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Health-promoting schools: a resource for developing indicators

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Preface

This book emerged from a series of workshops the Technical Secretariat of the European Network of Health Promoting Schools (ENHPS) initiated on practice and evaluation of the health-promoting schools approach. Five workshops took place from 1998 to 2006. The fourth workshop in November 2005 encouraged 40 participants from 33 countries to plan and carry out a case study in their country over a period of five months. The focus was developing and using indicators for health-promoting schools, and their work had to be relevant to the needs of the country. At the fifth workshop in June 2006, the case study contributors presented the preliminary case studies and the participants discussed them. Based on this, the case study contributors submitted final case studies.

These case studies, which appear in Chapter 6, constitute the most important contributions in this book. The case studies should not be considered representative for the countries involved; they reflect several current needs and challenges in countries. They illustrate the cultural diversity and pluralism within the ENHPS on concepts of health, methods of enquiry and interpretation of evidence. We hope this variety will inspire further developments at all levels in all countries.

We took responsibility for organizing the workshops and producing this book, including reviewing the case studies. The case study contributors and at least two of us reviewed and revised each case study in a dynamic process. We have found this process stimulating and fruitful and hope that the case study contributors have too.

Chapter 1 presents a brief historical overview of the ENHPS by addressing some of the most important events and conferences.

Chapter 2 discusses the stakeholders – students, teachers, parents, communities and researchers – and their potential roles in collaborating to develop health-promoting schools. Nevertheless, such collaboration often constitutes a challenge because values, cultures and traditions differ. The chapter summarizes the most important evidence on the effectiveness of the health-promoting schools approach.

Chapter 3 presents the basic concepts, values and principles of a health-promoting schools approach. Despite the cultural differences in Europe, the ENHPS has contributed to developing several overall common values and principles, such as student participation, empowerment, action competence and the settings approach. The chapter presents and discusses these common underpinnings based on key documents the ENHPS has developed.

Chapter 4 links the concepts and principles identified in Chapter 3 with the reports on indicators presented in Chapter 6. This chapter introduces some of the basic concepts of evaluation research. A main conclusion is that, since the health-promoting schools approach varies between countries, indicators must be developed within each country and must therefore be sensitive to context and culture. This means that indicators cannot be developed in a top-down approach, and the various stakeholders must develop and use the indicators in the settings involved. Chapter 4 discusses supporting these processes at the national, regional and local levels.

Chapter 5 focuses on how indicators set for schools by international agencies (such as United Nations agencies) can be integrated into health-promoting schools approaches. The chapter uses HIV as an example and aims to support agencies and nongovernmental organizations that are including schools and education services in their programmes.

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1. A historical perspective on health promotion in schools

Introduction

The European Network of Health Promoting Schools (ENHPS) is a practical example of a health promotion activity that has successfully incorporated the energies of three major European agencies in the joint pursuit of their goals in promoting health in schools. The ENHPS had its conceptual origins in the 1980s, but since 1991, the initiative has been a tripartite activity, launched by the European Commission, the Council of Europe and the WHO Regional Office for Europe. Starting with only seven countries, the ENHPS has enlarged over the years and now has 43 countries as members.

Such international collaboration is essential to minimize duplication of effort and to provide a framework that fosters and sustains innovation. It also provides a vehicle for disseminating models of good practice and creates opportunities for a more equitable distribution of health-promoting schools throughout Europe.

There is increasing recognition that new forms of partnership and intersectoral work are required to address the social and economic determinants of health. Investments in both education and health are compromised unless a school is a healthy place in which to live, learn and work. School communities respond to a dynamic set of factors affecting student achievement and learning outcomes. The health of students, teachers and families is a key factor influencing learning. Schools require a strategy that will provide teachers, parents, students and other community members with a set of principles and actions to promote health. A strategy built on the health-promoting schools framework has the potential to help school communities manage health and social issues, enhance student learning and improve school effectiveness.

Criteria and principles

From the early days of the ENHPS, countries were provided with a set of criteria they could use to develop their national networks of health-promoting schools (Barnekow Rasmussen et al., 1999). These criteria proved to be a very useful starting-point for the development of national programmes, which would all adhere to a broad concept of health but also allow the inclusion of necessary national and regional specificities.

Later on, at the First Conference of the ENHPS (1997a, b) in Greece, participants built on these criteria to set out ten important focus areas in the Conference resolution. This resolution was to be a tool for guiding the development of health-promoting schools, once again considering that national programmes need to be adapted to local conditions.

Mapping different models of health-promoting schools

In the development of the ENHPS, the national coordinators have, through a series of workshops, had opportunities for exchanging experiences and refining their aims for the national health promoting-schools programmes. There is a general agreement on these aims despite the diversity in culture and educational settings throughout Europe. This is illustrated by a number of examples of aims as expressed by the national coordinators in a process of mapping the different models of health promoting school programmes used in countries (Jensen & Simovska, 2002).

The aim of a health-promoting school is:

- to establish a broad view of health:
- to give students tools that enable them to make healthy choices;
- to provide a healthier environment engaging students, teachers and parents, using interactive learning methods, building better communication and seeking partners and allies in the community;
- to be understood clearly by all members of the school community (students, their parents, teachers and all other people working in this environment), the "real value of health" (physical, psychosocial and environmental) in the present and in the future and how to promote it for the well-being of all;
- to be an effective (perhaps the most effective) long-term workshop for practising and learning humanity and democracy;
- to increase students' action competence within health, meaning to empower them to take action – individually and collectively – for a healthier life and healthier living conditions locally as well as globally;
- to make healthier choices easier choices for all members of the school community;
- to promote the health and well-being of students and school staff;
- to enable people to deal with themselves and the external environment in a positive way and to facilitate healthy behaviour through policies; and
- to increase the quality of life.

Development of the ENHPS at the national level

At the national level, the participating countries have been encouraged to make a strong commitment to the project, which includes cooperation between the health and education sectors and between them and participating schools.

Partnerships between health and education ministries have been key elements of success. These partnerships include a formal written contract between ministries,

and this has proved important in relation to funding support and establishing continuity and sustainable development.

However, over the years there have been major challenges and barriers to the recognition and sustainable devolvement of national health-promoting schools programmes. One of the main risk factors for positive development has been political change in countries and regions and, following this, a change of priority-setting within the country. Despite these barriers, health-promoting schools initiatives have developed steadily throughout Europe since the early days of the ENHPS.

Evaluation has been carried out (Piette et al., 2002) aiming at documenting decision-making about ENHPS and determining what is needed to ensure its sustained support and dissemination. One focus was to find out what information decision-makers and key stakeholders needed to assess the achievements of ENHPS in their countries and the conditions for the further support of the project.

With the information collected, it was possible to define a set of stages for development that could be used for national coordinators to monitor progress and also as a tool to guide implementation and development.

The steps from pilot to policy can be summarized as:

- positive identification by decision-makers;
- disseminating information;
- building credibility;
- demonstrating relevance;
- demonstrating feasibility; and
- incorporating the policy into government policy.

Research has revealed the crucial importance of involving the education sector in the process of agreeing to the potential benefits, as the two sectors have different criteria and values in relation to effectiveness and impact.

It is vital that the education sector be convinced of the need to develop a policy on school health promotion. Such policy may be developed in isolation or, more likely, with support from the health sector or other partners. The need to convince decision-makers of the added value of health-promoting schools programmes has meant that providing the evidence base for successful school health promotion interventions is increasingly important. The European conference Education and Health in Partnership (International Planning Committee, 2002) has been supportive in this process. Here the latest research and examples of best

practice on linking education with the promotion of health in schools were presented. Recent research from health-promoting schools experiences from a large number of counties has been published (Clift & Jensen, 2005), and this will be a useful tool for planning, implementation and advocacy.

The Health Behaviour in School-aged Children study can serve as a tool in the process of monitoring the development of health-promoting schools initiatives. The study is implemented in 40 countries and regions in Europe.

The study aims:

- to monitor over time the health and health-related behaviour of young people;
- to acquire insight into the influence that school, family and other social contexts have on the lifestyles of young people;
- to influence the development of programmes and policies in order to promote the health of young people; and
- to promote interdisciplinary research into young people's health and lifestyles through the international networking of health researchers.

The study has a clear social marketing function – the findings can be used to build an understanding of pressing issues and build political commitment through climate-setting and awareness-raising. It could, for example, encourage the participation of young people through youth councils, peer education, schools etc., in analysing data and designing responses.

The study could also be used as a reference base for policy-making in countries: for example, by supporting country interministerial groups set up to address young people's health.

Conclusion

The ENHPS has indicated that the successful implementation of health-promoting schools policies, principles and methods can contribute significantly to the educational experience of all young people living and learning within schools.

Emerging evidence identifies the school, the family and the community as settings that potentially can provide protective or damaging environments for young people in making decisions about their health.

One of the main keys to success is partnership and collaboration not only between different sectors at the national, regional and local levels but also with everyone involved in the everyday life of the schools.

2. Education and health in partnership

Who are the stakeholders?
Effectively promoting health in schools requires that all stakeholders have a sense of ownership and involvement in the process. Terms such as intersectoral working and partnership approaches are essential approaches to promoting health in schools. The main players and stakeholders are:

- the education sector, including schools and teachers;
- the health sector and health promotion services;
- students;
- health promotion researchers.

The concept of health-promoting schools includes the associated community and the environment beyond the school gates. Many other people therefore have a legitimate interest in this work, such as non-teaching staff, those providing confidential counselling, school architects, school food providers, police officers and transport specialists. However, this chapter focuses on the main stakeholders and explores the vital understanding between education and health that has to be in place for health promotion in schools to be sustainable.

Relationship between the education and health sectors
Health and education are inextricably linked. Health status is closely related to access to school as well as ability to learn. Health behaviour is associated with educational attainment outcomes such as school grades (International Union for Health Promotion and Education, 1999a, b). These links mean that improving effectiveness in one sector can potentially benefit the other sector, and schools are therefore an important setting for both education and health.

The school curriculum in all countries has always been influenced by judgements made by governments and other policy-makers about what is deemed a priority in relation to the education of young people and the needs of society. Many European countries in the second half of the twentieth century had considerable debate on the role of schools and education more generally. In some cases, there was a move towards school education "producing" young people who were more able to serve the economic needs of the country. Once this principle of the curriculum being used as a vehicle to respond to national needs was well established, then governments easily extended it to tackle "crises" such as the HIV and AIDS epidemic or the growth of substance misuse.

Modern educational reports on the role of education in schools clearly often contain statements encouraging a very broad educational approach. For example, the report Curriculum design for the secondary stages (Scottish Consultative

Council on the Curriculum, 1999) took a holistic view of the curriculum, defining it in terms of the totality of learning experiences a school offers to its students. The "effective school" is perceived as a learning community that sees learning as a shared responsibility and one that values relationships within the school and with the wider community. The stated curricular goals are to enable students to be disposed to have:

- a commitment to learning;
- respect and care for self;
- respect and care for others; and
- a sense of social responsibility.

The report also refers to young people being enabled to apply their personal resources of knowledge, skills and dispositions in creative ways to deal responsibly with their emotions; to take increasing responsibility for their own lives; and to look after their personal needs, health and safety as well as being responsive to the needs of others.

This approach offers a vision of school education within which health education seems to fit very well. The vision goes far beyond preparing young people to be economically productive or simply seeing education as some form of specialized training to meet government priorities. In many countries people recognize that the wider ethos and social climate of the school is important as a context for learning in the classroom. This is compatible with a broad view of health and provides opportunities to explore its social and mental health dimensions. However, it could be argued that the reality of the curriculum does not always fully match the language of educational policy reports. In many countries the curriculum also reflects professional interests and historical legacy rather than an approach fully geared to the needs of young people in today's rapidly changing society (Eisner, 1998).

Tensions also arise between education and health in the limited time made available for the various curriculum areas, which risks pushing health issues to a peripheral position. However, it is encouraging that some countries have a vision of the curriculum that broadly supports what health promotion would wish to emphasize, and overcoming the resistance of those supporting a narrower traditional curriculum will take time.

In some respects the education sector speaks a different language from specialists writing in health education and health promotion, and being sensitive to this in partnership work is important. For example, some education reports conceptualize the term "curriculum" in an all-encompassing sense to mean the totality of

learning experiences a school offers to young people. In health promotion networks, the term curriculum is usually seen as the syllabus guidelines or the learning and teaching in the classroom, and the broader influence of the school is encompassed within the whole-school effect or health-promoting schools. At the European conference Education and Health in Partnership (Clift & Jensen 2005; International Planning Committee, 2002), Ten Dam (2002) explored the conference theme from an education perspective without having recourse to use the term health promotion once in her keynote presentation. She also challenged the view that the main justification for health education lies in the fact that "good health is a prerequisite for students' educational achievement". She stated that the main reason for schools to be involved in health education was that it could contribute to the main tasks of education, which were explained as developing identity and learning to participate in society. This example does not reflect a totally different vision from those working in health promotion, but it may reflect a different starting-point and somewhat different priorities. Not surprisingly, the education sector gives priority to education, as schools are in the education sector! This may seem very obvious, but the early developments of health promotion in schools in the 1980s seemed insensitive to this (Box 2.1) (Young, 2005).

Box 2.1 Phases in rolling out the health-promoting schools model

Initial experimental phase

- Early innovators (mainly from the health sector) raise the issue of health promotion with colleagues in the education sector.
- The education sector at first tends to perceive health in biomedical terms rather than as a social model, resulting in a deficit of partnership work between the education and health sectors.
- School health services primarily operate in a traditional prevention model.
- Nongovernmental agencies work with individual schools and individual education authorities on specific health issues.
- Early sporadic or short-term developments occur that may be driven (and resourced) by political concerns about specific topics such as HIV and AIDS or substance use.
- The education sector does not perceive related initiatives such as Community Schools and Eco-Schools to have anything in common with health-promoting schools because of the prevalence of the biomedical model of health within the education sector.
- Education policy-makers adopt some health-promoting schools terms. In the early stages, this apparent adoption of terms may not be matched by real changes in practice.

Strategic development phase

- The education sector starts to perceive the benefits of health-promoting schools in meeting social and educational needs in their schools and communities. Authorities start to build capacity through training and staff development.
- School health services embrace a wider health promotion role.
- A more strategic approach gradually builds through partnership work at the national (government) level and/or education authority or regional level.
- The health sector funds posts in the education sector.
- Trial and error and working together reduces antagonism between the education and health sectors and slowly and gradual increases mutual understanding between the sectors. This includes clarifying priorities, values, language and concepts.
- Some shared posts develop between the education and health sectors, with education contributing resources.
- More sophisticated research and monitoring of progress is developed as the political profile and the expectations rise.
- Models are developed to map links between education and health in relation to school health (St Leger & Nutbeam, 2000).

Establishment phase

- Policy statements at the national level that initially tend to be in the health sector feed into the education sector.
- Policy statements on specific school initiatives relating to health are increasingly placed in the context of health-promoting schools, such as curriculum policy statements and food provision policy in schools.
- The education sector takes on greater responsibility for health promotion in schools and integrates health promotion into mainstream education.
- At the level of the individual school, health promotion becomes institutionalized: that is, it becomes integral to the school's core values and normal ways of working.

Other challenges facing those building partnerships for school health promotion are the different goals and expectations of partners about what a school health educationprogramme can achieve. For example, some partners in the health sector may have expectations that a programme should aim to produce prescribed behavioural responses and, through this, directly affect health status. For example, a relationships programme may aim to delay or reduce sexual intercourse or to reduce teenage pregnancies or sexually transmitted infections as outcomes. Many people in the education sector do not feel this is an appropriate way of measuring the success of their course and that it should be measured using, for example, the level of the knowledge and understanding and skills development of the students. These different views of what can realistically be achieved need to be addressed, and it should not be assumed that they are totally incompatible. St Leger & Nutbeam (2000) mapped the various links and tensions between health priorities and education priorities in the schools setting in a model that is helpful for setting out a conceptual map of all the aspects of this complex partnership.

In many countries, increasing attention is being given to the moral and social tasks of education. In the Netherlands, for example, all secondary schools have a statutory obligation to provide "a broad personal and community-oriented education". This involves the acquisition of communication skills, learning about the norms and values of one's culture and of other cultures and how to deal with them and learning how to function as a democratic citizen in a multicultural society. In other countries, the subjects of "citizenship", "values education", "moral education" or "democratic education" are part of the curriculum.

The ENHPS has attempted to address the issue of conflicting priorities between education and health ministries by seeking to develop formal signed agreements that set out a programme or strategy for joint work. This has proved a practical resource for enabling a degree of sustainability for the development of health-promoting schools in specific countries.

It is useful because developing the formal written agreement involves partners in taking time to clarify their language, concepts and priorities and in reaching a consensus on the joint responsibilities and budget arrangements.

Within the school as a workplace, teachers are a key group not only in terms of their educational role but also in relation to the importance of their own health and feelings of being valued in the community. Considerable literature shows that young people are less effective learners when they do not like or respect their teachers, which suggests that health-promoting schools need to nurture the health of the professionals too.

Evidence also indicates that teachers who feel their employer is investing in their health and welfare are more positive about their role in the school (Monaghan et al., 1997). The idea of the teacher as a role model, which was prevalent in the early development of health-promoting schools, is emphasized less today. The evidence suggests that students are not much concerned with the physical health of staff but do feel that their teachers should model good interpersonal behaviour, such as respect, calmness and rapport (Gordon & Turner, 2001).

