participation in the project. Any changes concerning the rest of the teaching staff and the non-teaching staff centred on an improved awareness of the social model of health, the health promoting school and the contribution that staff could make to school development. Raised levels of confidence were reported and more professional attitudes, manifested, for example, by the ability of staff to reach consensus on sensitive policy issues in health promotion.

The main development at management and organisational levels was the raising on the list of priorities of the schools of health education and the health promoting school. This led to more structured approaches to planning, better co-ordination and the more flexible use of resources. Some schools also managed to involve a greater proportion of staff in the planning and implementation of their health promotion programmes than was the case formerly. Additionally, progress was made in line with specific objectives related to the concept of the health promoting school. With regard to the impact of the innovation on children, most teachers felt that it was too early to discern changes but nevertheless reported a heightened awareness among their pupils of the importance of health promotion and improvements in behaviour and self-esteem.

Although the majority of schools (fifteen of the twenty) had succeeded in implementing their action plans in part or in full, when assessed in terms of change, only modest incremental changes over the five terms were reported, with schools represented at all levels on the scale of achievement. In general, the challenge that remained was how best to diffuse the ideas and practices advocated by the project from the project link teachers to the rest of the staff. This was confirmed by the interviews of the classroom teachers, which showed that they did not have an overview of their schools' plans and activities in health. They tended to confine their responses to their own personal contribution to health education, without a clear picture of how this contribution fitted in with the school-wide programme of health education or the whole-school approach to health education. Taken together, these findings reflect the general problem that schools have in achieving educational change (Crandall *et al*., 1986; Fullan, 1991; Hopkins, 1994) and the difficulties they experience in diffusion (Anderson and Portnoy, 1989).

Engaging with the innovation

A substantial proportion of the schools (40 per cent) were unable to adhere to the two priority areas identified for development at the start of the project. The false starts made suggest that the needs and priorities of schools

often become apparent to them only when they have embarked on implementation. This observation has also been made by other studies on educational change (Fullan, 1991).

Evaluation studies consistently highlight the importance of the role of the co-ordinator and the need for the designated person to be of senior status and a position of influence in school (Allensworth, 1994; McBride *et al*., 1995; Moon *et al*., 1999b; NFER, 1998). Yet the majority of schools participating in the Towards Health Project were unable to meet the requirement of the project agreement in this respect. Being of senior status does not automatically confer leadership qualities, but data from the evaluation of the Towards Health Project suggest that it is important in engendering a sense of empowerment and may even be a critical factor in successful implementation where a school's organisational structure is lacking in other ways. Additional problems stemmed from the schools' inability to give the project link teachers the dedicated time needed to undertake their leadership and management tasks effectively. These observations are consistent with the findings of research on school policy and are indicative of the pressure on resources and the low status of health education in schools (NFER, 1993; Denman *et al*., 1999).

The contact between the project team members and the project link teachers was the principal means by which support and advice were to be tailored to the needs of the teachers and their schools. It was to provide further opportunities for the teachers to engage in problem solving, an important factor in the readiness of organisations to adopt, implement and maintain programmes of learning on health (Basch *et al*. 1986). Furthermore, it was to enable a mix of support and pressure to be applied, identified by the teachers in the present study and by other studies of school change, as an important characteristic of successful change projects (Hopkins *et al*., 1994). In the present project, the schools and their consultants were left to decide how to organise their contact. This led to marked variations across the schools in the frequency with which the consultancy service was used and therefore its potential benefit.

Policy was formulated at different points in the development cycle across the schools, with some schools writing their policies in the middle or at the end of the period of the implementation of their action plans stage. Observations of the processes and actions of the schools showed that in general the development of the health promoting school was piecemeal and erratic, with schools embarking on actions for limited periods of time and then moving on to other development areas not directly connected to the health promoting school. This is, at least in part, due to the multiple responsibilities of teachers and the limited time they have to devote to health promotion.

Influences on success

A wide range of influences, both internal and external to the schools, emerged as having influenced the pace and nature of development. These

exerted a mix of positive and negative effects and were cumulatively powerful in determining the degree of success and the shape of health promotion provision in the schools. Among the many and varied influences, the Towards Health Project was consistently endorsed as positive influence. The value placed by the respondents on the time provided for planning and administration, the training and networking opportunities and the school-based consultancy service concurs with the findings of two published evaluation studies in the UK, the European Network of Health Promoting Schools project (NFER, 1998) and the Wessex Healthy Schools Award Scheme (Moon *et al*., 1999a and b) and the essential characteristics of external change efforts, synthesised by Hopkins *et al*. (1994), Hopkins (1995) and Fullan (1991), from their reviews of pedagogic and organisational change. Yet, from the modest advances made in the project schools overall, it would appear that Towards Health had limited influence on the achievement of change, a common finding in the evaluation of external change efforts (Crandall *et al*., 1990; McLaughlin, 1990).

The factors that constrained progress originated from the internal management and organisational structures of the study schools, the communities they served and national policies. Of these factors, the schools' organisational structures were particularly powerful in militating against progress. The commitment and involvement of the staff, both teaching and non-teaching, were essential to the success of the project in the schools. Other studies have highlighted the importance of staff being aware of the benefits that an innovation can bring, the support of staff and the meeting of their training needs (McBride *et al*., 1995; Moon *et al*., 1999a and b; NFER, 1998). For the diffusion of the project in the schools, it was necessary that the project link teachers discharge their roles effectively and this, in turn, required communication and liaison with other members of staff coupled with sufficient time and resources to support the development process. However, in reality poor communication structures, a lack of time for administration and inadequate resources prevented the project link teachers from diffusing the project in their schools. This was exacerbated by the peripheral involvement of the head teacher at the implementation stage. Studies on school effectiveness and school improvement have found the leadership of schools to be of crucial importance (Fullan, 1986; Mortimore *et al*., 1988) yet, as found in the Towards Health Project, management frequently assume that their responsibility has ended once they have taken the decision to adopt an innovation in their schools (Houghton, 1987).

To ensure that the health promoting school is within the frame of actions taking place in schools it is essential to include it in the formal development plans of schools. This necessity was singled out by both the project link teachers and the head teachers in the present study and was highlighted by other evaluation studies of the health promoting school (McBride *et al*., 1995; NFER, 1998), Health Education (Anderson and Portnoy, 1989; Gold *et al*., 1991) and school change (Hopkins *et al*., 1994). Unfortunately, the

recruitment stage of the project did not coincide with the development-planning cycle of the schools recruited, an oversight which proved to be a major barrier to progress.

Schools that experienced particular problems

The five schools that experienced profound problems in getting beyond the starting line possessed common characteristics that set them apart from the majority of the study schools. They tended to start from a low level of development, were more likely to change their original objectives and to allocate the responsibility for project liaison (and the co-ordination of health education) to class teachers of junior or middle management status. A number of negative influencing factors appeared to interact in complex ways to bear upon project outcomes in these schools. Whereas all schools had to contend with pressures and conflicting priorities, these schools did not have any reserves in their capacity to deal with added, unexpected pressure. New legislation in sex education, for example, diverted them from their original plans for development and a school inspection halted development in all but the mandated subjects. Change was difficult to achieve as the school organisation was not supportive or facilitating of change. Deeply ingrained traditions existed of responding reactively to pressure and of employing crisis management techniques to solve problems. These traditions extended to health-negating practices, for example unhealthy foods being sold in the school tuck-shop – practices which the project link teachers perceived as being difficult, if not impossible, to challenge and change. Such were the internal organisational barriers in these schools that the project link teachers concluded that unrealistic objectives had been set by the school at the start of the project and that the schools had 'overreached' themselves. This contrasted sharply with the impression given by the teachers interviewed from the group of schools that had achieved their objectives and in some cases had progressed even further. Their responses reflected a balance between the positive and negative forces shaping health promotion in their respective schools, and a greater sense of control and optimism about the future.

Reflections on the evaluation

Sufficient actions were generated in the project schools in policy formulation and implementation to compile a practical guidance manual, consisting of exemplars of good practice, for dissemination to all schools in the county of Nottinghamshire (Towards Health Project, 1995). Project objectives concerning the formulation and implementation, by the schools, of realistic action plans during the period of their participation in the project met with less success. It is acknowledged, however, that although some schools were lagging behind others, some will have achieved their plans outside the timeframe of the project (Towards Health Project, 1995).

The evaluation design prevented the drawing of firm conclusions about the precise impact of the project on the development of the health promoting school in the project schools, in terms of the actual actions undertaken, the changes reported or the pace of development. It is likely, however, that some influence was brought to bear on the positive changes observed in the schools. Similarly, the small scale of the evaluation study and the highly-selected school sample place strong restrictions on the generalisability of the findings beyond, at best, the group of schools that had elected to apply for a place on the project. Nevertheless, the comparisons of the principal findings with the results of larger-scale studies of quasi-experimental designs in the health promoting school and review studies on school change, school improvement and school effectiveness, suggest that the challenges and problems facing the project schools reflect the concerns of the wider population of schools in the state-maintained sector. These concerns relate to the slow and uneven nature of the change process and the constraining nature of their internal and external environments. With regard to the health promoting school, any problems that schools face in attempting to adopt the approach will be exacerbated by the complex and multifaceted nature of the change effort, the inadequacy of their internal environments to support development and, importantly, the long-standing inadequacies of Government education policy in legitimising activity in health education and related areas.

The evaluation of the development stage of the Towards Health Project led to the conclusion that, given an interest in developing health promotion and specific conditions that support the teacher in charge of health promotion and the change effort, schools can progress in developing their health promoting status and benefit from the assistance and support of a project modelled along the lines of Towards Health. The schools that are likely to benefit are those that are already well underway in adopting the principles and practices of the health promoting school and are in a position to capitalise on the opportunities offered. Those engaged in supporting schools in the development of this area of work need to have realistic expectations and be prepared for the unpredictable nature of their schools' success.

In summary, the following are of importance for the successful development of the health promoting school:

In schools –

- the provision of a health education curriculum of high status;
- the co-ordinator having the status, time and skills to lead and manage staff (the co-ordinator should be remunerated for undertaking the responsibility);
- the awareness, confidence, support and involvement of as many staff as possible;
- training and support for staff;
- consultation with all groups in school and appropriate groups in the community – consideration should be given to the use of working groups;

- good management, organisational and communication structures;
- the placing of the health promoting school in the development plan;
- the involvement of the head teacher and other senior managers;
- a dedicated budget and adequate resources.

Provisions made by the Project –

- a vision that can be translated into practice;.
- flexibility and a realistic expectation of schools;
- practicality, so that teachers learn by trying out new ideas;
- training and support of staff, particularly the co-ordinator, being in the frontline of development;
- a mix of support and pressure;
- training that meets the specific needs of the co-ordinators in its content and the needs of schools in its organisation;
- networking opportunities for teachers;
- resources to enable teachers to be released for training.

8 The evaluation of the health promoting school: a European perspective

Introduction

This chapter places the evaluation of the health promoting school in a European context. It describes both a formative evaluation project commissioned by the secretariat of the European Network of Health Promoting Schools (ENHPS) and the subsequent development of a multi-dimensional evaluation instrument. This instrument has been used in different European countries as a means of collecting data on schools who are working within national healthy schools or health promoting school schemes and in particular to profile the health promoting school. It has also been used to collect data in a national context on the provision of health promotion in schools. More recent developments include refining the instrument to meet the evaluation needs of national dissemination projects such as the Irish Health Promoting Schools and Social Personal and Health Education Project, the Welsh Network of Healthy Schools schemes, and the English Healthy Schools Standard.

A formative evaluation project: The Implementation of the European Network of Health Promoting Schools (ENHPS) in Different National Contexts

This evaluation project (Parsons *et al*., 1997) took place in six countries between April 1996 and March 1997. Three eastern European, two northern European and one southern European countries were chosen. The six countries chosen – Lithuania, Ireland, Poland, Portugal, Romania and Sweden – were a sample of the thirty-seven countries who, at that time, comprised the membership of the ENHPS. The sample was selected on the basis of geographical spread; length of time countries had been members of the ENHPS; and a representative range of differing national economic conditions, administrative and control structures for education and public health systems.

The objectives of the research were to investigate:

- the extent to which the working practices and the structures established were consonant with the aims of the ENHPS;
- models of health promotion and health education being used to develop work in European schools;
- the political, social and managerial influences on schools that affected their health promoting ethos;
- support for schools in their management of institutional change in relation to health promotion.

This study provided an account of the different approaches being taken to establish health promoting schools in Europe. Further it allowed national initiatives to be compared and contrasted. The identification of good health-promotion practice, particularly in the setting of schools, was a prime objective of the study. This work complemented wider evaluation of the ENHPS (Piette, 1996; Piette *et al*., 1999). The main outcomes were to produce a report of the findings from the evaluation, four national case-studies and an evaluation instrument for assessing the progress of schools within the ENHPS.

Initially a framework for data collection was established. The framework was based on a conceptual analysis and development of the eco-holistic model of the health promoting school described in Chapter 3 (Parsons *et al*., 1996), pilot work undertaken in three European countries (Thomas *et al*., 1998), and fieldwork in local schools in the south of England.

The research methodology employed was mainly qualitative. It used a multi-focused approach to the collection of data including analysis of documentary evidence; face-to-face interviewing; telephone interviewing; and observation. Four days were spent collecting data in each of the six countries from representatives of relevant Government ministries, national and local health and education agencies and pilot project schools within the ENHPS.

The use of self-completion questionnaires was considered to gain comparable data across national projects or from schools within the national projects, particularly schools that were not visited in the six case study projects. However, the research team was dissuaded from using questionnaires by two factors that became evident during visits made and interviews conducted during pilot work: first, although the translation and comparability of data did not pose any major difficulties, the team judged that individuals would not complete questionnaires easily or willingly; secondly, there was some resentment expressed over other questionnaires that had been filled in, at some effort, where the acknowledgement or feedback was late or not helpful. These factors may be relevant to others researching health promoting schools in an international context. If questionnaires are used, consideration should be given to how to conduct and report on a given survey so that those surveyed are respected and informed.

Interviews were structured at three levels; international level, national level and school level. It was necessary to build up a picture of how the ENHPS functioned as an international project. Interviews were carried out, therefore, with two professionals of the technical secretariat of the ENHPS, based at the World Health Organization's European office in Copenhagen. It was important to determine their perception of the health promoting school and clarify the history of ENHPS, the management of the network at the international level and the support, in terms of activities and finance, that was available.

At a national level documentary evidence of individual countries' approaches to the development of the health promoting school was examined and a comparison made between member countries of the ENHPS. Government officers concerned with policy development in education and health in each of the six countries were interviewed. The main objectives of the interviews were to identify policies affecting school health promotion; ascertain the degree to which the national health promoting school policies reflected a social or behaviour change model of health promotion; and to gain an understanding of the context of official support. Government officers were asked to outline the nature of the investment in health promoting schools, describe their roles in policy making and summarise the part they played in managing health promotion in settings. In addition, documentary evidence on the health needs of each country and on school health promotion policies was examined.

At the institutional level a selected group of pilot schools from the ENHPS were visited in the six different countries. The object was to seek evidence and illustration of the implementation of a health promoting school policy and the impact of the ENHPS (see Table 8.1 for countries and schools visited during the period of the evaluation project). Evidence from schools was gathered and organised for analysis under the five headings shown below as key elements of the eco-holistic model of the health promoting school.

Management, planning and roles

Interviews with senior staff, analysis of organisation charts and job descriptions were the main source of information.

Formal curriculum

Documentary evidence of school policies, timetables or syllabuses were examined. Some evidence was obtained from the national co-ordinators of the ENHPS. Staff with a health-promotion role were interviewed about the aims, content, strategies and factors influencing health promotion in the curriculum. A few observations were made in lessons and other formal provision during school visits.

Table 8.1 Countries and schools visited in the ENHPS evaluation project

Country	*Dates of visits*	*Schools visited*	*Numbers of non-school personnel interviewed*
Lithuania	11–18 May 1996	Primary School 1 Secondary School 1 Secondary School 2 Secondary School 3 Gymnasium 1	16
Ireland	27–30 May 1996	Primary School 1 Primary School 2 Secondary School 1 Secondary School 2	8
Poland	10–13 June 1996	Primary School 1 Primary School 2 Primary School 3	10
Portugal	7–11 1996 October	Consortium of schools 1 (Kindergarten, Primary, and Preparatoria) Secondary School 1	12
Romania	18–21 November 1996	Primary School 1 Primary School 2 Secondary School 1 Secondary School 2 Secondary School 3 Technical School 1	10
Sweden	9–13 September 1996	Secondary School 1 Secondary School 2 Secondary School 3	8

The social and physical environment

Documentary evidence of policies on health and safety was examined. Observations of the physical environment and discussions with staff and parents about the social environment of schools were recorded during visits.

Feelings, attitudes, values and health-promoting behaviour

Interviews with project co-ordinators focused on the emphasis given in a national project to the affective dimension of health promotion and how schools were responding to the promotion of changes in health-related behaviour among pupils and staff.

Links with outside agencies, the family and community

Agents outside the school were interviewed about their role in the policy-making process and initiatives associated with the health promoting school.

Findings from this six-country study of the implementation of the ENHPS have been reported at length and in detail elsewhere (Parsons *et al.*, 1997). The quality of data collected and the scope provided for analysis enabled comparisons and contrasts to be made between the six countries, their national health promoting schools projects and the way they had implemented the concepts and guidelines of the ENHPS. It was possible from the analysis of data to arrive at twenty-three critical issues and recommendations for consideration by the technical secretariat of the ENHPS and its International Steering Group. However, the study highlighted five positive findings about how the ENHPS was perceived in the six countries visited.

- The ENHPS was seen by member states as an internationally credible vehicle for developing public health policy, forging healthy alliances and stimulating community action.
- It has also become a major influence on the development and enhancement of health education and health promotion in schools across Europe.
- Certainly the ENHPS has the potential to foster internationalism and equality of opportunity in the field of school-based health promotion on a scale that has still to be realised in other settings for health promotion.
- The network has evoked a high degree of enthusiasm amongst personnel at all levels of operation, management and control of school-based health promotion.
- Last but not least, the ENHPS has laid the foundation for deeper and wider developments and has operationalised, in the school setting, a philosophy of health promotion that reflects both ecological and holistic approaches.

In addition to the main report on findings from this study, four case studies of pilot health promoting schools from Ireland, Poland, Portugal and Romania were established. These enabled the research team to use the depth of qualitative data gathered to produce clear portraits of the kinds of institutions visited. By drawing on the distinctive features of these four schools the case studies helped to identify individual national characteristics that epitomised the richness of cultural diversity among, and particular health-promoting characteristics of, the pilot schools within the ENHPS. A detailed review of the Irish case study was provided in Chapter 2; examples of the distinctive features of the other three health promoting schools are provided below.

Primary School 3, Poland

This is a primary school of 1770 students aged 7–15 and 120 teaching staff. The school is in a town within a rural district of Poland that has high levels

of unemployment, alcohol use and single-parent families. Participation in the ENHPS has raised the profile of care for health within the school and has been a major factor in improving relationships with the local community. As is typical of Polish ENHPS schools, a member of the senior management (the deputy head teacher) is the health promotion co-ordinator at this school and works with a health promotion team of twenty-two people. Of particular significance, health education is integrated into many subjects across the school curriculum. Participatory learning and teaching and health promotion has been successfully introduced in the school through intensive teacher training. The school has considerable experience of drug education for young people. Relationships between pupils, teachers, parents and non-teaching staff are a focal point for development in the school as a health-promoting institution. The key focus has been on ecological and environmental issues, stress management and improving the school environment. Active international links have been established with the Slovak Republic, Czech Republic and a school in England.

School Consortium 1, Portugal

This is a consortium school consisting of kindergarten, primary school and preparatoria, dealing with an age range of 4–16 years, and set in the mountains 200 km north of Lisbon. As with all the ENHPS schools and consortia schools in Portugal, this school has close links with the local health centre and has its own doctor and school nurse. Distinctive features of the school include a very broad, democratising and empowering approach to health promotion and involvement in two other major national health-promotion initiatives. Key areas of development have been questionnaires to parents of kindergarten children asking them what sort of health education activities they would want to see introduced for their children; an environmental education programme for the primary school, and improving relationships with parents of children in the preparatoria. However, the most important feature of the consortium is the continuity of health-promotion provision across educational phases for children between the ages of 4 and 16 years.

Secondary School 2, Romania

This is a primary and secondary school of 1860 students aged 6–15, and 80 staff. The school is set close to the Danube waterfront in one of Romania's key industrial areas, where levels of unemployment are low. The school has long had a recognised health education policy and it is committed to developing the entire person. A team made up of the co-ordinator, staff and parents meet every month to co-ordinate the development of the health promoting school. The school carried out a survey to investigate pupils' conceptions of health-related issues. The project team then used the findings to develop the school's health-promotion policy. The school is working to

improve its internal and external environment. Special features of this school are the emphasis on developing good relationships between pupils, staff and the local community, a coherent health education curriculum taught through predominantly participatory learning and teaching, and the use of evaluation to determine the project's impact on children's skill and knowledge development.