The students

Students should be central to health promotion in schools. The education sector has been increasingly realizing the importance of involving young people more actively in their own learning (Clift & Jensen, 2005; Jensen & Simovska, 2005; Williams et al., 1989). In addition, the health-promoting schools movement pushing equity and democracy to the top of its agenda (ENHPS, 1997a, b) has provided a framework for giving these issues priority from a health promotion perspective.

Students should be involved in school projects and education for at least four reasons (Jensen & Simovska, 2005). The one most commonly presented is linked to reflections concerning the effects of certain health promotion activities: if students are not drawn actively into the processes, there is little chance that they will feel a sense of ownership of learning. If students do not develop ownership, the activities are very unlikely to lead to changes in students' practice, behaviour or action. The considerable interest within educational theory related to constructivist learning theories has contributed to an increased focus on this line of thought.

The second reason deals with the democracy-upbringing effects of participatory educational approaches. For instance, the overall aims in Denmark's *Folkeskole* (primary and lower secondary education) Act states: "The school shall prepare the pupils for participation, joint responsibility, rights and duties in a society based on freedom and democracy. The teaching of the school and its daily life must therefore build on intellectual freedom, equality and democracy" (Ministry of Education, Denmark, 2003). This policy context means that more moralistic activities aiming to impose predetermined behaviour on students may face significant difficulty.

A third reason relates to the ethical obligation to involve participants in decisions on health issues that are centrally related to their own lives. Such considerations, which are related to the liberal education aims facing schools, may also be active within many health organizations, such as those of a humanitarian nature.

The fourth reason involves the need for individuals to define terms or at least set out the parameters of a conceptual map. WHO's definition of health, with its subjective dimension of well-being, challenges health professionals to develop this involvement with the target groups in the process of defining what a healthy life or a healthy school means to them. Health professionals often emphasize the efficiency justification, whereas educationalists focus on the democracy-upbringing justification. These different reasons are not necessarily in conflict but are embedded in different rationales, priorities and values.

Parents, families and communities

The vital role of parenting in the early development of young people is well established, and evidence for the supportive role of parents within health-promoting schools is also accumulating. The traditional family unit is becoming less stable in many countries, and many children do not live in families with two parents. The increasing pressure on family life can affect parenting and, for example, the supervision or preparation of regular family meals.

Nevertheless, good outcomes are more likely when parents are actively involved in promoting the health of their children. For example, the active involvement of parents in a healthy-eating initiative in schools demonstrated more impact on the behaviour of young people in relation to food preparation (Perry et al., 1988). There are also interesting examples of parents and representatives of the community influencing food policies in schools through involvement in school nutrition action groups resulting in healthy alternatives being provided for the students. In some European countries with no school meal services, parents have become actively involved in cooperatives to provide healthy food for young people in the middle of the school day (Young, 2004).

Health-promoting schools require supportive communities, and the concept of the health-promoting school includes this idea of the school and its wider community and environment. The surrounding environment of the school needs to reflect the values being developed in the school. Practical examples of supportive community initiatives include:

- facilitating safe and active routes to schools;
- restricting the sale and advertising of unhealthy products near the school entrance;
- providing drop-in social centres for young people where they can raise issues confidentially; and
- providing attractive play and sports facilities in the school catchment area.

Health promotion researchers

The ENHPS is not a project but a strategic development spanning many years. Researchers have been significantly involved in influencing the shape and direction of the development.

One such initiative, the EVA project (Piette et al., 2002), was set up in 1994 to propose evaluation protocols to ENHPS members. This included the development process and qualitative evaluation, which suggested ways of recording and measuring features such as how strategic approaches in the school affect young people and the school environment. It also encouraged methods to measure how changes in the school affect students' health behaviour and the environment of the school. The complexity of a community such as a school offers great challenges for researchers. In undertaking this work, particularly the qualitative aspects, researchers may become players and partners in the development of the schools they are studying with what is effectively an action research approach.

In some European countries the ENHPS is closely related to the Health Behaviour in School-aged Children study. The Health Behaviour in School-aged Children study provides a unique data set on the health of 11- to 15-year-olds in many European countries, in some cases covering 20 years. The study takes a broad approach to examining young people's health in the context of social factors including family, peers, school and socioeconomic status and the developmental process of puberty. Gender and socioeconomic inequality is evident in many aspects of health behaviour. These findings have been instrumental in identifying the specific needs of young people of school age in relation to health promotion in many European countries. Although the study is not intended or designed to evaluate health-promoting schools specifically, it has provided evidence to support the view that schools can influence young people's health behaviour (Currie et al., 1990).

In some countries, such as Norway, data from the survey have been used for educational purposes in health-promoting schools. This approach is valuable both in helping young people with transferable educational skills such as interpreting data but is also important for exploring health issues generated by the students that are highly relevant to their lives.

The evidence supporting the health-promoting schools approach

This section summarizes the emerging evidence on the effectiveness of whole-school or health-promoting school approaches.

Research shows strong associations between young people's views of school and health-related behaviour. For example, the students most engaged in school are more likely to succeed academically and to display positive health behaviour. The corollary of this is that students who are most alienated are more likely to engage in high-risk behaviour. This is supported by another study (Currie et al., 1990) showing that young people who have problems at home are less likely to engage in certain types of high-risk behaviour if they feel good about school.

Other studies (Calabrese, 1987; Resnick et al., 1993) also suggest that schools can overcome or reduce the risk of alienating students by:

- providing opportunities for a meaningful contribution to school and community life;
- achieving more participatory approaches to teaching and learning;
- developing personal and social responsibility through school organization; and
- providing an anchor for students in difficulty.

A review of the international literature (St Leger & Nutbeam, 1999) broadly supported the effectiveness of a health-promoting school approach; since then various other studies and reviews have advanced the case further. In the United States, Allensworth (1994) and Kolbe (2005) have similarly advocated the effectiveness of comprehensive school health, which is the North American concept broadly similar to health-promoting schools in Europe, Asia and Australia.

In a major study in Scotland (West et al., 2004) smoking rates differed significantly in secondary schools, and this could not be explained by socioeconomic variables or other factors known to influence rates. Although the mechanism for how schools achieved lower rates could not be fully discerned, West concluded that the study indicated that the ethos of the school was important and that the study broadly supported the health-promoting schools approach.

A recent international review of the evidence of the effectiveness of school health promotion (Stewart-Brown, 2006) indicates that evidence supports the view that health promotion in schools can be effective. Stewart-Brown concluded that school programmes that were effective in changing young people's health or health-related behaviour were more likely to involve activity in more than one domain (curriculum, school environment and community), and as this reflects the health-promoting schools model, the evidence broadly supports this approach. Stewart-Brown also highlighted the need to have interventions of high intensity and duration. In addition, Stewart-Brown concluded that mental health promotion was one topic that appeared to be among the most successful and substance

misuse prevention among the least successful of those reviewed for school health promotion. Weare & Markham (2005) supported the conclusion on mental health promotion in schools, reviewing the features shared by effective initiatives in promoting mental health in schools.

Although these results are encouraging, they raise an issue of the language used by researchers working in the health domain. In general, such terms as "intervention" may be alien to the teacher, as they view education as a continuous process and many educationalists would not expect their effectiveness to be judged based on health outcomes such as the health status achieved by the students. Most teachers would focus on educational outcomes such as knowledge and understanding acquired or competencies demonstrated. Chapter 4 describes the debate on what should be measured, exploring indicators of effectiveness in more detail.

To conclude, the original concept of health-promoting schools was largely based on the thinking of experienced practitioners who sensed that an approach based on classroom lessons alone was unlikely to have much effect beyond the level of knowledge and understanding. Their view was that the important work of the curriculum needed to be modelled in the whole school and in the links between the school, the home and the community. These original ideas were not based on empirical research, but this research is now starting to show that health-promoting schools can influence health-related behaviour.

Much has to be learned about how this works, although the educational sociology literature can provide some guidance on this. The characteristics of effective schools have been studied more systematically worldwide in the past 20 years, and there is evidence highly relevant to health promotion (Creemers et al., 1989; Hopkins et al., 1994; Sammons et al., 1994; Scheerens, 2000; Teddlie & Reynolds, 2000). For example, effective schools have certain features in common such as the importance of clear leadership, setting well-defined goals and having high expectations of the students, fully involving students in the life of the school and creating a social climate and environment that students appreciate. It is becoming clearer that these features are also important in managing health-promoting schools as the process of change in schools and education systems begins to be understood better.

3. Health-promoting schools – key concepts and principles

Introduction

The work with evaluation and indicators of health-promoting schools has to be embedded within the fundamental values of the health-promoting schools approach. This chapter therefore presents some of the key concepts and principles that underpin the health-promoting schools approach in the European Region of WHO, acknowledging the diversity that exists among and within the European countries.

This chapter draws on several key documents and events such as the Ottawa Charter for Health Promotion (WHO, 1986), the resolution from the First Conference of the ENHPS (1997a, b) and the Egmond Agenda originating from the conference Education and Health in Partnership (International Planning Committee, 2002). The text links the concepts to the case studies on indicators and evaluation presented in Chapter 6.

The basis of health-promoting schools is the Ottawa Charter for Health Promotion (WHO, 1986), which changed the context for health promotion. The Ottawa Charter states that health promotion is a process about enabling people, meaning that people have to be active in acquiring the competence to "exercise more control over their own health and over their environment". Furthermore, the Ottawa Charter was built on five key blocks, which together constituted the settings perspective:

- building healthy public policy;
- creating supportive environments;
- strengthening community action;
- developing personal skills; and
- reorienting health services.

The health-promoting schools movement has largely tried to interpret these aspects of the Ottawa Charter in schools. This has been an interesting journey implying a shift in dominant paradigms over the years (Barnekow Rasmussen & Rivett, 2005). Two paradigms were operating when the health-promoting schools concept began to take off in the 1980s: the traditional health education approach and the health-promoting schools approach. Traditional approaches to health education used to be mainstream, although they differed from country to country. This traditional paradigm focused on disease, cures and young people's behaviour, with health being a closed concept defined by physicians. The health-promoting schools approach, by contrast, focuses on living conditions and lifestyles, considers well-being and the absence of disease and views health as an open concept in which young people should be involved in defining health (Jensen, 1977).

In relation to the process of education, the traditional approach prescribed a didactic, directive style aiming to change behaviour to avoid disease. The health-promoting schools approach looks at much more than just curing; it is a democratic process that aims to develop young people's competencies in understanding and influencing lifestyles as well as living conditions.

The traditional approach encouraged the teacher to act as a role model. The school environment was restrictive under the traditional approach, with smoking bans and the like dominating health. A school policy is fine, but there is a big difference between the principal imposing a ban and teachers, young people and parents jointly developing a health policy. There are many examples of the former option, but also increasing numbers of the latter option from health-promoting schools in recent years.

The traditional approach encouraged health professionals to come into the schools, do their bit and then go away. The health-promoting schools approach integrates health promotion into the whole context of the school and explores how the school can reach out to the community to facilitate health-promoting processes.

This means that promoting health in schools is about working with young people, trying to enable them to take action themselves in the school or the community and realizing that these learning processes are taking place only partly within the taught curriculum. The basic values of the health-promoting schools approach include:

- students' participation;
- the concepts of empowerment and action competence;
- the settings approach; and
- health policies.

Students' participation

The notion of student participation has become the most common value in the ENHPS. The terms used include "starting with the students", "linked to the students", "co-determination", "influence, "user involvement", "co-influence", "co-responsibility", "participation", "student-directed" and "involvement". The variety of language reflects the need to explore and define the concept of participation in more detail.

Several reasons are often stated for why a participatory approach is important in health-promoting schools (Jensen & Simovska, 2005). The most common one is

linked to reflections on the effects of certain health promotion activities: sustainable health-promoting changes presuppose ownership developed through participation.

The second justification deals with the democracy-upbringing effects of participatory educational approaches. The legislation governing schools in many countries has an overall aim of preparing young people for active participation and joint responsibility in a society based on freedom and democracy, and health promotion activities therefore need to support this aim through participatory approaches.

The third justification deals with ethical considerations concerning the obligation to involve participants in decisions about health that are centrally related to their own lives. The United Nations Convention on the Rights of the Child is often used as the basis of values in such organizations.

Finally, WHO's definition of health, with its subjective dimension of well-being, might challenge professionals to involve the target groups in the process of defining what a healthy life, a healthy school or a healthy community means to them.

Health professionals often emphasize the efficiency justification, whereas educators focus on the democracy-upbringing justification. These different justifications do not necessarily contradict, but they are embedded in different rationales and values.

These features are also significant for the health-promoting schools perspective, as they indicate that individuals need to develop their potential for making choices and to improve their skills for initiating the consequent actions. In other words, as stated in the resolution from the First Conference of the ENHPS (1997a, b), participation is closely linked to the development of empowerment and action competence.

Young people's empowerment enables 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.

Working with a participatory approach is not as easy as it often sounds. The developments in the ENHPS have drawn attention to several important questions, such as what involvement and participation actually mean and what the relationship is between the students and the professional when participatory approaches are being used in practice.

Student participation is sometimes equated with student determination: that is, the idea that the students should formulate their visions more or less on their own, work out a plan of action and set about changing the world or influencing their own life. Nevertheless, experience with student involvement often indicates that the teachers must involve themselves in the process and dialogue as a responsible but respectful partner. When trying to develop their visions and ideas for action, students need a critical friend who can challenge, support and stimulate them and with whom they can try out their own views. Consequently, a pure bottom-up strategy is not the only alternative to an expert-dominated top-down approach.

The model in Table 3.1 has been developed in close collaboration with teachers in health-promoting schools reflecting on their own practice, including the barriers they have faced (Jensen & Simovska, 2005). The aim of the matrix is to capture – in a simple way – how differently professionals view and use participation in their work with students. Taken together, the five rows represent different forms – or categories – of students' co-determination or involvement.

Table 3.1. Putting the concept of participation into operation

Although the boundaries between the categories are not strict, they represent different ideal types. The first category (non-participation) has been included here to make it quite clear that participation is not always possible. The second refers to a situation in which the teacher puts forward a proposal that students

	A. Involved in the project	B. Selecting the topic	C. Investigation	D. Vision and goals	E. Action	F. Evaluation and follow-up
5. Students suggest, common dialogue, common decisions						
4. Students suggest, student dialogue, students' decisions						
3. Teachers suggest, common dialogue, common decisions						
2. Teachers suggest, no dialogue, students accept or reject						
1. Given decisions (by teachers, legislation etc.), no dialogue, students clearly informed						

can take or leave. This may have nothing to do with involvement. The next three categories are distinguished by a combination of who offers an idea for discussion and who actually decides what to do. These three forms have been important in health-promoting schools; the principle of involving students sometimes implicitly presumes that this excludes the teacher (or any other adult) from presenting a proposal as the basis for discussion.

In the school context, this matrix nevertheless emphasizes how much the teacher needs to appear as a responsible adult with his or her own opinions when involved in projects built around student participation. The more the students are involved, the more important, presumably, it will be for the teachers to be visible and to play an active role in the discussions with their opinions, knowledge and insights.

The matrix reflects the assumption that participation in health promotion is linked to the context. The context might consist of several factors such as the nature of the project, the personality of the teacher, the preparedness of the students and the other stakeholders involved. This means that the environment in which participation takes place must be considered in planning, carrying out and evaluating participatory projects.

Further, the categories have been crossed with several questions appearing along the horizontal axis. These illustrate different questions or areas of decision that are often included in a school health project. The number and type of themes presented vary from project to project, and any given project therefore will have different types of participation in relation to different areas of decision. In other words, the aim is not to establish an ideal model for health promotion activities according to which involvement has to be applied in specific ways. On the contrary, the partners who are working together must spend some time discussing how to proceed. The model offers a basis for structuring such discussions.

The concept of participation, as outlined here, is one of the key values in health-promoting schools across Europe. In conclusion, young people's active participation is considered crucial for their ownership and therefore a prerequisite for the effectiveness of health-promoting activities. Further, a participatory approach does not imply that health content should be regarded as vague or superfluous or that the professional has a less important and active role to play. Teachers need flexible educational models and resources to manage participatory projects in health-promoting schools, and a participatory approach has to influence all aspects of a democratic health-promoting school rather than solely the teaching strategies.

Many of the case studies in Chapter 6 work with indicators related to students' participation. For instance, the cases from Finland, Poland and Switzerland demonstrate how indicators and quality criteria for young people's participation can be integrated in national schemes for health-promoting schools indicators. The study from Romania illustrates how indicators for students' involvement in improving the social climate can be developed at the classroom level. The study from Denmark used several participatory research methods to develop indicators corresponding to different forms of young people's participation. Finally, the case study from Ireland demonstrates how to involve young people in the process of developing health-promoting schools indicators.

The 10 principles for health-promoting schools

The First Conference of the ENHPS (1997a, b) in Thessaloniki developed 10 principles for health-promoting schools.

1. Democracy

The health-promoting school is founded on democratic principles conducive to the promotion of learning, personal and social development and health.

2. Equity

The health-promoting school ensures that the principle of equity is enshrined within the educational experience. This guarantees that schools are free from oppression, fear and ridicule. The health-promoting school provides equal access for all to the full range of educational opportunities. The aim of the health-promoting school is to foster the emotional and social development of every individual, enabling each to attain his or her full potential free from discrimination.

3. Empowerment and action competence

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 visions and ideas, enables them to influence their lives and living conditions. This is achieved through high-quality educational policies and practices, which provide opportunities for participation in critical decision-making.

4. School environment

The health-promoting school places emphasis on the school environment, both physical and social, as a crucial factor in promoting and sustaining health. The environment becomes an invaluable resource for effective health promotion, by nurturing policies that promote well-being. This includes formulating and moni-

toring health and safety measures and introducing appropriate management structures.