A further outcome of this formative evaluation project was the development of an evaluation instrument for assessing the progress of national health promoting school projects. Initially this was intended as a tool for members of the ENHPS secretariat to assist them in their reporting of developments within the network. However, the instrument has become the subject of four years of developmental work that has led to its use in establishing base-line data, evaluating health promoting and healthy schools and valuating health-promotion assets in schools. The second part of this chapter provides discussion of this instrument.

A multi-dimensional evaluation instrument

Concepts upon which the instrument has been developed

The instrument is underpinned by the kind of theoretical perspectives described in Chapter 2 that offer structural analysis of health-promotion approaches (Caplan and Holland, 1990; Beattie, 1991). It is based on a recognition of the importance of using a multi-dimensional analysis of health-promotion activity within particular health-promoting settings. In the case of the HPS, it recognises the dimensions of external influences and internal mechanisms by which schools are organised and operate. This enables the profiling and valuation of health-promotion assets within that setting to be undertaken from a truly ecological and holistic standpoint.

A major consideration, which emanated from the research team's experience of evaluating the health promoting school in Europe, was the importance of recognising the practical difficulties confronting teachers and local health-promotion support personnel when attempting to undertake evaluation in schools. For example, a lack of time and the limited evaluation research experience of teachers, local health and education advisers. These were clearly key issues that influenced the research methodology selected.

An expressed need, on the part of the technical secretariat of the ENHPS and national co-ordinators of health-promoting projects, to be able to generate base-line and annual review data quickly and efficiently was a further consideration. The research team at Canterbury Christ Church University College were therefore led towards a research framework that included aspects of rapid participatory appraisal and rapid assessment procedures, both of which have been well documented (Beebe, 1995; Annett and Rifkin, 1995; Ong, 1996; Harris 1997). The instrument also had to be flexible to enable it to be modified to meet the specific evaluation or valuation needs of

different school settings. This may include national and local differences, educational ideologies or cultural variations.

Two further factors influenced the development of the instrument. The first factor was related to the concept of health promotion. It was deemed necessary to align the methodology of the instrument with the fundamental principles of health promotion (WHO, 1986) and recommended approaches to health promotion research (WHO, 1998b). This was achieved by using research methods that emphasised collaboration, empowered those involved in the evaluation or valuation process and utilised a democratic processes of enquiry. The other influential factor, which provided focus and structure to the methodology, was the eco-holistic model of the health promoting school described in Chapter 3 (Parsons *et al*., 1996). This model was used as a reference point and a basis for developing a primary evaluation framework. The term 'primary evaluation framework' emphasises that this was the starting point and an initial guide to factors that can be valued or evaluated in schools. However, the flexibility of this framework enables factors to be added or omitted to meet specific national, regional or local needs. This point will be elaborated on later when describing how the instrument has been used to provide base-line data and monitor progress in schools pursing the English Healthy School Standard.

The eco-holistic model of the health promoting school highlights the existence of, and demonstrates the relationship between, factors that influence the structure and development of health promotion in the school setting. Some of these factors are external to the school while others are internally generated. This model forms a useful structural framework for enquiry, measurement and 'valuation' of health promotion. For example, *external factors* that could be measured include: international influences such as the requirements for applying to join the European Network of Health Promoting Schools, national legislation and guidance on health education in schools, national policies and initiatives of particular countries, and local health and education initiatives. *Internal factors* that could be used as the focus for evaluation include: support of management and governors and allocation of roles within the school; links with the outside community; the formal and contextual health education curriculum; the model of, or approach to, health promotion that has been adopted by the school; and outcomes such as feelings, attitudes, values, competencies and health behaviours of the total school population.

The eco-holistic model of the health promoting school only serves as a primary evaluation framework. Recent development work on the evaluation instrument has emphasised this point. Two examples are:

1 use of the instrument as a part of the national dissemination of the national health promoting schools programme in the Republic of Ireland;
2 development of the instrument as a method of evaluating schools'

progress within local schemes working for accreditation for the National Healthy School Standard in England.

An important finding was that, in order to meet specific national and local needs, it is necessary for projects or schemes to develop their own model of the healthy or health promoting school. However, even with this strategic development the eco-holistic model serves as a useful starting point and an example from which planning teams from individual schemes can develop their own models.

Shortcomings of the instrument

The rapid participatory appraisal approach might be criticised for its lack in depth of analysis and the rigour associated with experimental and purely quantitative methodologies. Additionally, the scope exists to develop a reliability test for the instrument, thus strengthening and improving the quality of the data gathered. However, these shortcomings have to be balanced against the advantages of an instrument that can produce graphic profiles very quickly of a school's health-promoting status based on agreed criteria.

How the instrument is used

It has been shown how the evaluation instrument uses a model of the health promoting school as a guide for establishing a framework. If, for example, the eco-holistic model was to be used, each of the internal and external factors described above could be used as clear foci for the collection of data. The model is particularly useful when establishing base-line data for a school or making a non-judgemental valuation of health-promotion assets in a particular setting. When using the instrument to evaluate a school against established objectives (or criteria) of a particular network or scheme, data is collected in the form of responses to specific indicators (or questions) that relate to the objectives (or criteria) of the specific scheme or network. Responses to these indicators reflect compliance with, or the degree of attainment of objectives/criteria. Between ten and fifteen indicators (questions) have been found to be appropriate for each objective/criteria. However, more indicators could be used if necessary.

The objectives and indicators form the basis of a questionnaire that is administered in the form of an interview. Evaluators score the questionnaire during interviews with a range of interviewees associated with the schools (see Table 8.2). The value of using this method of enquiry is that it ensures clarification of the indicators (questions) and allows additional qualitative data to be collected from respondents. Responses to each question are recorded using five-point Likert scales. Mean scores for each set of questions (i.e. mean scores for each objective) are then calculated and used to compile a spreadsheet of responses.

Table 8.2 Typical range of interviewees

Management:	Senior management/governors
Providers (of health education and promotion)	PSHE co-ordinator/teachers
Recipients (of health education and promotion)	sample of students
Significant others/local community	parents/support staff/school nurses

Data recording and profiling the school

The method of recording and profiling data involves the use of a radial profile graph (RPG) with multiple axes (see Figure 8.1). Each axis of the RPG represents an objective/criterion of the health promoting school and has a ten-point scale; zero being at the centre and the tenth point on the scale of each axis being placed on the perimeter of the graph.

The mean scores are recorded on each axis for each respondent, then the scores (points on each scale) are joined up to produce a profile of the health promoting school as identified by the respondent (see Figure 8.2). RPGs are drawn for each interviewee and, by overlaying profiles, comparisons can be made between the judgements of different members of the school or associated population.

The profiles created by these graphs will indicate any differences in perceptions of the health promoting status of the school. By calculating the mean scores for all respondents a general picture of the existing health-promoting status of the school can be determined (see Figure 8.3).

This composite RPG can be used on a yearly basis to assess progress and development of health promotion in schools. The RPG can also assess whether schools are meeting the specific criteria or objectives of health

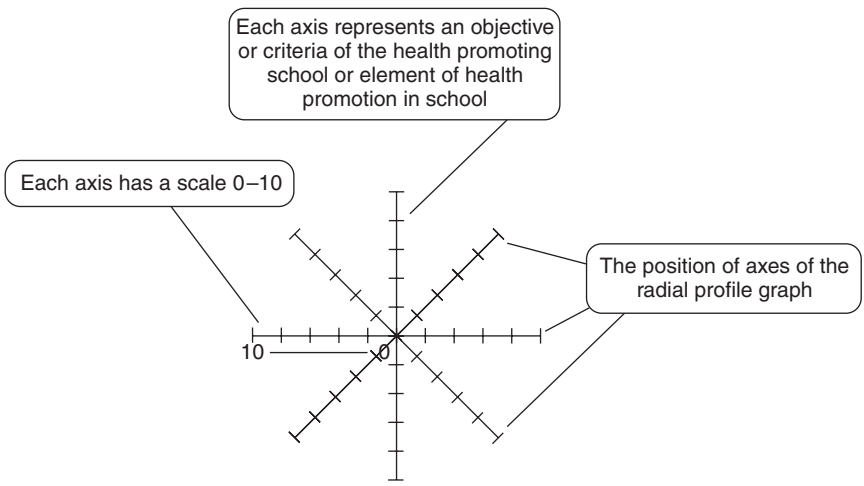


Figure 8.1 The radial profile graph (a)

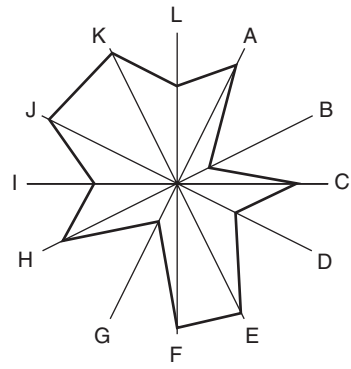


Figure 8.2 The radial profile graph (b)

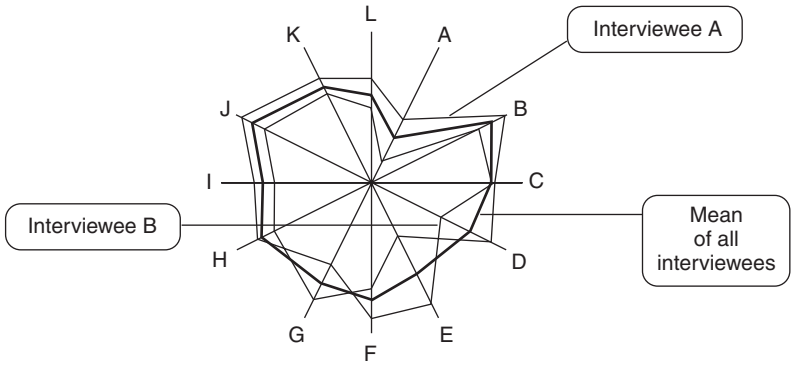


Figure 8.3 The radial profile graph (c)

promoting school networks or schemes. The calculations for scoring the RPG require a basic knowledge and understanding of statistics. The data analysis could be used as an information technology or mathematics project for secondary-school pupils, thus enhancing the community empowerment and cross-curricular potential of the evaluation instrument.

The data collection and scoring of the RPG can be undertaken manually or using a computer software package. Most schools will have access to a suitable statistical package that can calculate the mean scores and draw individual and composite RPGs (or radar graphs), for example Microsoft Excel. This package, with its 'Chart Wizard', has the advantage of being able to produce block graphs (see Figure 8.4) to indicate comparative data for respondents (e.g. judgements of pupils compared with teachers or parents compared with school management).