5. Curriculum
The health-promoting school's curriculum provides opportunities for young people to gain knowledge and insight and to acquire essential life skills. The curriculum must be relevant to the needs of young people, both now and in the future, as well as stimulating their creativity, encouraging them to learn and providing them with necessary learning skills. The curriculum of a health-promoting school is also an inspiration to teachers and others working in the school. It also acts as a stimulus for their own personal and professional development.

6. Teacher training
The training of teachers is an investment in health as well as education. Legislation, together with appropriate incentives, must guide the structures of teacher training, both initial and in-service, using the conceptual framework of the health-promoting school.

7. Measuring success
Health-promoting schools assess the effectiveness of their actions on the school and the community. Measuring success is viewed as a means of support and empowerment and a process through which health-promoting schools principles can be applied to their most effective ends.

8. Collaboration
Shared responsibility and close collaboration between ministries, and in particular the education ministry and the health ministry, is a central requirement in the strategic planning for health-promoting schools. The partnership demonstrated at the national level is mirrored at the regional and local levels. Roles, responsibilities and lines of accountability must be established and clarified for all parties.

9. Communities
Parents and the school community have a vital role to play in leading, supporting and reinforcing the concept of school health promotion. Working in partnership, schools, parents, nongovernmental organizations and the local community represent a powerful force for positive change. Similarly, young people themselves are more likely to become active citizens in their local communities. Jointly, the school and its community will have a positive impact in creating a social and physical environment conducive to better health.

10. Sustainability
All levels of government must commit resources to health promotion in schools. This investment will contribute to the long-term, sustainable development of the wider community. In return, communities will increasingly become a resource for their schools.

The concepts of empowerment and action competence

The first two principles emphasize the need for founding health-promoting schools on democratic and participatory principles conducive to promoting learning, personal and social development and health for all students, whereas the third principle embraces the overall aim of health-promoting schools. This principle has at least two important implications for how health-promoting schools work. First, the concept of health is not restricted to a behaviour-oriented approach as it includes young people's own lives as well as the living conditions in which they live and play. Health is viewed as a quality influenced by people's lifestyles as well as the broader setting. Health is therefore related to factors at school, in the community as well as the more global issues, and a health-promoting school has to acknowledge and address these different levels of factors during its activities.

Second, the aim of health-promoting schools is that young people develop their abilities, their commitment and the competence to influence and control their own health as well as the factors and determinants that are important to their health. The concepts of empowerment and action competence are used to describe these outcomes of health-promoting schools. Further, the development of young people's visions and dreams about their future life, school and community are crucial to motivate them to take action. Finally, the principle emphasizes the need for joint collaboration if young people's action is to generate and facilitate health-promoting change in the real world.

This means that health-promoting schools do not change students' behaviour in prescribed directions and do this by all means. Rather they involve young people in developing and qualifying their own ideas about healthier lives and healthier living conditions and taking action accordingly. When activities at health-promoting schools are labelled action-oriented, this indicates that young people – as part of the activities and the learning processes going on at the school – are taking concrete action to influence the real world towards healthier development. Their actions might, for instance, target their own behaviour in the classroom, the food served in the canteen or the leisure possibilities they have in the community during leisure.

Several case studies have taken up issues related to empowerment and action competence as overall aims of health-promoting schools. For instance, a workshop in Cyprus ended up with impact indicators for students' self-esteem, which is considered to be part of their empowerment, and the study in Finland emphasizes the importance of students' clarifying their value and setting goals as an indicator of their action competence. The case from Greece examines student's involvement in critical decision-making as an indicator of empowerment and social health in the school.

The settings approach

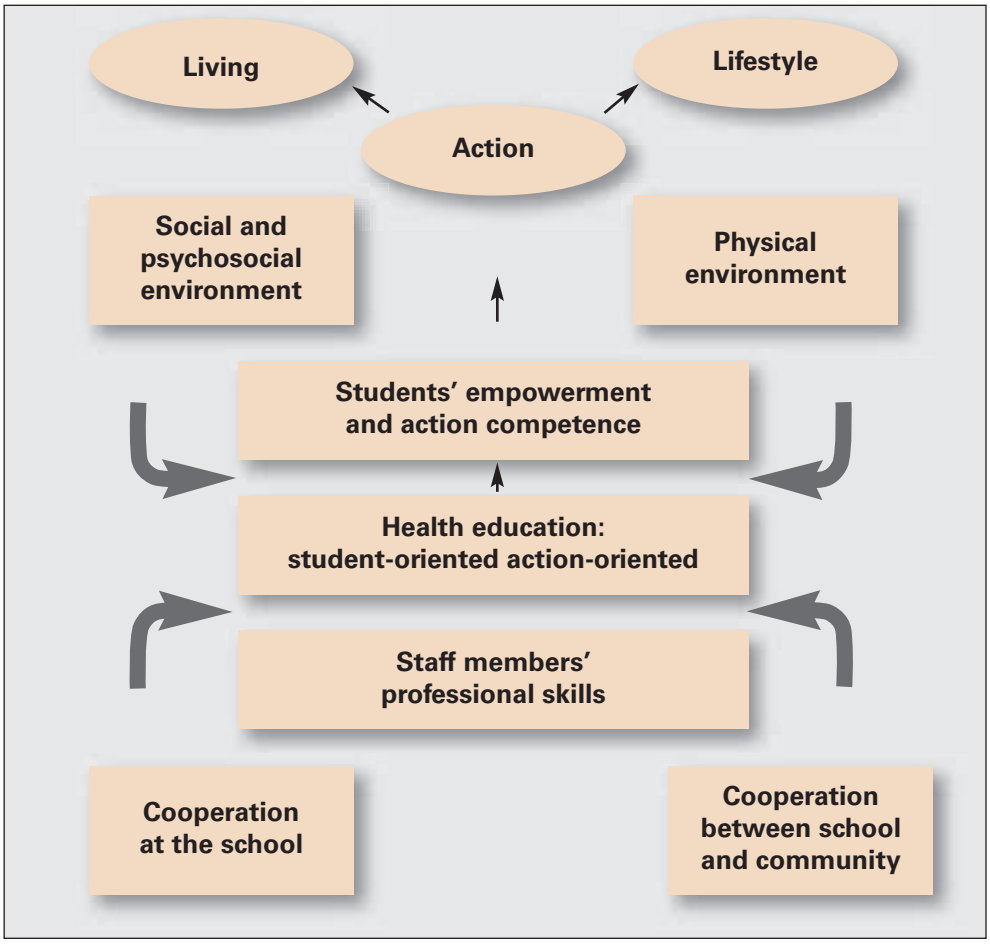
The 10 principles have to be put into operation in relation to the cultural context of the participating countries and their schools. Even so, together they indicate a common foundation for the development of health-promoting schools. In the book *Models of health promoting schools in Europe* (Jensen & Simovska, 2002), national coordinators from 10 European countries presented their model of health-promoting schools. Even if authors have many different visual ways of illustrating the model at work in their country, they share a common framework, which is inspired by the Ottawa Charter. They all – in some way or another – include the following elements:

- the school environment;
- the school curriculum; and
- schools' relationships with parents and the community.

Fig. 3.1 represents one way of illustrating these principles. The overall aim of developing empowerment and action competence has been put in the core. The model illustrates that schools' health education activities should be considered as one important factor in promoting empowerment and action competence at school. Further, the model indicates that numerous preconditions can support or hinder the overall aim. These preconditions include both cooperation (at the school and between the school and its surroundings) and the environment (social as well as physical) at the school. Finally, the staff members' competence in educating for health in participatory and action-oriented ways is an important precondition to making health education and promotion successful. Together these different elements and their mutual links constitute the settings approach.

Teaching and educational processes have been put in the centre in the model in order to stress that a health-promoting school is not only about providing the right food in the canteen and ensuring a smoke-free environment. Health-promoting schools is also about young people learning about and developing awareness of health. This implies that students and teachers are considered to be the key actors at a health-promoting school.

Fig. 3.1. Core components of health-promoting schools



Source: adapted from Jensen & Simovska (2002).

The school's teaching has to reflect the overall aim of a health-promoting school. This means that the teaching has to fulfil several criteria. One precondition for the students' developing their action competence is that teaching be made relevant, so that students feel a sense of ownership concerning the topics and themes with which they are working. The principles from the resolution from the First Conference of the ENHPS (1997a, b) speak of the importance in this in connection to the curriculum, and the principle points out that teaching should be organized in such a way that it is "… relevant to the needs of young people … as well as stimulating their creativity …".

To this end, teachers have to possess a range of important professional skills. On the one hand, they have to have a store of professional knowledge about health issues. In other words, teachers must possess insights into such areas as: the effects of health problems in our society, the root causes of the problems, strategies for solving the problems and promoting health and ideas about how people, including students as young citizens, can take action to influence such strategies.

At the same time, teachers must be able to use different methods in teaching, so that the students themselves become actively involved in carrying out investigations, formulating visions and initiating action. Teachers must thus acquire professional skills and teaching competencies as a decisive precondition for the development of empowerment and action competence among the students. As Fig. 3.1 shows, the professional skills of the teachers are an important basis of health-promoting schools.

This also means that adequate teacher training and professional support are crucial for investment of resources for a health-promoting school. This is also reflected in the resolution from the First Conference of the ENHPS (1997a, b) as one of the 10 principles deals with teacher training. The Egmond Agenda also emphasizes the importance of teacher education and professional development (International Planning Committee, 2002).

A health-promoting schools programme introduces concepts and methodologies that may be unfamiliar to officials in health and education ministries and other actors such as teachers … Building the capacity of personnel and providing opportunities for professional development has been shown to be an effective strategy in health-promoting schools policy. It has shown tangible benefits for learning, skills development and social capital.

In the model presented in Fig. 3.1, the arrows from the four boxes indicate that these factors influence education and the health and skills of the students. In

terms of the school environment, the physical and psychosocial environments are distinguished.

Does the physical environment of a school, for instance, allow flexible teaching processes and working in both large and small groups? What about hygiene at the school and what about the temperature in the classroom? Do the teachers create a safe and socially responsible environment in the classroom? Have the students, for example, been involved in formulating rules for social behaviour in their class and in their school? These questions indicate what the two boxes relating to the environment of the school cover.

A ministry or the school management may impose rules and requirements concerning the environment of the school. However, rules, values and requirements the students have helped to develop and formulate in cooperation with their teachers and others have much greater effects on students' lives than rules imposed from the outside.

The boxes concerning cooperation distinguish between cooperation within a particular school and cooperation between the school and the surrounding society. Interdisciplinary cooperation at the school – between teachers in different subjects and between teachers and professional health workers – is a condition for the all-round treatment of a variety of health themes. In turn, such interdisciplinary teaching is required if students are to build up a coherent set of perceptions concerning health topics and concerning how to influence conditions that affect health. For example, a biology teacher might deal with health in one way, whereas teachers in social studies and in creative subjects would bring out completely different aspects. Together they help contribute to the study of health as a multidimensional concept that forms part of the culture in a variety of ways. And together they help promote the ability of the students to take action in relation to health issues of interest for them.

The dominant culture of cooperation between teachers is decisive in providing opportunities for incorporating various viewpoints in the work. This also applies to cooperation between teachers and health personnel. For instance, some teachers consider a presentation by the school health nurse on sex and sexuality as an unfortunate interruption of normal teaching and not an optimal way to use the existing resources at the school.

Cooperation between the school and the local community opens up many exciting dimensions. Experts from the local area (such as technical experts, politicians, communication experts, doctors and artists) can be drawn into the teaching

offered by the school, adding a very valuable and inspiring authentic touch. On the other hand, the community may also gain benefit from the work done by the school if the students help to call attention to health matters in the local community and perhaps make suggestions or help to launch particular courses of action in the local community.

By investigating real-life conditions in the school district, the students can gain insights into matters related to health in a manner far more relevant than teaching within the four walls of the school normally allows for. The principle on communities in the resolution from the First Conference of the ENHPS (1997a, b) emphasizes this function, in which students and teachers become active agents in the local community:

… young people themselves are more likely to become active citizens in their local communities. Jointly, the school and its community will have positive impact in creating a social and physical environment conducive to better health.

The school has a role to play as a health-promoting social agent in the local community, and the community has a potential for providing a more authentic learning environment for the students.

An example helps to illustrate the possibilities. When the school focuses on the use and abuse of alcohol, thinking of the local community as a cooperative partner is obvious. Experts who deal with alcohol in various social situations can contribute to teaching by throwing light on the many roles alcohol plays in the culture. The students can go hunting in the local area to find and describe all the various situations in which alcohol appears. The observations thus collected may form the starting-point for a subsequent discussion in class of questions relating to alcohol, with the aim of preparing students for the fact that they will run into alcohol in many different situations both in their present lives and in the future. Role play and drama can be used to help prepare the kind of behaviour called for in these situations. Important discussions may be launched if students present these problems for parents or selected groups in the local community – in the form of presentations, drama, exhibitions and the like held at the school itself or in the community, such as at the local library.

This model emphasizes that teaching is a central activity of health-promoting schools and also illustrates several factors in the social framework that affect the development of students and the teaching itself. On the other hand, teaching itself can play an important part in shaping, changing and modifying these external framework factors. Examples that illustrate this are cases in which the work

done in class leads to the students setting up ethical rules applying to behaviour in the class or the social environment of the school.

In other words, there is a close and reciprocal relationship of influence between the teaching at school and the action competence of the students on the one hand and several factors relating to the school environment and cooperative partners on the other.

Many of the case studies in Chapter 6 deal with indicators related to the settings approach. For instance, the study from Croatia presents certain indicators for doctors' and nurses' attendance at adequate in-service training activities, and the case from Ukraine deals with the existence of national recognized courses in accordance with the health-promoting schools approach. The example from Cyprus demonstrates indicators of school–community collaboration, such as the frequency and type of positive contacts between families, community and school. The case study from Germany presents indicators that indicate whether a school is using health education, health promotion or disease prevention measures to promote educational aims (good and healthy school). In Ireland, the students developed several indicators, one of which was the "an atmosphere of mutual respect" among students and teachers. The joint case from Estonia, Latvia and Lithuania suggests an indicator of school–community collaboration focusing on the concrete cooperation between the school health committee and networks or institutions in the community. Finally, the example from the Netherlands has developed indicators describing how the regional public health service divisions approach the schools.

Health policies

The model described above illustrates the idea of a school as a setting or as a context. It has been useful in presenting the project for a broader audience, such as the parents or the teachers at a school. It has also been of value when different stakeholders (such as teachers, the school nurse and the local municipal health consultant) are discussing their possible roles and tasks within the development of a health-promoting school. In this respect it has also proven to be useful to structure the discussion about a school's health policy.

Schools can use the model in developing their own school health policy. The models serves as a tool for structuring the different areas in which a policy has to be formulated, and it helps to keep health education and health promotion in focus as an area where a policy also has to be developed. A school may decide that the social environment among the teachers is the most important issue to address before any other projects are initiated. The model will help to focus the

discussion on how to improve the social environment to create the best possible preconditions for student-oriented health promotion.

The previous section emphasized that young people's participation has to be thought through carefully in all aspects of a health-promoting school. This means, for example, that a health policy for a health-promoting school has to be developed by professionals and students together, which again means that such a policy has to change and grow continuously as concerns and attitudes change among staff and students.

These perspectives and principles on involving participants as stakeholders in the development of the health policy at the school have several implications. First, a school's health policy is developed locally and thereby reflects local interests, problems and priorities. Again, this means that different schools will develop different types of health policy. Second, a school's health policy should be a continuing and dynamic process and not a delimited task that is accomplished once. Strategies and tools must therefore be developed that enable the students, staff and parents to continue to challenge, develop and sustain the school's health policy. Local commitment and ownership are required for a health policy to be relevant and meaningful. Health policies in health-promoting schools should therefore be conceptualized as growing and living organisms.

4. Health-promoting schools – definition and role of indicators

Introduction

Schools are complex social and physical systems with structures and processes and with complex educational goals and aims. Insight into the interaction of these components allows knowledge to be developed about the school in general but also about health-promoting schools (Stewart-Brown, 2001, 2006; St Leger, 2000). This chapter examines indicators that can be selected to focus on key measurements that are necessary and sufficient to permit a judgement to be made about the quality of the structure of health-promoting schools, their processes and outcomes.

What is an indicator?

A suitable definition of an indicator is: *a sign that gives a fair and accurate representation of a part of the working of a complex system and changes within it* (Young, 2005). Peberdy (1997:296) puts it in another way when she says that an indicator could be compared to a road sign that "shows whether you are on the right road, how far you have travelled and how far you still have to go". This marker can be a characteristic of an individual, a population or the environment that is subject to measurement (Nutbeam, 1998). A system of indicators is a limited set of signs that reflects the current status and changes of a complex system and that is expected to reduce the complexity.

Indicators rely on qualitative as well as quantitative data. Qualitative data could, for instance, be students' opinions of the school canteen in a health-promoting schools project on healthy eating (such as "I would like the canteen to be less noisy. Make it better than just tables and chairs"; "You have to stand for about 10 minutes waiting on a table, to try to find a seat with your pals"; "The portions are really small"). The quantitative data might, for instance, be the number of students who take a meal in the school canteen or the number of healthy choices for healthy food students can make in the canteen. Qualitative data can be transformed to quantitative data, which means that a numerical value is assigned to a certain construct: for example, students' opinions about healthy eating in the canteen are categorized and then counted (McQueen & Anderson, 2001:69f).

Further, indicators reflect either the process or the product of a system's working. They can both be qualitative and quantitative. These distinctions comprise a four-field table of possible indicators (Table 4.1). For instance, students' active participation might be an important process indicator, and data can be gathered about this by counting the number of students who stay and work longer than the traditional lessons (quantitative) or by observing the relationship between the teacher and the students in a given health project in the classroom (qualitative).

Table 4.1. Table of indicators: examples from learning culture and satisfaction with school

	Qualitative data	Quantitative data
Process (learning culture)	Expressions of feelings of students about teaching in the classroom (such as fun or boring)	Responses in an adjective checklist on teaching the classroom
Product: output or outcome (satisfaction with school)	Drawings of students: "My school is a nice place to be" (such as colours and items mentioned)	Number of affirmative responses from students on the questionnaire item "My school is a nice place to be"

In school health promotion, indicators reflect aspects of the health-promoting school. These can be attributes of people (that is, health behaviour, health knowledge, health literacy, empowerment and the participation of an individual student, teacher, non-teaching staff member or parent), attributes of subgroups of the school population (that is, the health behaviour of school-aged children, teachers' health and the health attitudes of parents) and attributes of school environment or organization (that is, a healthy school building, healthy school yard, healthy transport to the school, school health management and the dominant teaching and learning approach).

Indicators are key concepts in quality assurance of health-promoting schools. They are therefore often called indicators of success or quality indicators. They indicate or point to good or poor quality of the health-promoting school (Ader et al., 2001; Rootman et al., 2001).

The levels of success of a health-promoting school might be called criteria for success or simply indicators of success, against which success can be assessed within the range of a certain indicator (such as teachers' mental health). Success indicators depend on the aims and goals of the programme, which again reflect the cultural values, norms and expectations of the stakeholders of health-promoting schools.

Table 4.2 puts these terms in the frame of the quality of the health-promoting school. An example illustrates the aspects.

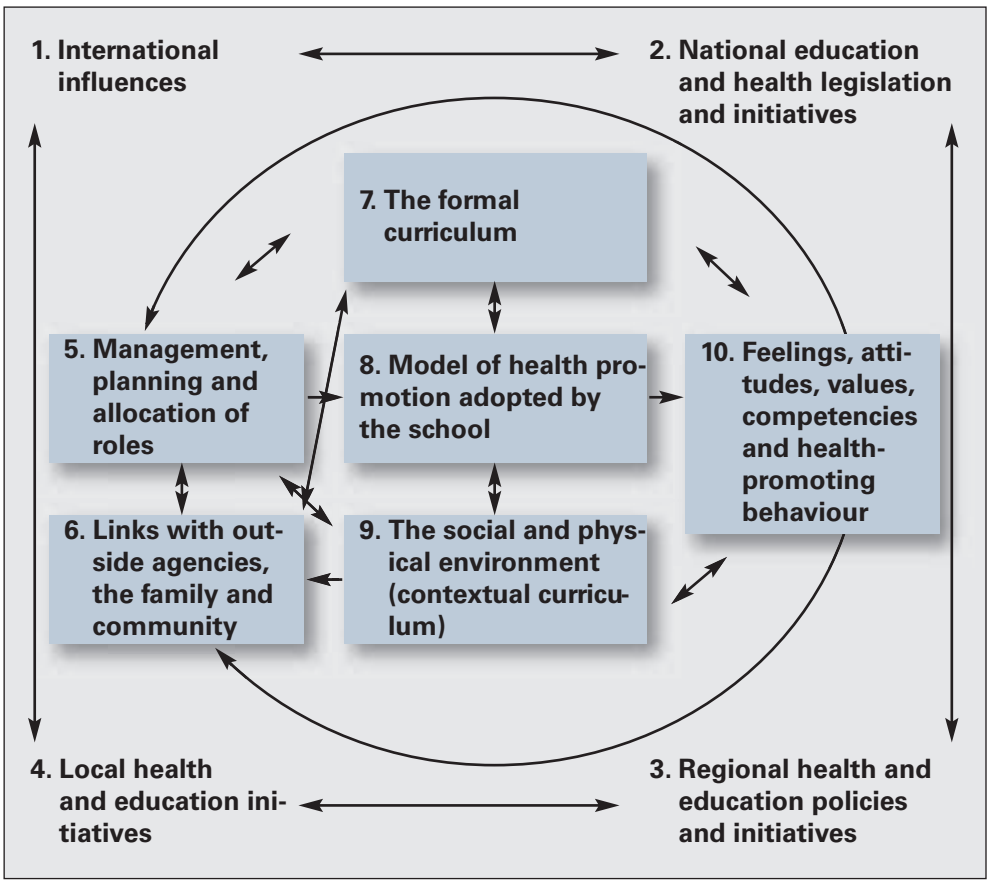
Table 4.2. Indicators in the framework of quality of the health-promoting school

	Health-promoting school	Indicators	Measurement of indicator	Criteria for success
Description of the meaning and range	Complex system of interaction of • Management • Curriculum • Physical environment • Etc.	Signs that give a fair and accurate representation of a part of the working of a health-promoting school	• Qualitative • Quantitative	• Level
Example	Management of the health-promoting schools as an aspect of the health-promoting schools	Existence of rules and regulations for resolving conflicts in the school as an aspect of the management of school culture	Check (observation or interview) whether rules and regulations for resolving conflicts exist in the classrooms	Previously defined percentage of classrooms in a specific school project

Indicators are not restricted to the school level. The ENHPS will have indicators at the regional, national and international level. At the international, national and school level, indicators of success are more about school development and improvement, the facilitating conditions that will lead to positive outcomes for students but also indicators of behavioural, cognitive, motivational or emotional change that characterize positive outcomes are useful.

Fig. 4.1 presents a picture of the complexity of the health-promoting school. This model locates the health-promoting school in the context of local, regional, national and international influences. Indicators can be developed for all these 10 different aspects.

Fig. 4.1. An eco-holistic model of the health-promoting school



Source: adapted from Parsons (1996).

Box 4.1, which is an example from Latvia (Kalnins, 2005), illustrates how some of the different aspects in the model above might be put into operation as indicators (the numbers in Box 4.1. refer to the different aspects mentioned in Fig. 4.1).

Box 4.1. Indicators of success of health-promoting schools in Latvia (Kalnins, 2005) (the numbers in parentheses relate to the eco-holistic model)

Data were collected via questionnaires, with 1001 returned from students in health-promoting schools and 1169 from controls, and 234 from teachers in health-promoting schools and 228 from controls. The numbers are small, but schools in Latvia are very small, some having only 50 students.

We also interviewed school directors, the student council and school health teams to better understand some of the quantitative data. We asked teachers, for instance, to what extent they felt they were able to integrate health into their subject.

The following provides examples of some of the indicators we used.

- **Health education (no. 7):** We looked at the presence of the school team, how many teachers went to training courses and the availability of health resources for the teachers. We also asked students what attention was being paid to health in their school.
- **School environment (no. 9):** We looked at how much students' preferences were taken into account in the design of programmes of activities and asked students whether they liked school, what they felt about the class atmosphere and their relationships with teachers. We asked, for instance, "are you afraid of the teacher?" and "if so, why?", to which the children would say things like, "the teacher shouts". We also asked about the methods used by teachers to deal with disagreement; negative responses included "[the teacher] laughed and ridiculed me" – very powerful messages indeed.
- **Developing life skills (no. 8 and 10):** We asked teachers how much opportunity they thought students had to develop life skills around such issues as smoking and alcohol use and asked students how competent they felt in dealing with pressures to smoke and controlling their anger.
- **Collaborating with families (no. 6):** We asked teachers about their involvement with families and asked students about how much they talked about health at home.
- **Collaborating with communities (no. 4 and 6):** We enquired about the kinds of resources schools received.

Table 4.3 presents a more systemic view. It is taken from a document on indicators reflecting the whole complexity of the structure and dissemination of health-promoting schools in the ENHPS (Pattenden et al., 1999). As a summary of the full document, Table 4.3 provides examples of indicators from each of the levels described above. The case study from Finland in Chapter 6 further explores this scheme.

Tabel 4.3. Indicators of health-promoting schools at the international, national and local levels

Indicators at the international level

Objective	Indicators	Criteria for success
Dissemination: 1.3 To support the further development of the health-promoting schools concept within countries	• Number of countries moving from pilot to policy as a proportion of the total number possible	• Increase in the number of countries moving from pilot to policy
Structures: 1.7 To ensure the sustainability of the ENHPS	• ENHPS seen as a successful project by members	• No drop-out countries
Impact: 1.11 Every child in Europe should have the opportunity to attend a health-promoting school	• Number of children in Europe attending a health-promoting school	• Proportion of children in Europe attending a health-promoting school

Indicators at the national level

Objective	Indicators	Criteria for success
Dissemination: 2.1 To increase annually the number of schools working within the health-promoting schools concept	• Percentage of schools working within the health-promoting schools concept • Schools involved are spread equally across the country and social groups	• Increase in percentage involved • Equal involvement of all areas of the country and social groups
Structures: 2.7 Established forum for dialogue between national coordinator and health and education ministries about health education and health promotion in the national curriculum	• Regular (at least annual) logged and minuted meeting	• Dialogue perceived as productive by all parties
Impact: 2.13 Countries have a national strategy for health-promoting schools in place	• Extent of cooperation between government departments over strategies, financial support and allocation of personnel	• High levels of cooperation and financial support
2.16 In-service training on the health-promoting schools concept is provided	• Proportion of teachers attending annual in-service training and attendance rates • Proportion of participants perceiving the training as useful and of good quality	• Increase in the proportion of teachers attending in-service training • Increase in the proportion of participants perceiving that the training has increased their capacity to fulfil their role in relation to the health-promoting schools

Indicators at the school level

Objective	Indicators	Criteria for success
Dissemination: 3.1 To ensure dissemination of the health-promoting schools concept within the school	• Percentage of staff actively involved in implementing the health-promoting schools concept • Percentage of students actively involved in implementing the health-promoting schools concept	• All staff actively involved in implementing the health-promoting schools concept • All students actively involved in implementing the health-promoting schools concept • Number and status sufficient to ensure the implementation of the health-promoting schools concept
Structures: 3.6 To ensure that effective school policies support the health-promoting schools concept	• Policy on health education in the curriculum • Relevant policies on aspects of ethos and environment, such as food; safety; bullying; discipline; tobacco; and alcohol and drugs	• Policies are in place • Policies are known about by whole school community • Policies are fully implemented
Impact: 3.12 To ensure that the whole curriculum contributes to the development of action competencies 3.18 To promote student satisfaction with school 3.22 To ensure partnerships with families and the community	• Proportion of students reportingthat there is opportunity to discuss concerns and take responsibility for their own health • Rate of truancy • Proportion of students who agree that school is a nice place to be • Number and type of activities undertaken by school to encourage parental involvement in their child's learning and school life	• Increase in proportion of students reporting that there is opportunity to discuss concerns and take responsibility for their own health • Decrease in truancy • Increase in proportion of students who agree that school is a nice place to be • Increased attendance by parents at consultation evenings and other events • Increase in number and type involving parents

Source: adapted from Pattenden et al. (1999).

What is a suitable indicator?

Suitable indicators provide a relatively simple way of representing selected features of a complex reality such as health-promoting schools and can also be used to measure change over time (Pattenden et al., 1999). But indicators should not only be simple but also relevant, useful and help to develop practice. They should be specific, measurable, achievable, realistic and timely (or, in some cases, time-bound) (SMART). But this cannot be defined absolutely. The extent to which a set of indicators is specific, measurable, achievable, realistic and timely depends on the conditions of the specific project or programme: the socioeconomic situation or level at which the project or programme is located. What a health-promoting school is all about differs from country to country and even between regions. So indicators need to take into account the human and financial resources available to achieve objectives. They cannot be produced in a vacuum – indicators need to be realistic and achievable – and therefore culturally sensitive (Young, 2006).

From the point of measurement, they also need to be valid, which means it must be clear what the indicator indicates. Does the body mass index measure bodily fitness or something else and is the measure of students' participation an indication of their genuine ownership? It must also be reliable, that means it should be a good measure of what it says it measures. It should be sensitive to measure changes. Because school health promotion aims to foster change, the indicator must be sensitive to the conditions given for those changes. As St Leger says (2000:725):

Unfortunately, in many school health studies indicators are chosen for measurement where the resources and time commitment of the program means it is unlikely that any effect will be observed, e.g. expecting behavior changes after a four-week classroom-focused nutritional intervention.

Table 4.4 Characteristics of indicators in the health-promoting school approach

Characteristic features of indicators and measurement	Explanation	Examples from the case studies (country)
Fair	Indicator is consistent with the values and aims of the health-promoting school and is in accordance with the values of the educational system in a given cultural context	Teacher's self-evaluation of the impact of their participation in the ENHPS (satisfaction from their participation in the health-promoting schools; Croatia)
Accurate and specific	Indicator reflects precisely the aspect under consideration	There is a place for the dissemination of the health-promoting schools concept in the school agenda (dissemination of the health-promoting schools concept; Estonia, Latvia and Lithuania)
Measurable	Indicator is quantifiable or suitable for qualitative study	Number of school activities that promote the holistic understanding of health (students' understanding of health as a holistic concept; Croatia)
Achievable	Indicator can be measured or interpreted without too much effort and cost	The health team or committee cooperates with other organizations and networks in the community (sustainability of the health-promoting schools concept to school community and outside the school, Estonia, Latvia and Lithuania)
Reasonable	Considering all aspects, the indicator in question is the most suitable one	Proportion of students reporting and demonstrating satisfaction with the programme (satisfaction of students with their participation in the ENHPS, Cyprus)
Timely	Indicator reflects evidence basis and innovative issues	Decide or choose the subject of health to work with (students' influence as part of students' participation; Denmark)

Objective measurement	Measurement of the indicator should be transparent and understandable	In my school I was precisely informed what it means that my school is a health-promoting school (student questionnaire on knowledge of the concept of the health-promoting schools, Poland)
Reliable measurement	Measurement of the indicator should measure precisely what it measures	I know what my role and tasks are in health-promoting school development (teacher questionnaire on knowledge of the concept of the health-promoting schools, Poland)
Valid measurement	Measurement of the indicator should measure what it claims to measure	In the school in which I work, I was informed what a health-promoting school means (non-teaching staff questionnaire on knowledge of the health-promoting schools, Poland)

Outcome indicators should always be combined with process indicators in the health-promoting schools approach. The process indicator should reflect whether the process in the school or at the other levels of school administration is a participatory process. Consider, for instance, two schools in which students eat in a nutritionally appropriate way. The first has used a purely participatory process to encourage healthy eating, whereas teachers in the second have enforced punishment and rules on eating behaviour for students. The outcomes are the same, but the processes are very different. The second school could not be called a health-promoting school.

Without participation people are not empowered, and without being empowered people cannot promote their health. Rootman et al. (2001:14) said: "Attempts to encourage public participation are critical to the process of empowerment" and "… we suggest that the primary criterion for determining whether a particular initiative should be considered to be health promoting ought to be the extent to which it involves the process of enabling or empowering individuals or communities". Outcome measures and indicators such as eating behaviour must therefore be designed and used carefully. Outcome indicators cannot stand alone and need to be linked to process indicators, including participation.

But what are suitable indicators? Sound theoretical knowledge of the working of the school system at the level where the project or programme is located is needed. Evidence from other similar projects (country reports on the effectiveness of health-promoting schools) may help to develop indicators. Observation or interview techniques can be used to measure indicators. Numerous instruments are available, and the case studies in Chapter 6 illustrate many of these.

What kind of indicators are needed?

From the management viewpoint, different kinds of indicators are needed depending on the phase of the project or programme. Planning of a project requires having the right people and a working environment that fits the task the people have to do, so these comprise important indicators at this stage. In the phase of the intervention itself, data are needed on the quality of the process (process indicators). The management process can distinguish between short-term results (such as increased awareness), intermediate results (such as teachers' competencies) and long-term results (such as students' empowerment and action competence as well as their practice and behaviour). Indicators are needed for all these different results.

Examining the intervention phase and thinking about which kind of interventions could be started to influence young people's health and empowerment effectively in schools shows how many different indicators are needed to represent a full picture of health-promoting schools. Box 4.2 provides some selected examples illustrating areas where indicators can be developed.

Box 4.2. What schools can do for health of students

- Provide opportunities for students to make meaningful contributions to the school and community life
- Provide an integrated health education programme
- Achieve more participatory approaches in teaching and learning
- Reinforce personal and social responsibility through the school organization
- Raise awareness of economic exploitation
- Provide an anchor for students in difficulty
- Adopt organizational practices that complement the teaching programme
- Offer a supportive social environment
- Foster links with health in the community
- Create a safe and secure physical environment

Source: adapted from Barnekow Rasmussen & Rivett (2005).

If a project or programme has specific targets, such as promoting cooperation with other social organizations to develop social capital in the region, then special indicators are needed. Sometimes they are not easy to find or to create. Box 4.3 lists possible characteristics related to social capital that can be used as a starting-point for developing indicators of social capital in health-promoting school projects.

Box 4.3. A range of possible indicators of social capital

- Number of social relationships and degree of social support
- Number and quality of formal and informal social networks
- Number of members of groups
- Degree of community and civic engagement (such as proportion of people voting)
- Existence of norms and values (such as the percentage shared)
- Existence of reciprocal activities (such as child-care arrangements)
- Levels of trust in other people

Source: adapted from Morgan (2002).

When a project is being initiated and is expected to go through a number of phases a stage model (Table 4.5) might be useful. The model considers six stages: identity, information, credibility, relevance, feasibility and policy (Piette et al., 2002). Policy encompasses both the decision to draft a policy and the adoption of the policy.