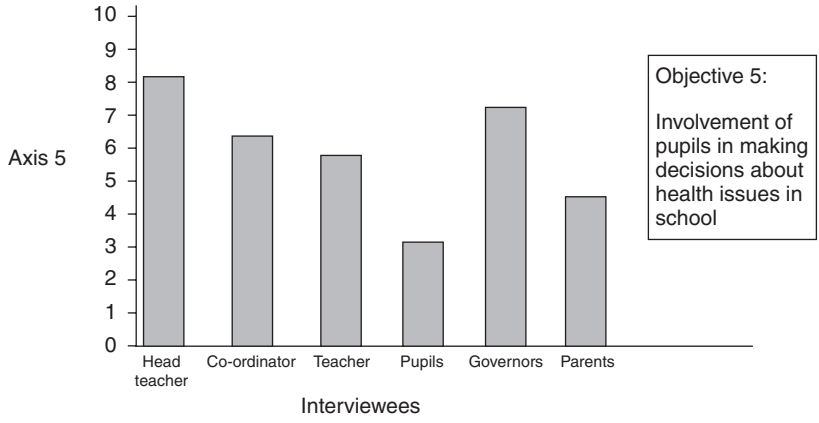


Figure 8.4 Block graph of comparative data of interviewees for one axis of the RPG

Reflections on the evaluation instrument

One of the strengths of this instrument is its flexibility. The instrument can be used to evaluate and profile the healthy or health promoting school against set objectives. Alternatively, it can be employed to provide a valuation of health promotion assets within a school. The latter is a useful way of providing base-line data for schools aiming to become health promoting settings. It enables schools to value what is already in place and build upon those elements of the health promoting school that may be missing or require development.

The process of using the instrument will be different for evaluating schools and for making a valuation of assets. In the case of evaluation, judgement is made on the basis of the positioning of the mean scores for the school on the RPG. The closer the graph comes to being a circle at its perimeter, the closer the school can be judged to be meeting the objectives/criteria of a particular healthy school scheme or health promoting school network. However, when using the instrument to make a valuation of assets it is the shape, rather than the positioning, of scores within the graph that becomes important. Peaks and troughs indicate strengths and areas where resources might be developed. This should be a non-judgemental analysis that empowers the school to value existing assets. In this respect it is an ideal way of motivating schools, at an early stage, to recognise the components of the health-promoting setting and providing them with the confidence to move forward with a positive agenda.

The principle of using the instrument to value health promotion assets has been extended to a national context (Georgieva and Chambers, 1997; Lahiff and Boldt, 1998; Stears *et al*., 1999). This particular use of the instrument has followed in the footsteps of audits of health promotion capacity

undertaken by the World Health Organization: Regional Office for Europe (WHO, 1997a; WHO, 1998a). This work had focused on the investment opportunities of health promotion in a rapidly changing European context and has been a focus of workshops and discussion at international conferences (Zigilo, 1998; ECHPD, 1998). Application of the instrument in this context involved undertaking a national audit that focused on the school setting. Work was commissioned by Health Promotion Wales and funded by the Welsh Office to research investment opportunities for health promotion in schools in Wales.

The instrument was used to collect data from three perspectives: the national perspective; the local perspectives; and the school perspective. At the national level people from the Welsh Office, higher education institutions, other governmental organisations and non-governmental organisations were interviewed, while at the local level interviewees were predominantly advisers drawn from local education and health authorities. Finally, at the school level a small sample of head teachers, health education co-ordinators and pupils from seven primary and three secondary schools were interviewed. Data were drawn from questionnaires containing indicators linked to eighteen objectives in addition to data gathered from nation legislation and guidance documents. The local and school sample groups were drawn from the north and south of Wales. RPGs were calculated and drawn for each of the three perspectives and qualitative data were analysed in order to provide commentary and support to the presentation of quantitative data.

The main findings from the valuation were clear, as portrayed by each of the RPGs. They related at the national (Welsh) level to the need for consideration of a mandatory place in the school curriculum for PSHE, and the need to enhance considerably the provision for PSHE and health-promotion within initial teacher education and training. At the local level findings identified a positive asset in the range of health professionals available to support the health promotion work in schools – although developments could include strengthening and targeting of the work of health professionals. A further positive asset was found at the schools level, where considerable progress had been made in developing links with family and community. Continued efforts were necessary, however, in order to broaden the health-promotion alliance. The instrument enabled a further twenty-five specific and key issues to be identified with regard to the health-promotion assets in schools in Wales.

During development work on the instrument with schools in East Kent it was possible to trial different methods of feeding back data to schools. One method that head teachers and their staff found particularly useful was the comparison of scores for managers, teachers, parents and pupils on a wide range of objectives. Two sets of variables were singled out, namely the views of teachers versus parents on the links between the school and the community and the views of teachers and pupils on the democratic process of select-

ing the health issues that were focused on in the school. By producing data in the form of block graphs these comparisons were conveyed to the head teachers and staff. School staff were surprised to find such disagreement on both sets of variables. This illustrates the potential of the instrument to identify important issues regarding communications and relationships within the school and beyond the school gates.

The instrument can be used across a wide range of cultural settings. For example in England it can be used in conjunction with the Healthy Schools Standard (DfEE, 1999) yet it can be equally adaptable to schools in Denmark, where such culturally-inspired objectives as 'action competence' (Jensen and Schnack, 1994) might be high on an evidence-based health promoting school agenda. A number of teachers in different countries have identified the potential of the instrument for collecting data that can be used during external inspections of schools. Clearly, preparation for school inspections would be enhanced by evidence of a monitoring process that measures the management of institutional change, the positioning of personal, social and health education within the formal and contextual curricula and the promotion of health within the school.

Recent work has been undertaken to develop the instrument for use both at a national (country) level and in schools. For example, The National Assembly for Wales: Health Promotion Division has produced a manual for local healthy-school schemes and schools in Wales that is based on the instrument described in this chapter (Stears *et al*., 2000). A similar publication has also been produced by the Irish Network of Health Promoting Schools.

These two publications have been developed in participation with key health and education personnel in the two countries. Workshops were organised to enable health and education professionals to tailor the objectives to meet their own national health promoting school or healthy school agenda. The work undertaken in Wales and the Republic of Ireland, together with recommendations from the ENHPS Evaluation Working Party (ENHPS, 1999), has highlighted the need for clear indicators to measure specific objectives of the health promoting school. Work has now taken place to ensure that national or local scheme-planning workshops focus upon developing clear objectives and comprehensive indicators.

Work is now in progress with a number of local healthy school schemes in England. The instrument is being used to provide base-line data and monitor the development of individual schools within separate schemes. The challenge here has been to modify the objectives within each scheme to meet the English Department for Education and Employment Healthy School Standard (DfEE, 1999). This has been successfully achieved and indicators devised to measure these objectives.

The other major development is associated with the analysis of data generated by the instrument. The latest versions of Microsoft Excel enable large databases of schools to be analysed and to provide detailed feedback to

individual schools. This includes highlighting specific areas within the school where developments could be made. It is now possible, using the instrument, to provide schools with specific information to guide their targeting, planning for whole-school development and progress toward the healthy school standard.

Conclusion

The philosophy underpinning the instrument is firmly aligned with the four principles for evaluation of health promotion advocated by the WHO Regional Office for Europe (WHO, 1998b).

These are that evaluation should involve:

- participation of those who have a legitimate interest in the initiative;
- multiple methods employing a broad range of information-gathering procedures;
- capacity-building initiatives that should enhance the capacity of individuals, communities, organisations, and Governments to address important health-promotion concerns;
- appropriateness evaluations of health-promotion initiatives that should be designed to accommodate the complex nature of health-promotion interventions and their long-term impact (WHO, 1998b, p. 6)

It is therefore important to develop a support mechanism whereby national and school health-promotion co-ordinators and advisory personnel can learn to customise the instrument to their own needs. With this end in mind, the two-day workshops referred to above have been developed by the Centre for Health Education and Research for schemes and groups of schools who might wish to use the instrument.

It is important to stress that the instrument described in this paper is only one suggested approach to providing evaluation of health promoting schools and valuation of health-promotion assets. The author and his research colleagues are aware of certain shortcomings of the research methodology, for example the fact that data are based on the mean scores of subjective judgements. However, criticisms of the methodology need to be weighed against the practical constraints facing evaluators in the field and the principles of health-promotion research.

This instrument is one of several approaches that are being considered alongside the European Network of Health Promoting Schools guidance document on indicators for the health promoting school (ENHPS, 1999). It is hoped that in the near future clear guidelines will be available, at both a national and international level, to enhance evidence-based health promotion in schools.

9 Conclusion: the future of the health promoting school

So, what does the future hold for health promoting schools? A number of key issues relating to the successful development of healthy schools have emerged from Chapters 1–8 and these are summarised in this concluding chapter. They include: ensuring that schools provide stability and structure for young people in a rapidly-changing world and that they are viable settings for promoting the health of young people; the development of skills in citizenship and democracy that form part of a healthy school's curriculum and prepare young people to participate in their own health promotion; the need for genuine partnerships in promoting health; the importance of a whole-school approach to health; links between healthy and effective schools; and, finally, building capacity and, thereby, sustainability.

There have been many changes in society in the UK over recent decades that are mirrored in other European countries. Moral, cultural and community frameworks have fragmented with successive generations in a post-industrial society. Some countries have been torn apart by war and others have witnessed comprehensive changes in the ideologies that underpin them. The disintegration of the traditional family, whatever its cause, has resulted in children being put under stress, often lacking the support of a caring, extended family. These changes have presented major challenges for those who are concerned to promote the health and well-being of children and young people, and will continue to do so in the future. They include the challenge of meeting the changing health-related needs of present and future youth populations in ways that are acceptable, appropriate and relevant. Within this challenge lies the crucial factor of government recognition of the need for financial investment in the health of young people in the future (Ziglio, 1998). Experience has shown already that, where health promoting schools receive adequate monies and resources, sustainability is supported and health promotion in school settings develops and grows. This applies to locally, nationally and internationally based schemes, including the English National Healthy School Standard (NHSS) and the European Network of Health Promoting Schools (ENHPS).

There is general recognition that schools themselves can offer stable environments within changing societies and provide young people with a

security that is often absent in their home and external environment. The daily routines, responsibilities and opportunities to develop strong and supportive relationships with a range of adults can help to give structure and consistency to children's lives. School organisation and management styles can support all aspects of a child's development – spiritual, moral, social and cultural – in a positive, safe and welcoming milieu. This in turn can provide support for the taught curriculum in PSHE and Citizenship and, by implication, health promotion. The potential for partnerships with groups within the local community further strengthens this stability and helps to make schools viable settings for promoting health.

A stable, happy and health-promoting environment in school, however, will depend on the health and well-being of the staff. It is important to consider the effects that sustained pressure for change on schools can have. Much of this in the UK centres on improving quality and educational achievement, legitimate goals for the health promoting school because of their health-protecting effect. But too much pressure causes stress for adults and this is likely to affect positive social interactions with pupils and the wider community. It is worth remembering that the health promoting school is a utopian concept that is difficult to achieve, producing its own short-term pressures even though it may reap benefits in all aspects of school life in the future. Governments will need to recognise that if school staff are over pressurised and continuously stressed, there is little likelihood of their being able to establish and maintain the kind of environment that underpins the healthy-schools concept. Political support needs to be consistent. It is essential to signal the importance of the health promoting school to schools and their communities, and to review urgently the degree to which schools have been able to integrate the healthy schools concept into the fabric of the school organisation. It is easy to pay lip-service to the NHSS in England, for example, without investigating whether it has achieved full integration into schools or whether more drastic measures are needed.

Effective partnerships are fundamental to public health practice and, in particular, to the future development of healthy schools. The principles of good partnership have been identified by Hardy and Hudson (1999) as:

- recognising and accepting the need for partnership;
- developing clarity and realism of purpose;
- ensuring commitment and ownership;
- developing and maintaining trust;
- clear and robust partnership arrangements.

These principles provide a useful framework within which to develop partnerships and will work well where all partners have consulted, worked out and agreed practical details and collaborate on their implementation. It is especially important for outside agencies working with schools to understand the constraints on progress and for both to set realistic aims and

targets. All partnerships are process driven and will require time for development. There are enormous challenges facing schools, communities and outside agencies in developing good partnerships. In areas targeted with resources, i.e. areas of deprivation, there is a need for much greater clarity of purpose, better co-ordination and co-operation in order to make good use of resources and to achieve a greater sense of coherence in what is planned and implemented. Community development shows the most promise for a way forward but schools will need to be more open and to be a resource for their communities, hitherto seen in the community school movement of the 1970s – and in some parts of the UK more recently. Once again, consistent government support will be essential.

The English NHSS guidance document (DfEE, 1999a) identifies partnerships as the first of its three main sections – partnerships, programme management and working with schools. Partnerships are required that involve local health and education services, school staff, governors and pupils, and statutory and non-statutory community groups and agencies. Partnerships with parents too are important when dealing with matters relating to their children's health, particularly when sensitive issues are involved, for example sex and relationships education. Although the school setting is unique within the community, a school cannot work in a vacuum, and future attainment in the development of healthy schools will depend, at least in part, on the success of these partnerships.

The nature of partnerships at international and national level is an issue in terms of control and empowerment. The technical secretariat of the European Network of Health Promoting Schools, based at the WHO (European Office) in Geneva, has played an enabling role with national co-ordinators, organised pump priming to support national efforts and has sought to bring national education and health ministries together to support a national scheme. At national level there is the need for facilitating funding, a supportive framework and a legitimated status for health promotion in schools. A top-down model of the health promoting school is inappropriate and would appear to be at odds with the notion of empowerment extolled by the Ottawa Charter and prompts questions about the degree of centralisation and the balance between control and empowerment of local agents. It is important to be aware that countries are often selective in the parts of the health promoting school project that they seek to implement, depending on their own cultural and philosophical mores. A major challenge for the future will be for the healthy-schools movement to address the tension that exists currently at all levels, local, national and international, between rhetoric about empowerment and the importance of involving pupils as partners, and the sometimes prescriptive nature of the protocols that are sent into schools.

It is clear that schools need to be truly democratic institutions and to reflect the work being done in the curriculum. This means that children will be involved in decision-making within school and, more widely, within their communities. For example, there is some promising work being done

by primary care groups in England. In discharging their duties regarding health improvement, they are holding community consultation events and asking residents to identify their concerns. Many have included children and young people in that process. Following needs assessment, the key question is how to tackle these concerns. What could be the contribution of the school among the many contributions needed from individuals, groups, families and organisations? Arguably this kind of approach will give children a better sense of their wider community, and the school's, and their place within it.

Skills development within PSHE, Citizenship and democracy education provides a foundation for healthy schools which will also equip young people for life beyond the school gate and in the future. It is best achieved through a range of teaching styles and active learning processes appropriate to pupils' age, ability and level of maturity. The management styles and ethos of the school will also contribute to skills development by providing pupils with opportunities to practise and consolidate the application of their learning. Work undertaken by schools in Denmark in this area over recent years reported outcomes that have changed the location of real power and control within society (Jensen, 1999). The grasp of action competence is fundamental to the process of empowerment if young people are to make positive decisions about their health behaviour – a move from mere tokenism to actual control. In this sense, skills development will help to fulfil the requirements of the Ottawa Charter that health promotion should not only provide healthy choices but also empower those involved to make appropriate decisions about their health. The role of advocacy is key in school health promotion, whereby individuals and groups both within schools and in the wider community work together to achieve change for the good of each other. Once again, the success of these aspects of a health promoting school will depend upon the school being a democratic institution that communicates with and involves all its stakeholders in its planning and implementation.

A whole school approach to health education and promotion is discussed with confidence and extolled a great deal, but achieved with difficulty (Moon, 1999). Yet it remains at the core of a healthy school and its proper definition and application need to be understood and put into practice if the healthy schools movement is to prosper in the future. It is based on the premise that health education and promotion will be much easier if their principles underpin all that happens within the school and if they involve actively all those connected with the school. Healthy eating messages, for example, will be conveyed and reinforced through what is taught in the classroom, what is provided in school canteens and tuck-shops, school policy relating to the use of external caterers and the active contribution of pupils, parents and people at home. A whole school approach will involve the whole school community (pupils, staff, parents, governors and community partners) in policy development and in physical, social and cultural activities.

In practice, however, it has been very difficult to involve the whole school community when time constraints are tight and there are many other demands on busy teachers, governors and parents. The perception still held by many that health education and promotion in schools is of low status means that there is still a danger that one enthusiast who is on the staff will be left with the responsibility of introducing and implementing a healthy schools programme. The time has come, however, to recognise that this is not enough and a broader-based and comprehensive approach to health promotion in schools is needed if healthy schools are to be sustained.

It is clear that, while a whole-school approach to health promotion is central to the healthy schools movement, it cannot be achieved overnight. Leadership and commitment by senior management in schools are essential and it will take a great deal of planning, time and hard work. It may be helpful for each school to explore the concept of a whole-school approach for itself, define it realistically within what is possible and achievable and to identify ways in which it can be realised. The roles of parents and the community in achieving a whole-school approach must not be underestimated.

There are indications that there may be an association between the health of young people and their level of educational achievement (Hopkins, 1995; Young 1998) and that there may be links between a health promoting school and an effective school (Novello *et al*., 1992; Boddington and Hull, 1996). Samdal *et al*. (1998) have highlighted the potential contribution of programmes such as the ENHPS to creating a school environment that students perceive to be safe and justly organised and, in turn, to improving students' educational experience and enhancing their well-being and health. There are similarities between the aims of a healthy school, for example effective partnerships, skills development and the factors identified by Rutter *et al*. (1979) as characteristics of effective schools (see Chapter 1). More research is needed but the suggestions that 'healthy schools create healthy students' and that, in turn, healthy students will be better able to learn, are axiomatic.

Achieving effective schools where learning is enhanced and academic improvements accomplished is of prime educational importance in all societies. The links between healthy and effective schools provide a sound basis for the future support and development of health promoting schools and need to be exploited.

The factors involved when considering the sustainability of a health promoting school initiative are closely linked with capacity building and include the following:

- funding flexible enough to support schools from all levels of society at different levels of achieving health promoting status and with differing and wide ranging needs;
- education and training of teachers who are the main contacts at the

interface between school and communities and will represent the health promoting school to outsiders;
- flexibility to adapt to changing circumstances and constraints and to step outside tight schedules and boundaries to offer realistic and appropriate support;
- the curriculum as having a symbiotic relationship with the school environment and what takes place in school;
- evidence-based practice, to underpin future developments, that is an outcome of internal monitoring, and evaluation that is carried out and owned by the stake holders.

The need for *funding* and resources has been highlighted already. It is not enough that the healthy schools development has become a strong political issue, in the UK or elsewhere. Chapter 1 has highlighted the roller-coaster pattern of political commitment and strategic policy development of health education and promotion over the past fifty years. Verbal support and encouragement, whether given at government or local level, will not provide schools with the subject status, time, skills and resources needed to implement the requirements of a national or European scheme. The lack of funding is linked undoubtedly to the low status accorded to health education and promotion and this has become a fundamental obstacle to progress. A major step would be for funding bodies to recognise that a school in a deprived area will need much more support than one in a 'middle class' district where parents and the community are actively involved already. Schools should be given the freedom to use their funds creatively to achieve their own unique aims and objectives. While acknowledging the need for firm political commitment at all levels, the future sustainability of health promoting schools is dependent on concrete resources and adequate funding to match the rhetoric.

Education and training of all school staff, especially teachers, in health education and promotion, and in the development of, for example, a whole school approach, is crucial to the future success of healthy schools. For teachers, training is needed at initial teacher education level and through in-service training when appropriate. A lack of training leads to a lack of understanding of the concept and its potential significance in the lives of those in school. It is worth recording the need for politicians and those in positions of power in any government or community to receive education about the health promoting school, what it involves for schools in their communities and their roles in helping them to achieve health promoting status.

Flexibility is essential because the health promoting schools initiative will not succeed if the requirements and guidelines for its implementation are too rigid and circumscribed. Each country will have a mixture of similar and different local and individual school needs and the scheme must be sufficiently flexible and adaptable to meet those needs. In the same way, some

countries may have more resources and assets available for distribution to schools than others and this will affect the work undertaken and the outcomes.

The curriculum, particularly those parts relating to PSHE and relationships education, forms the cornerstone of the health promoting school and is also linked with the need for flexibility. The health related aspects that support the development of a healthy school will need to be dynamic and progressive, skills-based and specific to different localities so that it will meet the differing needs of pupils in rapidly changing environments and equip them to make healthy choices and decisions for themselves.