Tabel 4.5. Stages and indicators of the process towards a sustainable policy

Stages	People concerned	Examples of indicators
1. Identity	Those who know the project well (all of them): teachers, person responsible for national or regional health education or promotion and school inspectors	Saying and explaining what works and why Reporting on the satisfaction of those involved, etc.
2. Information	Key decision-makers and politicians: all of them	Key people provide a piece of information mentioning activities and responding positively to them
3. Credibility	The key people who really have power, and in any case, someone with the highest rank in the education sector (from the government or a director of education) The process of selecting key people works as those people were interviewed in countries when stage 2 was reached	Key people express interest and a desire to know more
4. Relevance	The key people who really have power, and in any case, someone with the highest rank in the education sector (from the government or a director of education) The process of selecting key people works as those people were interviewed in countries when stage 2 was reached	People say why they are interested in school health promotion in relation to the education policy or solving problems encountered in the education sector They should express the wish to see, for this reason, the project extended to all schools
5. Feasibility	The key people who really have power, and in any case, someone with the highest rank in the education sector (from the government or a director of education) The process of selecting key people works as those people were interviewed in countries when stage 2 was reached	The different opportunities to extend the network are discussed and at least one possibility is proposed as feasible; this is a planning stage
6. Policy	No specific people are concerned here	There is a policy already accepted but not necessarily implemented

Source: adapted from Piette et al. (2002).

What is the role of indicators in the process of evaluation?

Indicators should play a crucial role in evaluation and therefore in the quality management of a project, programme or initiative in school health promotion. The reasons to carry out evaluation are manifold and need not be explained here in detail. Box 4.4 lists the main arguments.

Box 4.4. Reasons for evaluating health-promoting schools

Evaluation can:

- ascertain the current situation – preliminary evaluation will serve a benchmarking function;
- address the question "does it work?" and provide answers about the effectiveness and cost-effectiveness of an intervention or set of interventions;
- through reflection on what is done, and how and why it is done, lead to clarifying goals as well as questions of effectiveness and efficiency, added value and the performance indicators that should apply;
- function to maximize information about the quality and impact of the provision made, the form it takes and the way it is organized and thereby to maximize its contribution to evidence-based or evidence-informed practices and improve provision;
- be developmental in a formative role;
- motivate school staff and other health professionals and stakeholders and encourage teamwork;
- motivate students and others asked to provide information, who might feel valued by the special attention;
- enhance relationships between young people and adults;
- improve communication and commitment to the school through the process itself where parents, visiting performance groups, health professionals, members of the community, etc., are part of the evaluation;
- meet accountability demands from parents, the community, funders and inspectors; and
- be politically expedient at a time when teachers and other professionals are under pressure to provide evidence of being effective and adaptable.

Source: adapted from Stears & Parsons (2002).

During the evaluation process, indicators come into play at a certain point

Box 4.5. Ten steps for planning and evaluating a health-promoting schools project

1. Determine the reasons for evaluation
2. Specify the objectives of the action
3. Describe the action
4. Compare the objectives with the action
5. Determine which evaluation data are needed
6. Select an evaluation design
7. Collect data
8. Analyse the data
9. Write down the conclusions in an evaluation report
10. Use the conclusions as a basis for decisions

Source: van den Broucke (2002).

Step 5 points out the need to think about which kind of indicators are needed in the specific project or programme. Indicators differ depending on the level of the project (Box 4.6).

Box 4.6. Three levels of evaluation of health-promoting schools – three levels of indicators

International
- The success of ENHPS as an international network

National and regional
- The success of national health-promoting schools pilot projects
- The implementation of health-promoting schools
- The introduction of health-promoting schools in national and regional education policy

Local, school, class or individual
- The quality of health-promoting schools projects within schools
- The effects of projects on students' behaviour or health
- The effects of projects on the school environment, other schools and the local community

Source: van den Broucke (2002).

Step 5 in the evaluation path (Box 4.5) will differ depending on the type of evaluation research that is planned. As Stears & Parsons (2002) have said, it makes a difference whether the focus is on empirical quantitative research approaches or on interpretative qualitative studies examining processes and contexts. Box 4.7 presents an ordered framework and a hierarchy often used within the medical sciences. Levels 1–4 represent the experimental method. Levels 5–8 are more interpretative and qualitative in nature. Levels 9–10 are more exploratory approaches. The first categories of the hierarchy, which are often used within the medical research paradigm, are of limited value for health promotion let alone the health-promoting school.

Box 4.7. Hierarchy of evidence

1. Properly designed randomized controlled trials
2. Well-designed controlled trials without randomization
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 interviews, semistructured interviews and questionnaires; action research
8. Observation of practice and case studies
9. Life histories
10. "Fictional" accounts composed from scattered and relatively unsystematized information

Source: adapted from Stears & Parsons (2002).

Following Stears & Parsons (2002), Table 4.6 sets out an alternative scheme of health-promoting goals and processes. For the health-promoting school approach, the medical and disease-preventive goals and processes are not the appropriate ones. Preferable are those concerned with: empowering people and communities and radical change.

Table 4.6. Health-promoting goals and processes

Goals		Processes
1. Health-related behaviour change Better measurable health	Medical Disease-preventive	Inoculation Health topics on the formal curriculum
2. Locus of control - self-esteem - action competence	Individually empowering	A contextual curriculum stressing respect and positive regard
3. Promote active democracy - involve whole school - community	Communally empowering	School councils, students and others involved in decision-making, bringing parents and community in and reaching out into the community
4. Inclusive - addressing disadvantage - addressing inequality	Radically challenging	Principle-driven social action agenda

Source: adapted from Stears & Parsons (2002).

The goals and processes in Table 4.6 correspond with each other. Evaluators who see school health promotion as a broad and system-wide set of interventions will have an affinity with the methods further down the hierarchy in Box 4.7 and Table 4.6.

An evaluation panorama is helpful in putting in perspective the focus of an evaluation and the techniques used (Table 4.7). It responds to the complex reality of health-promoting schools. To give a full picture, different types of indicators are added to that panorama.

Tabel 4.7. The evaluation and indicator panorama – from specification to product

Intrinsic and value analysis	International, national, regional and local context	Institution al context	Processes	Product
Is the project based on the best research Is it informed by and the social good? Is it feasible with available resources?	Influence of inter- national vidence? organizations; national policies and priorities; funding at the national and local levels; and local efforts and initiatives	Policy and mission; roles; physical environment; and resources	Interactions; experiences; relationships; and school and community input	Knowledge; attitudes; values; competences; dispositions; and behaviour
Indicators of the quality of the structure, planning and concept			Indicators of process	Indicators of output: short-term and/or long-term outcome

Source: adapted from Stears & Parsons (2002).

Indicators of school health in the context of the educational quality of the school

So far indicators have been presented and discussed in the framework of health-promoting schools. In that concept, indicators are often conceptualized in relation to the process and outcome of health promotion and health education at the school. Nevertheless, the health-promoting school also has to address more general educational outcomes of the school: good teaching and learning culture and results, adequate leadership and management, good classroom and school climate and satisfaction with school. Indicators for health-promoting schools

therefore need to be conceptualized to relate to the overall aims of the school itself. Educational indicators could also be indicators for good learning results in health education and health promotion in a relationship with synergy (Paulus, 2005). The case studies from Germany and Switzerland provide an example of how to work with this.

Conclusion

Indicators are crucial in the process of assuring the quality of health-promoting schools. Suitable indicators are not easy to find in the existing literature and are also not easy to construct. They have to be tested to show that they are specific, measurable, achievable, realistic and timely and have suitable characteristics. Because indicators should indicate something relevant to health-promoting schools, sound knowledge of the working of this system and of health promotion in general is needed. Not only health-related knowledge is important but also knowledge of the educational system and of the quality assurance systems with educational indicators, criteria and standards. School health promotion has a lot to offer and can add value to educational quality frames of reference. But school health promotion can also learn from the educational sector about how to construct indicators that work well in the educational setting and how to define and link criteria and standards to the educational discussion on the good and effective school.

5. International agencies – the relevance of indicators

Introduction

The focus of this chapter is on how indicators that are being set for schools and education services by international agencies such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) can be integrated into health-promoting school approaches, how schools adopting health-promoting schools concepts and principles can enhance the intended outcomes of these indicators and how the indicators might be measured. The chapter is aimed at the agencies and non-governmental organizations that are considering planning and implementing activities on school health issues, and HIV is used as a main example. All countries in the WHO European Region were among the 189 countries adopting the Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session on HIV/AIDS in June 2001. The goals and targets of the Special Session included setting up comprehensive programmes to tackle prevention of HIV transmission, and young people, schools and their communities were included as places where these programmes might be implemented. Many countries in the WHO European Region are working closely with United Nations agencies and nongovernmental organizations to implement monitor and evaluate their efforts in addressing the United Nations goals and targets. This chapter has been included to support the countries in particular and organizations and agencies that are including schools in their programmes of response to the HIV and AIDS epidemic.

The chapter explores the notion of schools as settings for health promotion, the development of school health programmes as part of a health-promoting school process and how to integrate the HIV/AIDS indicators drawn up by UNAIDS based on the goals of the United Nations General Assembly Special Session on HIV/AIDS into such programmes.

Much of what is outlined in this chapter on the concepts and principles of health-promoting schools, monitoring and evaluation and the definitions for indicators is described in more detail in Chapters 2, 3 and 4.

School health programmes are viewed as important components of international and national responses to preventing ill health and promoting the health of young people. This is especially the case when they are part of national HIV prevention strategies. Schools may be seen as institutions in which health programmes can be easily placed or even a convenient venue or setting in which to place them. This assumption is understandable. Most young people are in school in most countries, so any education delivered through schools is likely to reach the target audience. The learning environment is conducive to the delivery of knowledge and skill development. Health can be taught as a topic within science

subjects such as biology and as part of the physical education curriculum. However, much research evidence, as described in Chapter 2, suggests that designing effective school health programmes is a complex process and needs to be well planned and understood and seen as an integral part of a whole-school plan.

This chapter offers support and guidance to international and national agencies and nongovernmental organizations wishing to introduce school health programmes into their country programming and that aim to contribute to addressing the various targets and indicators of, for example, the Millennium Development Goals and the United Nations General Assembly Special Session on HIV/AIDS. It is hoped that better understanding can be provided of how health promotion in schools can enhance the effectiveness of their programmes, through monitoring and evaluating the integration and use of national and international indicators and other effectiveness measures within a school context.

Approaches to health promotion in schools

As referred to in Chapter 3, the outcome of the first International Conference on Health Promotion in Ottawa was the Ottawa Charter for Health Promotion (WHO, 1986), which laid down the broad parameters for health promotion, by providing the definition, the theoretical basis and mechanisms through which health promotion might be introduced and sustained. The Charter described the settings approach and identified schools as one of the settings within which health promotion might be introduced and integrated through school structures and practices. The process was described as holistic and comprehensive, moving the notion of health and its promotion away from stand-alone, vertical and reductionist approaches (separate health topics delivered through one curricular area and by a single teacher and/or health professional) to a more integrated process involving the whole school. Health promotion in schools requires viewing the formal structures and other informal processes within the school as opportunities for promoting health. This would include identifying aspects of the school such as the curriculum, not just health education alone but also other subject areas, classroom teaching and learning styles, school management and organization, the school social and physical environment and the school in its wider community of parents and community groups. All these aspects of schools are entry points for promoting health. In schools wishing to introduce health promotion approaches, everybody in the school is seen as an actor who can contribute to the process. Earlier chapters describe this in more detail. Chapter 3 describes the concepts and principles of health-promoting schools in more detail.

Schools as settings for health promotion

Since the Ottawa Charter for Health Promotion was adopted, much work has

been done to build on the conceptual understandings and processes of effective health promotion and to identify the most effective practices that contribute to improving health by promoting health in the school setting. Chapter 2 outlined some of the theories and practices. Understanding now emerging from research into health promotion in the school setting is showing that schools can develop effective health promotion programmes when they are delivered comprehensively (Stewart-Brown, 2006). However, building comprehensive programmes, involving all partners within the school, also poses quite a challenge in their planning, implementation, monitoring and evaluation. In developing school health promotion programmes, new ideas and thinking are needed on not only the processes of teaching and learning but also on school structures and organization. Other programmes such as thinking on effective schools or the child-friendly schools initiative of the United Nations Children's Fund (UNICEF) (Box 5.1) may already be addressing these issues, but one of the main differences in the concept of health-promoting schools is that changes in how health is perceived need to be included. Health promotion challenges people to see health as a resource for living and poses that the responsibilities for health development do not lie within the health care sector alone but within many other social sectors, both statutory and non-statutory, and include the responsibilities of the individual.

Box 5.1. Child-friendly schools

Child-friendly schools strive for quality in the following five areas.
Quality learners: healthy, well-nourished, ready to learn, and supported by their family and community
Quality content: curricula and materials for literacy, numeracy, knowledge, attitudes, and skills for life
Quality teaching-learning processes: child-centred; (life) skills-based approaches, technology
Quality learning environments: policies and practices, facilities (classrooms, water, sanitation), services (safety, physical and psychosocial health)
Quality outcomes: knowledge, attitudes and skills; suitable assessment at the classroom and national levels

Source: http://www.unicef.org/lifeskills/index_7260.html.

The WHO definition of health goes further than defining health in terms of ill health and the treatment of disease. Health is further defined as having social and emotional dimensions through which disease can be prevented and health sustained. Health is therefore a holistic and integrated state of physical, social

and emotional well-being. Contributory factors or determinants of health are increasingly being recognized as elements to address when defining and identifying how health is promoted and sustained. In this sense, people often encounter common health issues and decisions away from doctor's clinics and other health facilities. Decisions of a seemingly everyday nature are now being perceived within a health context, especially in relation to children and young people. Some decisions have far-reaching health effects.

- What should I pack in my child's school lunch box?
- Where is the safest place to cross the road to get to school?
- How should I respond when my friend offers me a cigarette?
- When my boyfriend and I have sex, how do I make sure he uses a condom?
- How do I as a teacher talk to my students about drugs when I have not been trained and I am not sure of my legal position?

Looking at health in these contexts shows that health is not the responsibility of schools alone but a shared responsibility, involving planners and decision-makers, communities and groups as well as individuals. The school cannot be responsible for providing solutions to all the health issues students encounter, but schools can play a part in building students' ability to make informed decisions about their health and acting on them.

When looking for entry points to introduce health promotion, a school could use one or all of the questions above as a means to building a process that could effectively assist an individual or a group in making informed decisions about their actions. A school adopting a health-promoting school approach builds not only knowledge but also understanding, skills, competencies, attitudes and values that students can learn and put to use in their daily lives. In this way, the whole environment of a school setting can be used for building health.

Finally, health promotion in schools should not be seen as an additional and burdensome responsibility for the school to take on. Many of the processes embodied within a health-promoting school approach have been successfully introduced as dimensions for developing the educational process in schools. These include transferable learning in such diverse areas as communication skills, decision-making and critical thinking. Health-promoting schools and effective schools also share an interest in creating a safe but stimulating learning environment in which all students feel valued, using interactive teaching and learning techniques, participatory learning methods and setting high expectations for the students.

Developing school health programmes as part of a health-promoting schools approach

Are schools suitable institutions for developing health programmes? The central task of schools is to develop and educate students, and each school is a unique institution and community, building its education programmes around the priorities and needs of its students in a planned and developmental way. Most countries have a national curriculum with prescribed curricula and subjects. Any additional subjects or ways of working that are offered or recommended need to be planned into the structure of the school's work plan and delivered in the way that most suits the school. There is considerable diversity across countries; some national curricula have health education as a compulsory subject or theme, others contain compulsory as well as optional elements and others are completely optional.

Health topics can be sensitive. Drugs, tobacco or nutrition topics can contain elements that conflict with student's lives outside school, so they have to be introduced in a sensitive and collaborative way, with the involvement of parents and other groups in the community. When addressing sex and relationships and HIV education, involving parents and key community groups, such as religious groups, is very important. Their participation and involvement in the very early stages of planning can help in successfully developing these very important programmes.

Evidence is now emerging of the role the school environment can play in reinforcing and supporting students' learning and development, especially concerning adolescent sexual behaviour, pregnancy and sexual transmitted diseases, including HIV infection.

The creation of a safe and supportive school environment is now being recognized as a protective factor in student's lives. All the elements of the school environment that contribute to these have not been completely identified but are likely to be connected with a supportive social school environment, participation of students in the life of the school, good relationships between staff and between staff and students, participatory management and mixed, student-centred teaching and learning styles. Many of these factors can be found within the 10 principles of health-promoting schools established at the First Conference of the ENHPS (1997a, b) held in 1997 (Chapter 3).

Teachers and schools often feel unprepared for developing and introducing health topics of a sensitive nature. Without proper preparation, many teachers can feel that they do not have the competencies to deliver programmes on issues

such as sexual health and relationships or HIV education. Training and development for teachers and others involved in programmes, such as school physicians, needs to be offered for programmes to be effective and sustainable. Teachers trained in new approaches and methods need to be supported by school policies and structures, so it is important that, on returning to the school following a training course, teachers are able to practise their new skills and understanding and reflect on how their work fits into the school strategies and how their new learning will be disseminated and adopted.

An underpinning factor that contributes to developing health-promoting school approaches that are effective and comprehensive is the strong support provided by policy-makers and decision-makers within national and regional structures. Schools and those that work with them, such as health and welfare services, find that, when they introduce health issues into their work, the existence of policies and strategies that include health education and health promotion contribute considerably to developing sustainable programmes.