Evidence-based practice highlights the need for the assessment and evaluation of healthy schools, particularly at individual school level, in order to provide evidence of effectiveness and success. There is no longer a need for expensive large scale national and regional evaluation initiatives and the future focus must be on school-based evaluation. There is, none the less, a need for the urgent development of rigorous, sensitive, appropriate, tried and tested evaluation tools. Unless the health promoting schools initiative can be shown to have a positive impact on the health and well-being of those in schools and, thereby, on the wider community, then its sustainability in the future is in doubt. Chapter 4 has shown that RCTs are difficult to apply to the health promoting school in the search for causality. Depending on the objectives of an intervention, evaluation may consider all or some of the following at all levels of the school: policy, organisational development, partnerships, process and outcome – at the level of the school. At project level, the success of recruitment strategies, programme reach (diffusion), organisational change, partnership development, audit and other areas as necessary will need to be investigated. Schools are at different stages in developing as health promoting environments. Setting the HPS within a development planning cycle will require schools to monitor their progress. Evaluation needs to fit the objectives and reflect the complexity and scope of the health-promoting school. The most appropriate model is action research in which the teacher, who knows the school and how it functions, is a reflective practitioner. An evaluation that is carried out internally will be ongoing, sustainable and much more empowering than one imposed from outside the school.

There has been a rapid growth of healthy schools or health promoting school initiatives in the past decade and it seems likely that this will continue while governments or international bodies support their development. The concept of the HPS, however, is complex and hard to implement in ways that involve all stakeholders, despite its apparent simplicity and potential for practical application. Identifying the components of a whole school approach and putting them into practice can be fraught with difficulties, albeit surmountable, and is dependent on a variety of factors, both internal and external to the school. Nevertheless, there is sufficient evidence now to show that a carefully structured and supported framework for intervention

can have positive health-related effects and outcomes on school ethos, management structures and practice, the curriculum and, to a greater or lesser extent, on some pupil behaviours.

The future of health promoting schools looks promising. There is still much work to be done and real, sustained commitment to funding needed from governments, but, with the support and impetus of local, national and international initiatives, it seems likely that the day will come when 'Every child and young person in Europe ... will have the opportunity of being educated in a health promoting school' (WHO, 1998c).

Appendix 1
Summary of research studies related to the health promoting school

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
1. Connell, Turner and Mason USA, across 20 states 1984	Grades 4–7 in American public schools 1071 teachers of Grades 4–7	30,000 pupils	0	No	Yes	To evaluate the implementation costs and effectiveness of 4 comprehensive HEd. programmes – School Health Curriculum Project (SHCP) Project Prevention, Health Education Curriculum Guide (HECG) and the 3Rs and High Blood Pressure (HBP).

R = Use of random allocation
C = Use of a control group

K, A, B = Knowledge, attitudes and behaviour

Methods of evaluation	*Main findings*	*Recommendations*
Pre-test and post-test scores obtained by pupil questionnaire for overall knowledge, attitudes and practice and for programme-specific knowledge. Questionnaires for teachers.	The programmes achieved their aims. Increased health knowledge amongst all programme pupils compared with controls. Healthier attitudes in intervention group. Self-reported health skills and practice greater in intervention (I) sample – biggest increase in decision-making skills. Self-reported smoking showed 3 times as many control pupils smoking at start of 7th grade than I pupils. At mid-grade 8% of I pupils smoking compared with 12% in control group. In-service training related positively to programme implementation. Programme support materials a positive influence. More classroom hours needed to produce greater attitude change than knowledge or behaviour change – stable effects reached at 50 hours. Teachers faithful in implementing knowledge components; less so with attitudes and behaviour. SCHP required most hours to deliver, most costly but also most effective re. time involved.	* A sizeable commitment of classroom hours should be made to a health programme. * Teacher training should be built in – not necessarily extensive but enough to understand programme rationale and timing fully and be well-informed re. health issues. * Funding should be available for programme and support materials. * Further research is needed to provide systematic information about the appropriate ratio of adoption costs to implementation factors, e.g. number of programme activities or intended classroom instruction hours. * Further research is needed into ways in which health education and promotion can contribute to development of healthy behaviours. * There is an urgent need for validated research tools for use in school settings. * Perceived support of the school board, local district etc. is a vital component in motivating teachers. * More studies are needed – longitudinal – into links between child health behaviours and health outcomes. * More behaviourally-based prevention programmes are needed. * Health ed. should start at a younger age. * Need to generate data useful for establishing thresholds for programme impact and maintenance of impact.

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
2. Nutbeam *et al*. Wales 1986	75 secondary schools 75 staff – 1 from each school	0	0	Yes	No	To identify: – organisation of HEd. in schools; – parental and outside agency involvement; – HEd materials in current use.
3. Smith *et al*. Wales 1989/90	87 secondary schools 87 staff – 1 from each school	0	0	Yes	No	To assess: – development and content of school HEd.; – implementation of policies; – involvement of outside agencies; – understanding of HPS concept.
4. Moon Wandsworth, London 1993–5	10 primary schools The head and one teacher from each school	All pupils	20 lunchtime staff 10 caretakers, 5 caterers	No	No	To assess the success of an HPS project in raising the profile of health and changing health-related practice in schools. Did it work?

Methods of evaluation	*Main findings*	*Recommendations*
Questionnaire to heads or PSHE co-ordinators	95% teach HEd. 78% planned programme. 82% have co-ordinator. 93% pupil smoking policies. 33% staff smoking policies. 5% packed lunch policies. 13% policies on tuck-shop. 82% use outside agencies. 78% parental involvement. Main topics covered drugs, smoking, alcohol, personal rels., nutrition, exercise, sex, safety and dental health.	* Health education needed at younger age. * Co-ordinators need time status, authority and experience. * HEd. training vital for staff. * Greater involvement of parents and outside agencies. * School policies should support and match curriculum content. * Need for research tools for HEd. * Concept of HPS offers a challenging but achievable goal for Welsh schools – should work towards it.
Structured interviews with HEd. co-ordinators	100% teach HEd. 94% have co-ordinator. 33% have HEd. allowance. 84% provide training. 59% pupil smoking policies. 14% staff smoking policies. 39% policies on HIV/AIDs. 13% policies on tuck-shops. 87% use outside agencies. Main topics covered drugs, smoking, alcohol, personal rels., nutrition, exercise, sex, safety, and dental health. 37% had heard of HPS. 20% said school already health promoting; 40% nearly, but poor understanding of the concept.	* All schools teach HEd. – a firm base for HPS development in Wales. * National Curriculum presents a challenge to HEd. – needs monitoring. * More work on health promotion policies and their implementation – and should include non-teaching staff, parents and other adults. * Need for enhanced community links. * Greater support from LEAs and evaluation trials needed for HPS. * Welsh schools moving towards a whole-school approach but more work needed on meaning and components of a health promoting school and how to recognise one.
Project diaries SSIs, with teachers. Pupil observation. Review of class work. Pre and post testing. Staff discussions. Behaviour monitoring.	Raised awareness of whole-school approach – the HPS – and PSE profile. Helped co-ordinate good practice. Focus for action – provided incentive. Introduced new initiatives. Met all our targets. Bullying prevention very successful. Greater links with the community. Increased knowledge of health promotion staff – who they are, how they can help.	* Funding to extend project – another LEA-based co-ordinator. High profile for HPS. * Resources and training. * Governor and parental involvement vital. * Regular updates of relevant health information in schools, and good practice. * Free time built in for school co-ordinator. * Network of HPS practitioners.

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
5. Allensworth USA 1994 Ross *et al*.; Gold *et al*.; Errecart *et al*.; USA 1991	Public secondary schools across 7 states 150 teachers	5000 secondary-aged pupils 3 groups – intervention group, control group, 'naturalistic' group (defined as already teaching THTM)	0	No	Yes	To assess: – effectiveness of THTM programme in changing pupil K, A, B; – effects of training on implementation and pupil outcomes; – effects of teacher preparation and personal characteristics on school environment; – effects of variation in implementation on outcomes.
6. Coggans and McKellar Scotland and England 1995	20 secondary schools 392 teachers	1679 pupils aged 11–16	8 support staff	No	No	To: – investigate effective health promotion in school; – review role of peer influence; – assess health-related K, A, B; – identify good practice in health promotion.

Methods of evaluation	*Main findings*	*Recommendations*
		* Key role of school nurses & support staff. * Healthy eating – urgent. * Practical examples of evaluation tools.
Pre-tests and post-tests by questionnaire for all pupils and for teachers. Telephone interviews with intervention and 'naturalistic' teachers. Implernentation logs for THTM.	The curriculum had a significant effect on selected student outcomes – most successful in improving knowledge. Also improved attitudes and several priority behaviours, e.g. self-reported use of illegal drugs and alcohol. Lack of behavioural effects at junior high/middle school level. Training a key factor in faithfulness in programme implementation. Faithfulness to text and proficiency in teaching were related to improved pupil knowledge. Active involvement of teachers and pupils in decision-making about programme and preparation of an action plan aided faithfulness to text.	* Training and certifying health educators are important for effective health education programmes. * Multiple analytical strategies for such evaluations are feasible and necessary. * Emphasised the importance of using multiple research strategies and analyses and triangulation as a measurement-issue in research design. * A large number of variables can affect curriculum implementation, particularly among new and inexperienced teachers. These need attention in the future. * Pupils should be involved actively in programme planning and implementation.
Health-behaviour questionnaire for pupils. Questionnaire for staff. SSI (80) with PSHE and other teachers.	Higher self-esteem links with positive attitudes to school and good relations. Self-empowerment means pupils less likely to smoke. Health-related knowledge and positive attitudes to school link with greater empowerment. Significant relationship between and respect amongst staff and pupils – greater health empowerment. Good communication related significantly to positive attitudes & greater knowledge of HIV/AIDs. Improved PSE brings better attitudes to school and relations with staff.	* Practical strategies for HP policy making and implementation. * PSE, pastoral care and emphasis on quality of relationships keys for promoting health. * Need to raise status of PSHE with teachers. * Senior management support crucial. * Avoid simplistic, unproven interventions. * Role of individual in own development. * Further research into behaviour change. * Re-appraisal of criteria for measuring success of drug, alcohol education. * Quality of family relationships, not type, a key factor in prevention. * New and radical approaches to nutrition.

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
7. McGregor and Currie Lothian, Scotland 1995	2 pilot, then 6 – all primary Whole staff in each	Primary years 3, 5 and 7 in each school	4 school nurses Approx. 24 parents	No	No	1. To develop criteria for auditing an HPS in 2 pilot schools. 2. To test the criteria in 6 schools.
8. Wilmot Cambridge-shire 1995–6	4 secondary (2 controls) 4 primary schools (2 controls) Project co-ordinators Primary head teachers Questionnaire to all staff	2 secondary pupils in one school, 4 in the other Smoking survey in secondary schools	School health professionals, non-teaching staff, health authority project sponsors and manager of the Health Promotion Service Steering group member, Governors	No	Yes	To assess: – development and implementation of smoking, sex education, nutrition policies; – availability and quality of training; – links between primary and secondary; – knowledge and attitudes about health.
9. Sobczyk *et al*. Kentucky, USA 1995	9 elementary, 3 middle, 3 high schools, growing to 24 in second year 3 teachers from each school sent on 1 week training	All pupils	None	No	No	To evaluate: – effectiveness of HP Schools of Excellence Project; – levels of pupils' K, A, B; – impact on staff.

Methods of evaluation	*Main findings*	*Recommendations*
Draw and write of HPS with pupils. WHO health behaviour of school children questionnaire with yr 7. SSIs with adults.	Inconclusive results because there were many variations between schools. Needs assessments and a mixed-methods approach. Generally, categories include food and drink environment, relationships, safety physical activity, substance use, curriculum, self-esteem, bullying.	* Mixed methods approach to encompass complexity of HPS concept and differing priorities in schools are necessary to enable schools to assess health status and set targets. * Project provided a framework for conducting needs assessments in primary schools.
Structured and SS interviews. Questionnaire. Documentation. Observation.	Health promotion staff see role as providers of training and resources. School nurses feel work is duplicated. Steering group uncertain of role. Insufficient contact between co-ordinators and project managers. Recruitment strategies needed. Teachers not fully involved in plans. Alliance between health and education needs attention. Project schools produced more policies than controls – no progress with healthy eating but action taken on smoking policies. Much more training in project schools – good quality. Effective links between schools. K and A results inconclusive.	* Need for multi-agency steering group with a clearly defined role. * Induction for co-ordinators should include introduction to partner agencies. * Briefing pack for schools and supply cover. * A system of bidding for participation needed. * Project needs to continue – funding needed. * Schools need to demonstrate commitment – health project team in place. * Whole-school staff involvement. * Needs based approach. * Democratic process of policy development. * Project training days for all. * Provision of tools and expertise for schools. * Adoption of whole-school approach to health. * Regular review of policies esp. nutrition. * Consultation and partnership with parents. * Budget and named PSHE co-ordinator.
One week staff summer institute. Fitness assessment of pupils – body weight etc. Questionnaire survey of pupils. Costs ledger.	Teachers showed gains in dieting behaviour, car safety, screening take-up. No changes in pupil behaviours at any age but positive changes in attitudes and knowledge in most areas – responsibility, healthy body environment, rights and roles, sexuality, safety, substances, disease prevention. Costs averaged $135 per pupil.	* Need to identify most effective way to influence behaviour change. * How to maintain improvement in the long-term. * Need for comprehensive and integrated approach. * Longitudinal studies research are needed into what works best in school health education. * Positive outcomes indicate the need for future funding of such programmes.

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
10. Nic Gabhainn and Kelleher Eire 1993–6 Irish Network of Health Promoting Schools	5 secondary schools and 5 primary schools Some staff in each (no numbers given)	195 primary pupils 171 secondary pupils	None	No	Yes	To assess: – the impact of the HPS project on schools in helping them to meet own aims factors which promoted or delayed success.
11. McBride Western Australia 1993–6	60 primary 19 comparison 91 teachers pre and post 137 teachers *either* pre or post	0	47 admin, support staff, health personnel, parents and local community pre and post 80 *either* pre or post	No	Yes	To assist schools to: – achieve HPS status; – make changes supportive of health promoting activities.

Methods of evaluation	*Main findings*	*Recommendations*
Questionnaire with sec. pupils. Draw and write with prim. pupils SSIs with teachers.	Too short – behavioural results inconclusive. D and W revealed greater awareness in pilot schools than in comparison group. All schools made major progress towards achieving their set aims and targets.	* Teachers should be aware of their key role in HPS and its implementation. * Need to clarify extent of commitment required for schools with teachers. * Schools could be paired. * Needs assessment for each school. * Staff development an important component. * Resources and budgets need to be allocated systematically. * School policies known and reinforced. * Specialised assistance to be available. * Structural alterations sometimes necessary – funds needed. * Guidance needed on inter-school links – and with the community.
Survey questionnaires. Telephone interview – 20–40 minutes. 3 collections of data over 20-month period. Information checked with school data.	Management changes included more health committees, policies, plans, time given, staff support, budgets, agency and local community links, HP for staff. Teachers' knowledge increased, more time given, health teaching methods used, greater HP activity and school HP knowledge score. Non-teacher participants improved knowledge, more HP activity and greater involvement. Provided implementation model and practical strategies for schools.	* Whole school approach. * Range of activities. * Involvement of parents. * Link school HP to major public concerns. * Modify food services. * Continue to develop HPS. * Sufficient funding. * Professional training. * Support structures. * Research findings to inform progress. * Analysis of planning documents. * Long term follow-up. * Non-government schools needs. * Theory-based interventions. * Surveys need reliability and validity testing. * Data collections to inform practice. * Longitudinal study of impact on pupil behaviours * Research to assess key factors in involving parents over time.

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
12. Morgan North Eastern Health Region, Eire 1996	10 intervention secondary schools 'A number' of control schools 97 teachers approached – a response rate of 79%	Neither of these given 15 classes from inter. schools 10 classes from controls	None	Yes	Yes	Consider and report on effectiveness of the healthy schools project in secondary schools. Advise on how best North Eastern Health Board can meet PSHE needs of pupils in partnership with parents and education.
13. Lanarkshire CC, Scotland 1997	2 primary schools, staff in both	Some senior primary pupils Numbers not given	Parents, community members	No	No	Overall aims to – address schools' community needs; – encourage partnership with parents and community; – provide information and skills for HPS to teachers – focus on drugs.

Methods of evaluation	*Main findings*	*Recommendations*
Questionnaire for teachers. Questionnaire for pupils. Site visits and observations. Meetings and discussions with: advisory group; co-ordinators; school principals.	The HS project embodies components appropriate to the needs of secondary pupils. Programme has been well-received in schools – valued by staff. Staff commitment to project. Most teach full programme – positive effects on relationships with pupils and own views on health matters. General satisfaction with different aspects – training, support, resources – but cover needed for staff. Organisational factors within schools had major effect on success of project. Attitude of principal a major factor. Programme materials have to be adapted for pupils with SEN. Significant differences emerged between control and intervention groups on items relating to taking responsibility, self-esteem, perceived positive behaviour outcomes in adulthood and attitudes to substance use. Results in intervention schools generally more positive than in controls.	* The project should continue and expand. * In-service should continue with emphasis on skills development and experiential learning. * Support for teachers of pupils with learning disabilities should be developed. * Greater focus needed on creating a positive environment in schools. * Links between Northern and Eastern Health Boards, Department of Education and Science, parents, school management should be fostered. * Provision of cover for teachers on in-service needs consideration. * Need to take account of future national initiatives in the project's development. * The project has made an important contribution to the health of school children.
Questionnaire for community and parents. Structured interviews with teachers, parents, pupils. SSIs with heads. Observations.	Evaluation explored how far objectives reached. These were: – HPS policy for each school; – parents involved and parents' room established in each school; – health-related training provided for parents and community; – staff training provided in drugs; – fitness training for teachers; – stress management for teachers; All were accomplished apart from the last objective.	* Satisfactory funding levels vital for helping schools to achieve HPS. * Parental and community involvement will work but needs time and commitment.

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
14. Loggie Northern Region of England 1997	1 primary school Teaching staff – numbers not given	None	20 HSA supporters	No	No	The aims were to: – assess HSA spread in region; – identify local strategies for school support; – identify geographical area for evaluation; – profile 1 HPS.
15. NFER/ HEA Final Report of ENHPS project England 1998	48 schools – 16 pilot or intervention 16 Reference 1 schools 16 Reference 2 – included 10 special schools	Selected sample from each school – cohorts, years 4, 5, 6, 7, 8, 9, 10, 11	Parents in pilot schools, local support agencies	No	Yes	Main aim to investigate and assess ways in which schools can contribute to health of pupils, teachers and wider community through a health-promoting environment.

Methods of evaluation	*Main findings*	*Recommendations*
Questionnaire. Case study – interviews, discussions, observation.	All supporters have HSA in work plans. Training is provided. HSA enjoys high profile. Outside agency support group useful. Annual recruitment events. Healthy alliance between HAs and LEAs. HSA had major impact on health and well-being in one primary school (no criteria offered in report).	* Further develop healthy alliance. * Produce model of good practice based on results. * School and community shared goals for health. * More parental involvement through pilot projects. * LEAs to promote HPS concept as outcome of HSA * Strategies needed to motivate schools to re-register.
Pre and post audits of all schools. Regular visits. Pupil questionnaire. Pupil focus groups. Parent quest. Staff quest in pilot schools. Telephone survey of local agencies.	Learning gains for pupils had occurred during project – higher self-esteem in intervention schools. Intervention group less likely to say they smoked or drank alcohol. For staff – positive changes in curriculum but little evidence of monitoring policies; keener understanding of healthy environment; useful links with other schools; parental involvement focus; wider range of approaches in PSHE lessons; increase in whole staff training; resources catalogued.	* Audit essential for review. * Role of HPS co-ordinator is central. * Senior management support crucial. * Health Development Plan needed. * Balance between ambition and reality. * Greater staff, pupil involvement in planning developments – linked to needs in schools. * Working group of teaching and support staff, parents, pupils useful. * Clear contracts for outside agencies. * Support staff involvement. * Dedicated time needed but flexibility is key. * Evaluation, linked to aims, must be built in. * Celebrate achievement regularly!

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
16. Barkholz and Paulus Germany 1998	Primary and secondary Some staff – numbers not available	None		No	No	To assess impact of the ENHPS project on pilot schools and on the country overall.
17. Lewis Staffordshire, England 1998	Primary, secondary and special schools – 534 altogether – all schools in Staffordshire Sample of teaching staff – nos. not given	Small numbers of pupils involved in discussion	Members of Steering Group School 'Visitors' (Award supporters)	No	Yes	The aims were to: – discover health promotion provision and activity in award schools; – determine change following award process; – assess differences in levels of support given to award and non-award schools; – provide evidence for future policy and practice.