Integrating international indicators with health-promoting schools approaches

Chapter 4 describes how health promotion in schools can be monitored and evaluated and defines indicators for monitoring health programmes. Information on the current methods and thinking in evaluating health-promoting schools is offered. Chapter 6 includes case studies from schools and national health-promoting schools programmes in several European countries, some of which describe how indicators have been developed to assist in measuring the progress of health-promoting schools initiatives.

United Nations agencies have also been working to identify how progress at the national and local levels might be assessed in various areas, many of which are health-related and concern the health of young people and schools. Millennium Development Goals 5 and 6 relate specifically to young people (Box 5.2).

It might be helpful then to look at some of the indicators set by international agencies related to schools and young people and discuss how they could be integrated into the planning and implementation of school health programmes and contribute to developing health-promoting schools approaches.

The Declaration of Commitment on HIV/AIDS established a number of goals for achieving specific quantified and time-bound targets, including reducing HIV infection among infants, young people and adults and improving HIV/AIDS education, health care and treatment. Box 5.3 lists the goals for young people, some of which are consistent with the Millennium Development Goals.

Box 5.2. Millennium Development Goals 5 and 6 and indicators for these

Goal 5 **Improve maternal health**
Goal 6 **Combat HIV/AIDS, malaria and other diseases**

Each goal comes with a number of targets and indicators.
Goal 5, target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

- **Indicators**
- 16. Maternal mortality ratio
- 17. Proportion of births attended by skilled health personnel

Goal 6, target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

- **Indicators**
- 18. HIV prevalence among pregnant women aged 15–24 years
- 19. Condom use rate of the contraceptive prevalence ratea
- 19a. Condom use at last high-risk sex
- 19b. Percentage of 15- to 24-year-olds with comprehensive correct knowledge of HIV/AIDS
- 19c. Contraceptive prevalence rate
- 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10–14 years

[a]Among contraceptive methods, only condoms are effective in preventing HIV transmission. Since the condom use rate is only measured among women in union, it is supplemented by an indicator on condom use in high-risk situations (indicator 19a) and an indicator on HIV/AIDS knowledge (indicator 19b). Indicator 19c (contraceptive prevalence rate) is also useful in tracking progress in other health, gender and poverty goals.

Source:
http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm.

Box 5.3. Goals in the Declaration of Commitment on HIV/AIDS related to children and young people

53. By 2005, ensure that at least 90 per cent, and by 2010 at least 95 per cent, of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers.

63. By 2003, develop and/or strengthen strategies, policies and programmes, which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by: ensuring access of both girls and boys to primary and secondary education, including on HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good quality youth-friendly information and sexual health education and counselling service; strengthening reproductive and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible.

47. By 2003, establish time-bound national targets to achieve the internationally agreed global prevention goal to reduce by 2005 HIV prevalence among young men and women aged 15 to 24 in the most affected countries by 25 per cent and by 25 per cent globally by 2010, and to intensify efforts to achieve these targets as well as to challenge gender stereotypes and attitudes, and gender inequalities in relation to HIV/AIDS, encouraging the active involvement of men and boys.

Source: http://www.unaids.org/en/Goals/UNGASS/default.asp.

The Declaration of Commitment on HIV/AIDS also included a pledge from the United Nations General Assembly that it would devote at least one full day each year to reviewing the progress achieved in realizing the goals. To facilitate this ongoing review process, UNAIDS (2002) and its partners have developed a set of core indicators that facilitate the monitoring of measurable aspects of the various international and national actions, national programme outcomes and national impact objectives envisaged in the Declaration of Commitment on HIV/AIDS.

UNAIDS indicators

Engagement by school
The first indicator is set at the national level and seeks to measure: "the percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year".
The purpose of this indicator is: "to assess progress in implementing life-skills-based HIV/AIDS education in schools to combat HIV/AIDS".
This indicator comes with one addition that specifically addresses life skills-based provision: "percentage of primary and secondary schools where life-skills-based HIV/AIDS education is taught."

UNAIDS (2002) interprets these indicators.
It is important that life-skills-based HIV/AIDS education be initiated in the early grades of primary school and then continued throughout schooling, with content and methods being adapted to the age and experience of the students. Where schools provide both primary and secondary education, at least one teacher should have been trained to teach life-skills-based HIV/AIDS education at each of these levels.

The indicator provides useful information on trends in the coverage of life-skills-based HIV/AIDS education within schools. However, the substantial variations in the levels of school enrolment that exist within and between countries must be taken into account when interpreting (or making cross-country comparisons of) this indicator. Complementary strategies that address the needs of out-of-school youth will be particularly important in countries where school enrolment rates are low.

The indicator is a measure of coverage. The quality of education provided may also differ between countries and over time.
As indicators are defined here, these indicators are outcome indicators and do not measure impact.

Life skills-based education is an integral component of a health-promoting school. Life skills-based education is an integrated educational process in which students develop the three components of life skills: knowledge, skills and attitudes. The processes of life skills-based education are now understood in greater detail, meaning that the process is encouraged to be taught through various subjects rather than through the process of teaching and learning the life skills-based education components isolated from a context. The life skills-based education guidance document Skills for health (WHO, 2003) is useful in better

understanding life skills–based education and the design of life skills–based health education programmes. Through its participatory and active learning processes, life skills–based education can contribute considerably to developing health-promoting school planning and implementation. Life skills–based education contains teaching and learning methods that are relevant to building a safe and supportive learning environment and to creating a school environment that supports participation and the building of good social relationships between staff members and students. Life skills–based education can positively affect the building of understanding and attitudes that are essential to include in an educational programme that addresses sensitive areas often encountered in HIV education. Measuring the implementation of life skills–based education in schools at the national and local levels is important to understand how HIV education is being addressed. However, when organizations decide to include life skills–based education in their country support programmes in reaching the United Nations goals and targets, further work might need to be done to ensure that not only is life skills–based education being delivered but that it is also being delivered most effectively. Schools that are building health-promoting school approaches have a better opportunity to ensure effective life skills–based education. They ensure this by establishing a whole-school environment within which a life skills-based educational process is accepted as a legitimate educational process that fits within the ethos of the school.

As set out above, the UNAIDS indicator for life skills-based education is outcome-oriented, solely determining the extent to which life skills-based education is being practised and delivered. This may be useful at certain levels, but measuring this indicator will not provide information on the effectiveness of life skills-based education. It is therefore strongly recommended that process indicators be used to accompany the outcome indicators. Process indicators will be more qualitative in nature and examine the structure and the delivery of a life skills-based education programme and expected learning outcomes. Indicators of life skills-based education processes will also be set to measure the development of competencies of teachers and students and the development of attitudes, values and skills used in decision-making.

Young people's knowledge

The next UNAIDS indicators focus on the ability of young people to identify ways of preventing the sexual transmission of HIV and understanding common misconceptions about HIV transmission: "The percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission".

The purpose of this indicator is: "to assess progress in achieving universal knowledge of the essential facts about HIV transmission".

As an outcome indicator, this is seeking to assess the level of knowledge of people 15–24 years old; in most countries in Europe many are still be in schools or other forms of formal education. This indicator also focuses on sensitive issues related to HIV many schools might have difficulty in addressing.

Information alone is not enough to have change people's decisions on behaviour. Although this indicator relies on the ability of young people to repeat facts, its underlying intention is that not only will young people know and understand the main routes of sexual transmission of HIV but that they will act upon that knowledge and take measures to protect themselves. For young people to both know and act upon knowledge, especially in relation to personal behaviour, they need to be able to develop their knowledge, skills and attitudes in relation to the issue, so this indicator is closely linked to the previously discussed indicator on life skills-based education.

The indicator also addresses the need to discuss and understand the various misconceptions concerning HIV transmission. This concerns understanding not only that a person who looks healthy can also be living with HIV but also that people living with HIV can be stigmatized and discriminated against.

The health-promoting schools approach offers one of the best opportunities for successful implementation of the processes of developing knowledge, attitudes and skills in the sensitive way necessary when addressing the topics of HIV, sexual health and related preventive measures. This creation of a safe and supportive educational and school social environment for successful programmes relies upon good planning and the involvement and participation of many stakeholders both in the school and the local community. In a health-promoting schools process, the integration of health and education programmes addressing this indicator accompanies a planning process inviting students, parents, teachers and key community leaders and organizations to participate. Data on the HIV and AIDS situation might be sought from the local health authorities, and additional information concerning the sexual and reproductive health of young people would be included. Studies to identify young peoples' attitudes towards school, friends and other social issues might also be gathered. Data from studies such as the Health Behaviour in School-aged Children study might also be used. These data might be used to assess the needs of young people in the area and assist in planning and preparing school health programmes. If all the key stakeholders can be involved in these processes, the needs of young people will be

identified, making it much more likely that appropriate and successful action is taken.

Condom use among young people

The final UNAIDS indicator most relevant to schools concerns young people's use of condoms. The indicator seeks to measure the "percentage of young people aged 15–24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner".

The stated purpose of this indicator is: "to assess progress in preventing early-age exposure to HIV through unprotected sex with non-regular partners".

UNAIDS (2002) identifies some measurement methods for this indicator by suggesting sets of questions that might be used to gather data:

1. In the last 12 months, have you had sexual intercourse with a non-regular partner who was neither your spouse nor someone you were living with?

2. If the answer to question 1 is "yes": how many non-regular partners have you had sex with in the last 12 months?

3. If the answer to question 1 is "yes": did you (or your partner) use a condom the last time you had sex with your most recent non-regular partner?

UNAIDS (2002) also further interprets the indicators.

This indicator shows the extent to which condoms are used by young people who engage in non-regular sexual relationships. However, the broader significance of any given indicator score will depend upon the extent to which young people engage in such relationships. Thus, levels and trends should be interpreted carefully using the data obtained on percentages of young people who have started having sex and (of these) that have engaged in a non-regular partnership within the last year.

The maximum protective effect of condoms in non-regular sexual intercourse is achieved when their use is consistent rather than occasional. The current indicator will provide an overestimate of the level of consistent condom use. However, the alternative method of asking whether condoms were always/sometimes/never used in sexual encounters with non-regular partners in a specified period is subject to recall bias. Furthermore, the trend in condom use in the most recent sexual act with a non-regular partner will generally reflect the trend in consistent condom use with such partners.

Condom use is just one measure of protection against HIV/AIDS. Delaying first sex, reducing the number of non-regular sexual partners, and remaining faithful to one's non-infected partners are equally important. Thus, countries are strongly advised to report on the suggested additional indicators on median age at first sex and higher-risk sex in the last year, using data from the same survey instrument as the one proposed for calculating the core indicator.

Similar to the previous indicator, great care needs to be taken to involve all stakeholders if the information on the use of condoms is to be collected within a school context. UNAIDS suggests that the measurement tool for these data be population based, and it may be that schools could be included in this approach. Since the age of first sexual intercourse seems to be declining in the WHO European Region and this is accompanied by a rise in sexual transmitted infections, knowing whether young people are actively taking steps to protect themselves from HIV transmission and other sexually transmitted infections is very important.

Similar to knowing how to protect oneself from HIV infection, the programmes to educate and inform young people on the need for condom use and how to use them properly need to begin well before the age of 15 years to be successful. Similar to the previous indicator, the approaches adopted by health-promoting schools provide one of the best ways for successfully planning and integrating this issue into school health programmes. Such organizations as UNICEF and the United Nations Population Fund have developed ideas and guidance on such programmes.

The WHO (2006) publication *Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries* provides further information on successful methods in and approaches to preventing HIV transmission. This publication systematically reviews research into prevention programmes in different parts of the world. It concludes that schools are a key setting for successful HIV prevention programmes.

The United Nations Office on Drugs and Crime (2004) has also prepared a range of programmes on drug prevention for schools. This provides comprehensive information on programme planning and implementation as well as sections on monitoring and evaluation. The approaches of the programmes are based on a broad set of values similar to health-promoting school concepts and values and thus will augment many of the goals and targets enshrined within the United Nations General Assembly Special Session on HIV/AIDS and Millennium Development Goals for supporting the health and development of children and young people.

Conclusion

This chapter has briefly described the concepts and principles behind health-promoting schools and how the health-promoting schools approach can enhance the implementation of programmes developed to address some of the United Nations goals and targets set by the Millennium Development Goals and the United Nations Special Session on HIV/AIDS. Chapters 2 and 3 provide further insight and greater detail on the concepts and principles of health-promoting schools.

The United Nations indicators are helpful in identifying progress in establishing sustainable HIV and related health programmes in schools and communities, but it is hoped that greater understanding has been provided on how these indicators can be augmented by integrating them into a school process called the health-promoting school. The United Nations indicators set broad parameters for programmes but will not necessarily change or affect young people's behaviour on their own. To accompany the broad indicators, sets of process indicators need to be identified that will measure the qualitative nature of the programmes needed to address the outcome indicators. The health-promoting schools approach is one of the best processes schools can adopt to integrate programmes within which both process and outcome indicators can be set to measure progress. This chapter is introductory in nature, provided to raise the awareness of organizations to the links between the United Nations goals and indicators and the processes in schools that can be introduced to create opportunities for realizing the goals and indicators.

It is hoped that this will raise understanding and interest in health-promoting schools and that organizations embarking on programme planning with the intention of addressing the United Nations goals can use the information in this chapter and the rest of this resource to enrich programming and planning in the pursuit of improving the health of adolescents and young people.

6. Developing indicators – examples of good practice across Europe

Introduction

This chapter presents 20 case studies that were written as an outcome of a series of ENHPS workshops during 2005 and 2006 organized by a task force on the evaluation of and the development of indicators for health-promoting schools.

Researchers from each country participating in these workshops were asked to undertake work over a five-month period related to the development of indicators for health-promoting schools. The work had to be relevant to the needs and priorities of their country in relation to indicator development and would ideally contribute to the development of health-promoting schools.

It was recommended to select a level of indicators for the research (classroom, school, local or regional and national) and to develop a working plan. The researcher was encouraged to involve the ENHPS national coordinator from the beginning. The working plans were discussed and agreed upon with the task force responsible for the workshops. The task force offered support during the research.

At a workshop in November 2005, all participants agreed with this procedure, and the results were presented in a workshop in June 2006. In total, 20 case studies were carried out within this time frame.

Tables 6.1–6.4 summarize the case studies on health-promoting schools indicators. For ease of understanding the concerns of different reports, they have been divided into four groups:

A. overviews of indicator development at the national level;
B. development of indicators for regional strategies and support structures;
C. using indicators at the school and classroom level; and
D. involving teachers and students in developing indicators.

We also indicate the country, authors, aims of the research, level of indicators and methods.

The last section reflects on the material contained in these reports.

Health-promoting schools – summary of case studies of good practice

Tables 6.1–6.4 summarize the case studies.

A. Overviews of indicator development at the national level

Table 6.1.

Country and author(s)	Aims of the case study	Level of indicators	Process
Croatia Ivana Pavic Simetin, Marina Kuzman, Iva Pejnovic Franelic & Nina Perkovic	Presents an overview of the current situation on health promotion in schools at the national level, focusing on: • the level of collaboration in the area of health promotion between the Ministry of Health and Social Welfare and the Ministry of Science, Education and Sport; and • assessment of in-service training for school doctors and nurses	National level – national policy and collaboration; participation of health professionals in nationally provided training in the promotion of health among young people	Collecting national documents; reviewing the documents; finding statements on indicators; linking with health-promoting schools principles and approach: analysis undertaken by authors A questionnaire to gather data on the participation of school doctors and nurses in nationally provided training courses: questionnaire data gathered from 104 school doctors
Estonia, Latvia and Lithuania Kadi Lepp, Anita Villerusa & Aldona Jociute	Describes the frameworks of indicators already in place in Estonia, Latvia and Lithuania The aim of the specific project described was the development of an instrument for school self-evaluation of the health-promoting schools concept, to be used in common in Estonia, Latvia and Lithuania	School level – indicators for the dissemination of the health-promoting schools concept at the school level	Numerous methods for gathering data: participatory action research (involving health-promoting schools coordinators and representatives from the educational sector), theory-based research (using the resolution from the First Conference of the ENHPS (1997a, b) and the Egmond Agenda (International Planning Committee, 2002)), formative research (organizing the initial phase and pretesting phase) and analysis of documents and experiences available in each country

Country and author(s)	Aims of the case study	Level of indicators	Process
Germany Britta Michaelsen--Gärtne	Outlines a national project to integrate health indicators into the framework of indicators for school quality and to combine health indicators and educational indicators. Particular focus on mental health, exercise and nutrition	School level – a comprehensive set of indicators organized in a dimensional framework of school quality	Questionnaires on school quality reflecting the dimensional framework have been designed for completion by teachers, students and parents
Greece Electra Bada & Katerina Sokou	Provides an overview of the work undertaken in Greece to develop a national framework of indicators related to the international, national, regional, school and class levels	International, national, regional, school and class-level indicators	A wide variety of methods have been used in the process of developing a national framework of indicators
Iceland Jórlaug Heimisdóttir	Presents the Iceland strategy map for health-promoting schools that contains indicators for the factors that are considered to be critical to success in increasing the under-standing and adoption of healthy lifestyles bychildren and their families The aim of the study reported is to measure the effectiveness of educational materials developed to enhance children's decision-making skills, self-esteem, goal-setting, stress management and effective communication	School level – a national framework of indicators	The specific project described is a development (action) project that will be evaluated, rather than a research project. Several methods will be used to evaluate whether the project is successful Use of the Health Behaviour in School-aged Children questionnaire is planned