Methods of evaluation	*Main findings*	*Recommendations*
Questionnaire. Interviews. Discussion groups.	3-year time frame too short. Useful guidelines on HPS, with framework for analysis of school performance – need for committee to plan and oversee project. Lack of resources hampered progress. Network of supporters essential. Many regional initiatives. Evaluation difficult in schools. Project training days successful. New technologies cause problems. New states contributed to dynamic structure of HPS. Other ENHPS links established.	* Health promotion model now recognised in schools – needs to be disseminated further. * Build on teacher awareness and support. * Cultural boards must have clear guidelines. * Regional days and meetings demonstrated new perspective – need to continue. * The HPS project should now be made available to all schools in Germany. * More research is needed concerning evaluation in school settings. * Teachers need training and support in the use of new technologies. * Project training days need to be built into programme.
Questionnaires to all schools (25% response only). Personal interviews with some staff. Meetings with Steering Group. Discussions with visitors. Brief discussion with some pupils. HEd. lesson observation (5).	Related marketing, content, implementation, support structures, teacher understanding of PSE, HEd., health promotion, and future plans. Little difference in support given to award and non-award schools. PSHE co-ordinator a key factor in success. Compared with non-scheme schools, more award schools: – had HEd. policies or statements and involved staff in their production; – had wider curriculum organisation and coverage of health issues – and greater coherence and progression; – provided more health-related activities for staff and pupils; – claimed positive attitudes towards health promotion and PSHE; – forged strong links with outside agencies and the community; – actioned their intentions re. health; – understood the concept and benefits of – health promoting school.	* Long-term publicity strategy needed. * Schools need help in understanding meaning and appropriate use of terms, e.g. PSHE, health promoting school, PSE. * Policy implementation needs attention. * Award criteria provided schools with a structure and targets – some adjustments and additions needed, particularly in area of substance use. * Steering Group should usefully produce a policy and planning document setting out objectives for next phase of development. * Need to look at plans for the scheme's growth in the future and how it can be managed. Three-year contracts very useful. Perhaps a two-tier system that will allow successful schools to leave the scheme and others to join. * Schools could be actively

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
18. Thomas, Benton, Keirle and Pearsall England and Wales 1998	124 secondary schools responded in Wales (all 232 targeted) 241 responded in England (546 randomly selected to give 1 in 6 sample) PSHE co-ordinator or substitute in each school	None	None	Yes	No	To assess: – existence of HEd. Policy aimed at pupils and teachers; – policy related to smoking, alcohol, exercise, nutrition, illegal drugs, HIV/AIDs; – involvement of outside agencies in policy-making; – health education co-ordinator post – time given to develop HEd. Curriculum; – training provision for co-ordinator.

Methods of evaluation	*Main findings*	*Recommendations*
		involved in planning the next stage. * Designate one visitor as project manager to undertake deployment of visitors, promotion and running of scheme.
Postal survey using questionnaire	77% of schools in Wales (W) and 59% in England (E) had defined HEd. policies. In E, policies often statements of intent and/or a curriculum framework. In W, usually more comprehensive, dealing with implementation and practice. In W, policies most likely to relate to pupils *and* teachers were nutrition and exercise. In E, alcohol and drugs. Relating to pupils only, smoking and drugs in W; alcohol and drugs in E. Very few in either had a comprehensive policy. 82% in E and 76% in W used outside agencies in HEd. 86% in E and 93% in W had a PSHE co-ordinator. 23% in both E and W allow extra time to co-ordinators. 92% of co-ordinators in W and 68% in E were trained. 64% of schools in E and 61% in W claimed to be health promoting but only 3% in W and 6% in E fulfilled 7 criteria for inclusion in policy. 80% in W and 58% in E had heard the term HPS previously.	* Schools need to be made aware of the components of a health promoting school and become familiarised with the concept. They should: * adopt a holistic approach; involving all in school; * appoint HEd. co-ordinator; * provide extra time for co-ordinating HEd.; * formulate comprehensive health policies; * involve parents, pupils and outside agencies in policy; development and implementation; * ensure policies are directed at all school members – not just pupils; * provide opportunity for health-related training sessions for all staff on regular basis; * practise what they preach – all school members becoming role models; * increase links with families and with professionals in the local community.

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
19. Parsons et.al. Implementation of ENHPS in Ireland, Lithuania, Poland, Portugal, Romania and Sweden 1997	10 primary 13 secondary 72 staff	0	64 personnel from ministries of health and education, local professional support and parents	No	No	To investigate: – working practices and structures; – models of health promotion and education; – political social and managerial influences; – support for schools in the management of change.

Methods of evaluation	*Main findings*	*Recommendations*
Multi-focused methodology using: analysis of documentary evidence; structured interviews (face to face and telephone); observation and case-studies.	ENHPS: * is an internationally credible vehicle for developing public health policy, healthy alliances and community action; * Has become a major influence on the development of health education and promotion in European schools; * Has potential to foster internationalism and equality of opportunity in the field of health promotion; * has evoked a high degree of enthusiasm; * Has operationalised in the school setting and eco-holistic approach to health promotion.	* Preserve devolved nature of ENHPS. * Increase resources and staffing. * Increase internationalism and networking. * Central logging of national projects and initiatives. * Develop regional workshops and meetings. * Care in the use of cultural and linguistic interpretation of projects and developments. * More issues of Network News with dissemination of good practice in Central, Eastern and Southern European countries. * Sustained commitment from national ministries of health and education. * National projects need to focus on monitoring and evaluating HPSs and value cultural significance and individuality of projects. * Need for enhancement of teacher training in health promotion and HEd. * Schools need to seek support of parents and members of local communities. * School project teams need to consider how resources can be used flexibly and adapted to include approaches to develop pupils' independence and communication. * Need at national and international levels for dissemination of good practice.

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
20. Stears *et al*. Wales 1999	7 primary 3 secondary 20 staff	100 10–16 yrs	6 personnel from national ministries and agencies 11 local health and education support personnel	No	No	To undertake a valuation of the health promotion assets in schools in Wales.
21. Moon *et al*. Hampshire, Dorset and Wiltshire 1995–8	15 secondary 80 staff	Approx 6000 Years 7, 8, 10 and 11	Caterer, caretaker, school nurse parent, governor from each intervention school	No	Yes	To evaluate the effectiveness of a healthy schools award scheme in changing health promotion processes and practice and influencing the health-related attitudes and behaviour of pupils.
22. Denman (PhD thesis) Nottingham University 1999	10 secondary 7 primary 1 junior 1 infant 1 middle 20 project link teachers	Varied across schools depending on foci of schools' objectives	Varied depending on foci of schools' objectives	No	No	To promote the formulation and implementation of policies in line with the concept of the health promoting school. 20 schools involved in action planning and

Methods of evaluation	*Main findings*	*Recommendations*
Questionnaire completed by interview and analysis of legislation, guidance documents and reports.	* 18 key issues were drawn from this study to direct strategic planning by the National assembly for Wales. * Weakness of existing teacher training in health education and health promotion and strength of local resources available to support health promotion in schools.	* Consideration to provide a mandatory place for PSHE in the school curriculum in Wales and enhance teacher training in this area. * Strengthening and targeting of the work of health professionals operating at the local level to support schools. * Need to further develop schools links with the family and local community.
– Health-behaviour questionnaire for pupils. – Focus group interviews with year 10 pupils. – Semi-structured interviews with teachers, other staff, parents and governors. – School audit with PSHE staff and senior management. – Curriculum and policy review. – Observation of school and lesson. – 2 collections of data pre and post intervention (18 months between).	At follow-up: * audit showed that intervention schools made more progress across all 9 key areas of the award than the controls; * more intervention schools had PSHE policies in place; * there was a small but significant decrease in smoking uptake for boys in intervention schools; * older girls performed better in every area in intervention schools; * parents, other staff and governors fully support HEd. in schools and wish to be involved actively; * pupil responses concerning taking responsibility and empowerment were more positive; * 5 intervention schools made major curriculum changes (none in controls); * the award structure and implementation had raised awareness and provided a catalyst for change.	* Further funding for research studies over time to demonstrate benefits of a healthy school approach, particularly how these link with academic achievement. * Profile and status of HEd. needs to be raised at national level. * HEd. and health promotion must form part of initial teacher training. * A national structure of support for healthy schools schemes, including substantial funding * Network of healthy schools co-ordinators, one in each LEA. * Concept of a whole-school approach needs to be explored, defined clearly and ways to achieve it identified. * Development of rigorous, sensitive, tried and tested tools for evaluating healthy schools is vital.
Action research by project link teachers. Project evaluation: – postal survey of written policies in HP and related issues at start and end of project;	Varied across twenty schools. Trends indicated an improvement in state of development of policies and topics covered. Schools varied in the extent to which they achieved change in line with their objectives. School factors influencing success: good management, organisation and communication structures;	* Internal conditions in schools need to be conducive to change. * Projects should be practical, flexible and realistic. * Projects should apply pressure in addition to providing support. * Training and networking opportunities for teachers essential. * Local and national policies

Authors, location and dates	*School type and no. of teachers involved*	*No. of pupils and years*	*Others, e.g. parents, caterer*	*R*	*C*	*Aims of intervention*
						developing materials. Provided with financial resources, training and consultancy service. Materials disseminated through programme of consultancy and training
23. Rivers *et al*. England 2000	Audit of 65 healthy schools programmes in 101 LEAs covering 2500 schools Evaluation of 8 pilot sites Evaluation follow-up in 7 schools	Not given	Parents, governors, key professionals, pupils	No	No	The National Healthy Schools Scheme builds on the concept of the healthy school to promote educational achievement, health and emotional well-being.

Methods of evaluation	*Main findings*	*Recommendations*
– observation, documentation research and interviews of project link teachers and other staff; – evaluation of training by questionnaire.	involvement of the headteacher; HEd. curriculum in place; link teacher of senior status; link teacher with time for administration; HPS in development plan; support of the community.	supportive of HEd. and the HPS to build status.
Telephone interviews and document analysis. Review of secondary data. In depth, structured interviews. Case studies. Interviews.	Programmes managed by multi-agency steering group. Two main types of programme were 'needs-led' and prescriptive. Programme activity helped stimulate wider links with the community. A consensus that HPS activities had benefited schools and pupils. Partnerships work best when they include a wide range of stakeholders with a common vision. Effective partnerships need long lead-in times. Senior level support for co-ordinators at programme and school level crucial. Many viewed HPS as an initiative to improve aspects of school life not directly associated with academic achievement. Working towards NHSS helped schools structure management and planning.	* Requires a high profile at senior level in health and local education authorities. * Dissemination should be facilitated. * Need for named co-ordinator and a larger working group. * All staff can contribute. * Schools need support to link with wider community. * More programmes should involve young people systematically. * Programmes should represent the communities they serve.

Appendix 2
Research instruments obtainable through the web

The evaluation of the Wessex Health Schools Award

- School observation schedule
- Focus group schedule
- Semi-structured interview schedule
- Questionnaires for students in secondary schools

Towards Health: a project approach to developing health promoting schools in Nottingham

- Health education policy survey questionnaire
- Semi-structured interview schedule to examine change in health promoting schools

Researching the health promoting school in Europe

- National co-ordinators' interview schedule
- School co-ordinators' interview schedule
- Teachers' interview schedule
- Other agents' interview schedule
- Documentation and observation schedule
- Audit tool designed for use with the Network of Health Promoting Schools in Wales

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