Country and author(s)	Aims of the case study	Level of indicators	Process
Poland Barbara Woynarowska & Maria Sokolowska	Presents an overview of a national project. The aims were: • to build a new framework for the development and evaluation of the health-promoting schools model and to establish national standards for health-promoting schools; • to establish sets of dimensions and indicators relevant to each standard and to develop tools for their measurement; and • to carry out a pilot study in selected schools in order to test the usefulness of these dimensions, indicators and tools.	School level – a comprehensive system of indicators for self-assessment of five national standards for health-promoting schools in Poland An example is given of the tool used to assess indicators related to the first national standard: the health-promoting school helps the members of a school community to understand and to accept the concept of health-promoting schools	Questionnaires for school self-assessment have been developed. Examples are given of the structure and content of the questionnaire with respect to the first national standard
Portugal Gregória Paixão von Amann	Describes a national strategy on implementing the principles and dimensions of a health-promoting school and evaluating this implementation and its impact on the educational system, health system and the community	Presents ten key indicators for the health-promoting school For example: Percentage of schools with a management structure and policy on health promotion (organizational dimension – project team, management, policy, budget, students', parents' and teachers' involvement)	Describes work involving: Analysis of legislation and supporting documents Questionnaire survey on evaluating health promotion in the school setting

Country and author(s)	Aims of the case study	Level of indicators	Process
Scotland Anne Lee & Ian Young	This report traces the development of quality indicators for health-promoting schools in Scotland over the past decade	A system of indicators of school quality has been developed in Scotland. Of the 33 performance indicators specified, 10 have been identified as relevant to health promotion in schools	The report describes how indicators for the health-promoting school have become embedded within government policy and practice in the education sector
Slovenia Vesna Pucelj	Describes national-level work: Exploring the possibilities for including health promotion in the school environment Determining the effectiveness of the project in specific schools of the Slovenian Network of Health Promoting Schools	National, school and individual-level indicators – related to implementation, understanding and effectiveness	Work in developing indicators and assessing the effectiveness of health-promoting schools in Slovenia is in process Project has involved organizing of meetings, consultations, workshops and questionnaire-based surveys
Spain Pilar Flores Martínez, Alejandro García Cuadra, Nuria Benito López, Santiago Hernández Abad, Ainara Paniagua García & Laura Gallego Hernández	A national programme to strengthen health promotion in schools is in process. The aims of the programme currently are: • to analyse the situation of health promotion in schools, focusing on: the commitment and collaboration between health and education; health education in the curriculum; in-service training; the health promoting environment; and policies and participation; and • to increase the involvement of the regional coordinators in the Spanish Network of Health Promoting Schools	National, regional and school level indicators have been developed Example at the national level: statements that are supportive of the health-promoting school approach are found in official documents Example of indicators at the school level: provision of healthy food, canteen, water, school dining room, supervised diets, etc.	Document analysis, consultations and questionnaire surveys

Country and author(s)	Aims of the case study	Level of indicators	Process
Sweden Bengt Sundbaum & Jörgen Svedbom	Describes a project that is still in the process of being established to develop indicators with a particular focus on drugs and alcohol education It is intended that the indicators selected will reflect the key dimensions of the health-promoting schools approach in Sweden: that is, indicators for: degree of participation, attention to health, attention to gender issues and the adoption of a cross-curricular approach	The indicators about to be developed will cover mainly the classroom and school levels, reflecting the programmes, materials, methods, activities and processes in classroom teaching	A reference group has been established consisting of researchers, practitioners and people who are experienced in the field of drugs and alcohol education. This group has started the process of selecting indicators
Switzerland Edith Lanfranconi	Outlines Switzerland's approach to good and healthy schools Presents a comprehensive framework designed as a basis of self-assessment by schools of the extent to which they are health promoting	School level – a national framework to support schools in self-assessment of successes and development needs with respect to health promotion	Self-assessment instruments have been designed for use by schools to help measure their success in health promotion

Country and author(s)	Aims of the case study	Level of indicators	Process
Ukraine Oleg Yeresko & Viktor Lyakh	Provides an outline of Ukraine's approach to health-promoting schools Outlines an ongoing project to develop indicators for health-promoting schools for Ukraine	National level – so far two main indicators related to health-promoting schools curriculum have been agreed: Nationally recognized course on health promotion in place with a programme in accordance with health-promoting schools policies and requirements Number of specialists who have been trained on the nationally recognized course on health promotion and the number who followed the course during the past nine months	Analysis of documents (policies, national legislation, statutory orders of the Ministry of Education etc.), observations (at the school level), interviews (with teachers and school administration staff), pre- and post-class questioning for students, consultations etc.

B. Development of indicators for regional strategies and support structures
Table 6.2.

Country and author(s)	Aims of the case study	Level of indicators	Process
Czech Republic Tomáš Blaha	Presents an outline of a national system of indicators and instruments designed for self-evaluation by schools The aim of the specific project reported is to facilitate and support the regional strategy process in establishing 14 regional coordinating teams involving assessing the needs of partners involved, identifying the risks associated with the process, and evaluating its effectiveness	A national set of indicators operating at the school level has been developed and tested Regional level – qualitative and quantitative indicators of the success of the regional strategy of the Czech health-promoting schools programme outlined	Data on the use of the self-evaluation questionnaires has been gathered Research planning for the regional assessment is still in process
Netherlands Christine Hekkink, Goof Buijs & Zeina Dafesh	The aim of the research is to provide insight into the approaches that regional public health service divisions in the Netherlands use to help schools take steps towards promoting better health and well-being. Attention is given, in particular, to providing information, resources and advice on evaluation	Regional level – indicators relating the role regional health-promoting schools play in supporting schools with respect to health promotion	National questionnaire survey of regional public health service divisions: departments of health promotion and youth health care in 32 (of 39) regional public health service divisions responded

C. Using indicators at the school or classroom level
Table 6.3.

Country and author(s)	Aims of the case study	Level of indicators	Process
Denmark Jeanette Magne Jensen	The aims of the project reported are: • to develop indicators of students' participation that are comprehensive to the basic values of the health-promoting schools approach; and • to describe appropriate methods for assessing these indicators.	Classroom level – focusing on indicators of students' participation and ownership of school health promotion	The methods in the project are a mix of observations, focus-group interviews, individual interviews and document analysis, to explore students' active participation and sense of ownership in class-room learning
Finland Kerttu Tossavainen & Hannele Turunen	Provides an overview of Finland's framework of indicators operating on the international, regional, school and individual levels, together with a national research programme Reports teachers' assessment of the achievement of and possible changes in health promotion practices in selected schools in the Finnish Network of Health Promoting Schools	School level – indicators related to general infrastructure, clarification of mission, active participation, curriculum development, evaluation skills, implementation and networking	Data were gathered by questionnaire from 24 teachers who acted as coordinators at the school level and responded both at the beginning and at the end of the three-year period
Romania Livia Teodorescu	Study undertaken by a classroom teacher evaluating the impact of two broad strategies for addressing problems of aggression and violence in the classroom	Class level – indicators relating to positive social interaction in classrooms and reduction in aggression and violence	Observation and student questionnaires used to gather data on aggression and violence and changes in response to pursuing strategies to prevent antisocial behaviour and to deal with it effectively when it arises

D. Involving teachers and students in developing indicators
Table 6.4.

Country and author(s)	Aims of the case study	Level of indicators	Process
Cyprus Soula Ioannou & Olga Kalakouta	Presents a workshop in Cyprus on the development of key areas of impact and associated indicators to evaluate health-promoting schools programmes in Cyprus at the school level	School level – indicators for school self-assessment across all components of the health-promoting school approach	Participatory workshops: nine teachers and three staff members of school health services
Ireland Siobhan O'Higgins, Elena Nora Delaney, Miriam Moore, Saoirse Nic Gabhainn & Jo Inchley	This research focused on enabling students to identify indicators pertinent to them. Indicators, once identified by students, could be used for exploring whether such indicators are present in their school or in other schools	School, classroom and individual – indicators developed by young people themselves with respect to health-promoting schools	Participatory workshops: 16-year-olds in three schools participated in three kinds of workshops to develop and analyse indicators for health-promoting schools

Examples of good practices

A. Overviews of indicator development at the national level

Overview of health-promoting schools at the national level in Croatia

Ivana Pavic Simetin, Marina Kuzman, Iva Pejnovic Franelic & Nina Perkovic

Introduction

The ENHPS introduced the first health-promoting schools project in Croatia, with school health services included from the beginning, due to how school health care in Croatia is organized. The main health-promoting schools principles have been adopted into the everyday practice of school doctors: working with and including students, parents, school staff and local community. Also, during the past decade, many health promotion projects for children and for the general public have been conducted locally or nationally involving the school health services. Since 1999, health promotion has been introduced as a cross-curricular subject in primary schools in Croatia.

In terms of the Ottawa Charter for Health Promotion (WHO, 1986), the core principles for health promotion in schools have been reorienting health services and developing personal skills.

Reorienting of health services includes:

- moving the health sector (school health service) in a health promotion direction, beyond its responsibility for providing clinical services; and
- paying closer attention to changes in professional education and training (school doctors and nurses).

Developing personal skills includes enabling people (students, school staff and family members) to learn, throughout life, to prepare themselves for all of its stages, facilitated in school as a setting.

The main health-promoting schools principles are based on the resolution from the First Conference of the ENHPS (1997a, b) and the Egmond Agenda (International Planning Committee, 2002).

School health services activities are preventive health care measures, emphasizing health education and individual counselling aimed at students, school staff and family members. In the future, the health-promoting schools approach to school health services will be reoriented, as these are regarded as the main channel for implementing the health-promoting schools concept.

Indicators

The indicators in this case study operate at the national level.

Collaboration includes: statements in the official documents on collaboration between the Ministry of Health and Social Welfare and the Ministry of Science, Education and Sport on health promotion in schools.

Training includes:

- the proportion of professionals (school doctors and nurses) attending in-service training;
- the proportion of participants assessing the skills and knowledge gained in the educational courses as being useful in everyday work;
- the proportion of participants assessing the educational kit they received in the educational courses as being useful in everyday work; and
- assessment of school doctors' needs for in-service training on the health-promoting schools approach to preventing overweight and obesity in the school population.

Aims of the work

The aim is to create an overview of the current situation of health promotion in schools at the national level, focusing on collaboration and training. The type of collaboration in focus was the level of collaboration on health promotion between the Ministry of Health and Social Welfare and the Ministry of Science, Education and Sport. Training focused on assessment of in-service training for school doctors and nurses:

- previously conducted in-service training: attendance rate and usefulness; and
- the need for in-service training on the health-promoting schools approach to preventing overweight and obesity among schoolchildren.

Collaboration

The timetable and procedures for the review of existing and draft official documents containing statements on collaboration between the two ministries on health promotion in schools were:

- December 2005 –January 2006: collecting the documents;
- February 2006: reviewing the documents for statements on health-promoting schools;
- March 2006: finding and combining the statements;
- April 2006–June 2006: writing the report.

Training

The Croatian National Institute of Public Health (which hosts the national health-promoting schools coordinator) provided three comprehensive educational courses as the leading organizing institution (see Box 6.1 for background information on the need for a course on nutrition):

- dietary guidelines for schoolchildren – spring 2004, for school nurses;
- preventing bullying in schools – spring 2004, for school doctors; and
- mental disorders among schoolchildren: early detection and prevention – winter–spring 2005, for school doctors.

Box 6.1. Need for in-service training on the health-promoting schools approach to overweight and obesity in the school population

Evidence on the prevalence of overweight and obesity in Croatia was derived from three different sources revealing a rising trend in overweight among children.

- In the 2002 Health Behaviour in School-aged Children study, self-reported height and weight showed that 13% of boys and 6% of girls were overweight in Croatia. These figures rise with age among boys: at 15 years there were 16% overweight boys and 6% overweight girls in the sample.
- One health measure of the school health service is systematic examinations of students (primary school: enrolment in grades 1, 5 and 8 and the first grade of secondary school). Part of these examinations is following up students' growth and development. According to the medical records from these check-ups, using national percentile distribution (Prebeg, 2002) from 1997/1998 until 2002/2003, about 5% of children were under the 10th percentile and about 9% over the 90th percentile.
- The Medical Ecology Service of the Croatian National Institute of Public Health regularly assesses the nutritional status of schoolchildren. During recent decades, 14 000 schoolchildren 7–15 years of age were included in these examinations.

Average data for Croatia for 1997–2002:

- 5% of children obese;
- 11% overweight;
- 70% weight within desirable range;
- 13% underweight; and
- 1% very underweight.

Obesity among children has increased since 1997.

According to the Health Behaviour in School-aged Children study in 2002, eating habits as well as physical activity and sedentary behaviour are rather poor among children in Croatia:

- 15% never have breakfast during workdays;
- only 70% have breakfast each working day;
- 87% of children eat breakfast on the weekends; and
- no more than one third of children eat fruit and vegetables each day, which is decreasing with age, and a similar number of children eat sweets and drink soft drinks regularly.

Data on physical activity and sedentary behaviour reveal many disturbing facts. Thus, physical activity decreases with age, and at the age of 15 years, only 33% of boys and 17% of girls are physically active one hour a day or more. At the same age, 31% of boys and 25% of girls watch television at least four hours a day (working days).

Recognizing the need for action, a joint project between Flanders, Slovenia and Croatia has been outlined on developing a method for guidance in dealing with overweight and obesity among children of school age, as a way to determine and harmonize procedures in preventing overweight and obesity.

In-service training on the health-promoting schools approach to overweight and obesity in the school population seems a logical continuation of activities. In the questionnaire for school doctors, the current situation was assessed through the following question.

Which of the following activities do you currently do in your everyday work? (health promotion, health education for students, health education for parents,

health education for school staff, intervention in the school diet, intervention in the school sport programme and help with the comprehensive school policies).
The response categories were 1 to 5 (1 – not in one school, 5 – in almost all schools).

The need for in-service training was assessed through the following question.

Do you feel the need for education in the following areas? (healthy diet and habits, sedentary behaviour, parental involvement and family interventions, primary prevention in the community, health promotion in schools and implementation of the guidelines for preventing obesity among schoolchildren).

The response categories were 1 to 5 (1 – not at all needed, 5 – very much needed).

Table 6.5 presents data on the assessment of the school doctors' needs for in-service training on the health-promoting schools approach to overweight and obesity in the school population.

Table 6.5 School doctors' mean self-rated needs for in-service training

Current everyday work activities *(1 – not in one school to 5 – in almost all schools)*		**Need for education in the listed areas** *(1 – not at all to 5 – very much needed)*	
Health promotion	3.8	Healthy diet and habits	4.1
Health education for students	4.2	Sedentary behaviour	4.1
Health education for parents	2.9	Parental involvement and family interventions	4.2
Health education for school staff	2.7	Primary prevention in the community	3.8
Intervention in the school diet	2.6	Health promotion in schools	4.1
Intervention in the school sports programme	2.5	Implementation of the guidelines for preventing obesity	
Help with the comprehensive school policies	2.7		

Each course was conducted once in each of the four largest cities in Croatia (Zagreb, Rijeka, Osijek and Split). For each course an educational kit was prepared and distributed to participants containing: written theoretical materials related to the topic; and working materials (transparencies and PowerPoint presentations) to conduct workshops with students or school staff and parents and instructions for its use.

Evaluation

The anonymous questionnaire for school doctors was sent to school doctors' home addresses in December 2005. Data were collected in January 2006. The questionnaire was sent to all doctors who had worked in school health services since 1998. Questions regarding the educational course on eating guidelines for schoolchildren were aimed at school nurses working in the team with a school doctor. For each of the three educational courses, two questions were asked.

Have the skills and knowledge gained in the educational course been useful in your everyday work?
Has the educational kit that you received in the educational course been useful in your everyday work?

The responding categories were on a 1 to 5 scale (1 being the lowest and 5 the highest) and the option "Didn't attend the course". The attendance rate was estimated based on the answer "Didn't attend the course".

Main findings

Collaboration

On 22 March 2006, the Government of Croatia adopted the National Plan for the Activities Aimed at Protecting the Rights and Interests of Children for the Period 2006–2012 as the basic document for activities in all important areas of well-being of children, including education and health. The Croatian National Institute of Public Health played an active role.

Parts of the Plan related to health promotion indicators.

- Ensuring the promotion of physical and mental health among children and youth
  - Main stakeholders: Ministry of Health and Social Welfare, Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity, Ministry of Science, Education and Sport, Croatian National Institute of Public Health, county public health institutes, local and regional authorities, hospitals, professional associations and nongovernmental organizations.

- Involving children in creating, conducting and following up health promotion programmes
  - Main stakeholders: Ministry of Health and Social Welfare, Ministry of Science, Education and Sport, Croatian National Institute of Public Health, universities, local and regional authorities, professional associations and nongovernmental organizations.

- Creating healthy eating programmes for preschools, schools and other institutions for children
  - Main stakeholders: Ministry of Science, Education and Sport, Croatian National Institute of Public Health, Ministry of Agriculture, Forestry and Water Management, Croatian Medical Association, Croatian Society for Preventive and Social Paediatrics, Croatian Paediatrics Society and Croatian Society for School and University Medicine

- Ensuring the implementation of healthy eating programmes in all schools and other institutions for children
  - Main stakeholders: Ministry of Science, Education and Sport, Ministry of Health and Social Welfare, Croatian National Institute of Public Health, local and regional authorities, Croatian Medical Association and nongovernmental organizations

- Raising awareness about the importance of healthy eating in preventing obesity and other disease prevention programmes
  - Main stakeholders: Ministry of Science, Education and Sport, Ministry of Health and Social Welfare, Croatian National Institute of Public Health, Croatian Medical Association, Croatian Paediatrics Society, Croatian Society for School and University Medicine, local and regional authorities and nongovernmental organizations

The Plan lists the activities, deadlines, indicators (number of children, youth, parents and/or schools involved, strategic documents developed etc.) and the funding needed separately for each activity.

Although various documents have contained statements on collaboration between the Ministry of Health and Social Welfare and the Ministry of Science, Education and Sport for the period ahead, the National Plan for the Activities Aimed at Protecting the Rights and Interests of Children for the Period 2006–2012 is regarded to be a basic document. Ensuring the promotion of physical and mental health among children and youth is a basic measure in terms of obligations for both ministries in health promotion. Other previously listed measures will be of great importance in health promotion concerning overweight and obesity in the school population.

Training

The questionnaire was sent to 170 home addresses; 104 completed questionnaires were returned (response rate 61%). The nonresponse rates to individual questions were low, varying from 1.9% to 4.8%.

The professional background of the doctors who answered the questionnaire: school medicine specialists (79%), residents in school medicine (16%) and practising physicians (5%).

Table 6.6 presents data on the attendance rate and perceived usefulness of the adopted skills and knowledge and educational kit in everyday work for each of the three courses.

Table 6.6. Feedback from participants attending courses

Dietary guidelines for schoolchildren	Rating 4 or 5 (%)
Perceived usefulness of the skills and knowledge in everyday work	68
Perceived usefulness of the educational kit in everyday work	72
Didn't attend the course	16
Prevention of bullying in schools	
Perceived usefulness of the skills and knowledge in everyday work	55
Perceived usefulness of the educational kit in everyday work	49
Didn't attend the course	21
Mental disorders among schoolchildren: early detection and prevention	
Perceived usefulness of the skills and knowledge in everyday work	57
Perceived usefulness of the educational kit in everyday work	49.0
Didn't attend the course	27

The total number of school nurses is comparable to the total number of school doctors, as one school doctor works in the team with one school nurse.

Attendance rates were high for all three courses. Possible explanations include:

- each course was conducted once in each of the four largest cities (Zagreb, Rijeka, Osijek and Split), which ensures good accessibility for all participants;
- courses were free of charge;
- credit towards the education required for licence renewal by the Croatian Medical Association was ensured; and
- the head of the Croatian National Institute of Public Health officially invited the participants.

Attendance was highest at the educational course on dietary guidelines for schoolchildren (84%). As it was a course for school nurses and as not many education activities are organized for nurses, they were highly motivated to come. Complimentary comments were heard many times during the course. Compared with two educational courses for school doctors, the lower attendance rate at the course on mental disorders among schoolchildren: early detection and prevention could be explained by the fact that the course was held second, which probably diminished the interest of the participants.

The perceived usefulness of the skills and knowledge and of the educational kit in everyday work was also highest for the educational course on dietary guidelines for schoolchildren, probably for the same reason as the high attendance rate. Another possible explanation is that school nurses are not as demanding concerning their basic education. Further, the Croatian Medical Association recently introduced educational requirements for licence renewal for school nurses, so they have not undergone different types of education and training so often. On the other hand, school doctors have been saturated with different types of education due to their comprehensive basic education and great number of training and education sessions needed for licence renewal. Since the education is therefore extremely demanding and has expectations that are difficult to meet, the results on the perceived usefulness of the skills and knowledge and of the educational kit are more than satisfactory.

In the responses on the current everyday work activities, the high mean value for health promotion activities should be emphasized (3.8). Overall, the mean values for the implementation of some current health promotion activities conducted as everyday work are not very high. Possible explanations are the obligatory extensive health care measurement plan with standardized measures and too many students designated to one team, about 5000 per team. The highest mean value for conducting health education for the students (4.2) in everyday work could be explained by the fact that health education is a regular activity of the school health services. Lower mean values for health education for parents (2.9) and school staff (2.7) reveal that it is easier for school doctors to work with hildren than with adults, which is in accordance with their basic education.

Assessment of the school doctors' needs for in-service training demonstrated great interest and the need for education in all investigated areas, with the mean values raging from 3.8 to 4.6. The lowest mean value for primary prevention in the community could indicate that the school doctors experience difficulty in achieving changes in the community and that they perceive it as being beyond the range of their obligations.

Recommendations for future health-promoting schools projects
The educational courses proved to be well attended and accepted by participants, establishing a valuable pattern for future in-service training. Reorienting health services from a traditional role towards health promotion and the need for in-service training on the health-promoting schools approach, namely on overweight and obesity, has been clearly outlined. The basic document for activities in health promotion at the national level has been launched. These are therefore good reasons to recommend further health promotion activities on overweight and obesity in the school population and also engaging school health services.

Challenges for future research in health-promoting schools projects
The main challenges are:

- to make the evaluation an integral part of the limited projects' budget and framework;
- to shift the focus of the evaluation from process results to real positive change in the life of students; and
- to enhance the effectiveness of interventions in the system and community.

Self-assessment tool for dissemination of health-promoting schools on the school level: collaboration between Estonia, Latvia and Lithuania

Kadi Lepp, Anita Villerusa & Aldona Jociute

Background

In March 1993, with ten schools in each of its networks, Estonia, Latvia and Lithuania joined the ENHPS. Since 1997, the health-promoting schools concept has been disseminated in all three Baltic countries. Currently, 85 schools and 73 preschools are involved in the Estonian Network of Health Promoting Schools. The Latvian Network of Health Promoting Schools has 120 schools, and the Lithuanian Network of Health Promoting Schools has 159 schools of general education and 195 preschools.

Indicators are currently used in all three countries with respect to the dissemination of the concept of health-promoting schools, which refer to activities aiming to disseminate the health-promoting schools concept among members of schools and the community outside of school, as the development of the health-promoting schools has moved from an initial pilot stage into a stage of wider implementation in all three countries. Indicators are assigned to schools to help them to do self-evaluation.

It was considered valuable to work collaboratively across the three Baltic countries on the elaboration of indicators in the area of dissemination of the concept of the health-promoting schools for the school self-evaluation that could be used in common by these schools.

National frameworks of indicators and evaluation

Estonia has two different tools for school self-evaluation. One will become compulsory for all educational institutions in 2007 and the second (determination of the capacity of school health teams – capacity index) is recommended for use in all health-promoting schools. Estonia revised its indicators on 20–21 March 2006 when regional coordinators of health-promoting schools and representatives from the educational sector discussed indicators during a meeting. The meeting decided to propose some indicators of capacity index for common evaluation in all three countries.

Latvia has a framework of indicators, which are used early in evaluating the pilot health-promoting schools.

In Lithuania a pilot study of an internal audit method was started towards the end of 2004 in close collaboration with Moletai Educational Centre and schools of general education in the Municipality of Moletai. This Municipality has led the process of developing the method for internal auditing of educational institutions. At the end of December 2005, the first draft of the internal audit method was produced, covering six areas related to health-promoting schools. One of the six areas relates to the dissemination of the concept of the health-promoting schools. The structure of the health-promoting schools indicators has been developed to be consistent with the method for internal auditing in educational institutions so that both could be undertaken together.

Self-evaluation of the health-promoting schools at the school level
An essential element of evaluating health-promoting schools is an appropriate set of indicators. Indicators are developed according to the health-promoting

The level of health-promoting activities in schools can be assessed within a framework of 4 levels:

- level 4 – achievements predominate;
- level 3 – there are more achievements than weaknesses;
- level 2 – there are serious weaknesses; and
- level 1 – weaknesses predominate.

Indicators might be evaluated using qualitative as well as quantitative criteria or signs of success.

Evaluation of health-promoting schools should be an ongoing process and should involve all members of the school community. Team members from health-promoting schools should answer the questions asked in Table 6.7.

The sources of information for completing the form include: overall school programme; health promotion programme; projects on specific health topics; action plans of the boards of health-promoting schools; reports of meetings and conferences; annual school reports; publications; and registration of activities, field notes and diaries.

The methods for gathering information include: interview, focus group discussion, analysis of documents and observation.

Aim and objectives

The aim was to develop an instrument for the school self-evaluation of indicators for dissemination of the health-promoting schools concept to be used in common in Estonia, Latvia and Lithuania.

The objectives were:

- to select the common indicators on dissemination for the self-evaluation instrument;
- to elaborate a method for the self-evaluation instrument;
- to test the self-evaluation instrument in selected schools; and
- to prepare the final version of the indicators for dissemination of the health-promoting schools concept for the school self-evaluation in Estonia, Latvia and Lithuania.

The indicators chosen to assess dissemination relate to the school.

Description of work

The work was divided into three stages: preparatory stage, implementation stage and final stage.

Several discussions were organized among the coordinators in Estonia, Latvia and Lithuania and research via e-mail to share the available information concerning indicators, to make a common agreement on procedures for project performance and to approve a draft work plan and lead country for the project.

Each country has revised existing indicators. For this purpose different procedures have been used: revising existing indicators (Estonia, Latvia and Lithuania), discussing indicators during meetings (Estonia), testing the indicators and method for self-evaluation at two workshops (Lithuania), one with participation of the regional coordinators of health-promoting schools and representatives from educational sector (28 people) (Estonia) and another with coordinators of health-promoting schools from different types of schools (21 schools) (Lithuania).

Data obtained from schools were analysed separately in each country. Findings and suggestions were summarized for the final version of indicators on dissemination and methods.

The updated indicators as well as the method for the self-evaluation at the national level were translated into English and distributed to Estonia, Latvia and

Lithuania via e-mail. After discussion, common indicators were chosen, which are related to the dissemination of the health-promoting schools concept.

An agreement was reached on indicators to be used in dissemination, together with the method to be followed for the school self-evaluation.

Outcomes

The outcome of this collaborative project was the development of an instrument for the school self-evaluation using indicators for the dissemination of the health-promoting schools concept at the school level.

Table 6.7 reports the agreed indicators as signs to be used as the basis of a self-evaluation instrument in which school coordinators would assess each indicator on a four-point scale as described above.

Challenges

The main challenges during the planning and implementation phases of the project were pursuing an international project having no special budget and organizing joint meetings to discuss issues as they arose. An additional difficulty was the short time in which to plan and implement the project.

In the future, if collaborative work is to be facilitated, it is important to consider the allocation of a budget and to make official agreements between the institutions that represent the three countries.

Table 6.7. Indicators and signs for the dissemination of the health-promoting school concept

Aim: to ensure dissemination of the health-promoting schools concept and examples of good practice to the school community and to the community outside school.

	Indicators	Signs
1.1. Dissemination of the health-promoting schools concept within the school community	1.1.1. There is a place for the dissemination of the health-promoting schools concept on the school agenda 1.1.2. Extent to which the means for the dissemination of health-promoting schools concept have been implemented 1.1.3. Extent to which school community members are familiar with the health-promoting schools concept 1.1.4. Extent to which the school community members are involved in implementing the means related to the health-promoting schools concept	Is the dissemination of the health-promoting schools concept making progress? What means (methods) is the school implementing to disseminate the health-promoting schools concept? How many members of the school community (generally and particularly teachers, students, parents, other staff, health specialists and parents) are familiar with the health-promoting schools concept? How many members of the community are taking part in the process of disseminating the health-promoting schools concept? Who is involved in this process? (only the health-promoting schools coordinator, principal, teaching staff, students, other staff and health specialists)

	Indicators	Signs
1.2. Dissemination of good health-promoting schools practices	1.2.1. There are means related to disseminating examples of good practices on the school agenda 1.2.2. Extent to which the school community members (generally and particularly teachers, students and other staff) present examples of good practice 1.2.3. Scope and diversity of the examples of good practices collected in school 1.2.4. Extent to which the school community members (generally and particularly teachers, students, other staff and parents) are familiar with good practices	Is the plan for good practices making progress? What kind of means? How many members of the community take part in the process of disseminating the examples of good practice among the school Who is involved in this process? (only health-promoting schools coordinator, principal, teaching staff, students, other staff and health specialists) What kind of information exists about good practices? Are the members of the school community informed about where to find information about good practices? Are the examples of good practice available for everyone? How do teachers evaluate examples of good practices? How many teachers find examples of good practice valuable for them?

	Indicators	Signs
2.1. Dissemination of the health-promoting schools concept and good practices to the community outside school	2.1.1. There is a place for disseminating the health-promoting schools concept on the school agenda 2.1.2. Scope and type of contacts with other schools 2.1.3. Scope and type of the contributions to the community outside the school 2.3.4. Extent to which the school community members take part in the process of disseminating the health-promoting schools concept and examples of good practice	Is the school plan making progress with the dissemination of the health-promoting schools concept and good practices to the community outside the school (to other schools and institutions? How many contacts have been organized to present the health-promoting schools concept and examples of good practice? How diverse are these events? What kind of information (material) has been prepared and presented to the community outside the school? How much information (material) has been prepared and presented to the community outside the school? What means of communication does the school apply for disseminating the health-promoting schools concept and examples of good practice to the community outside the school? How many members of the school community (generally and particularly health-promoting schools coordinators, teachers and students) take part in disseminating the health-promoting schools concept and good practices outside the school?

Development of the national programme for health-promoting schools in Germany

Britta Michaelsen-Gärtner

Background

In Germany, schools are required to develop their educational quality based on the prescribed frameworks in place in most of the federal states (Länder). The quality and effectiveness of schools are therefore very important. Other topics than health promotion are given greater priority, and schools often claim that in the current situation they do not have enough resources (money, time and staff) for health promotion. To be successful in this situation, the issues of health and health promotion can only survive and even attain a stronger position in schools if they are an integrated part of the day-to-day business of schools. This means that health promotion has to be integrated into the process of developing quality in schools to show that health is an investment that promotes school success.

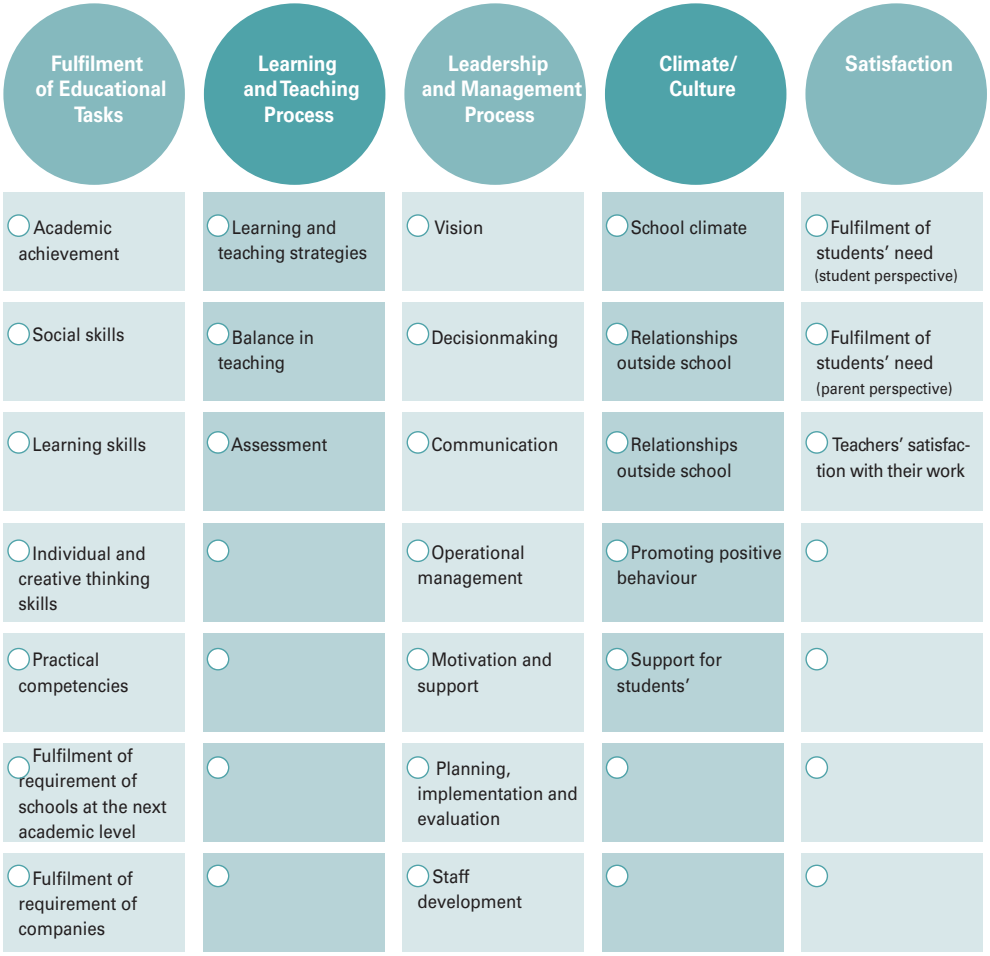
Indicators for the good and healthy school

In Germany we are currently working on the development of indicators for the good and healthy school (*Gute gesunde Schule*). We have produced a preliminary version that is applicable for testing in schools.

The good and healthy school is a new concept in school health promotion developed in Germany and Switzerland. It is being used in two pilot projects explicitly in federal states. OPUS-NRW – Network of Health and Education has been operating in North Rhine–Westphalia (www.opus-nrw.de) and Anschub.de (www.Anschub.de) in Bavaria, Berlin and Mecklenburg–Western Pomerania. The aim of the good and healthy school is to promote of the educational quality of school through health interventions. Even health education has to show how it contributes not only to certain health outcomes that are part of a good school but also to the general education outcomes of the school.
The educational quality of schools is often represented in systems of quality dimensions that characterize a good and/or effective school. They are further characterized by criteria that outline in more detail what the dimensions comprise. Indicators show how these criteria can be identified in reality. This gives an idea of how to measure the indicators.

Fig. 6.1 presents the quality dimensions of a good school. It is called SEIS (Self-Evaluation in Schools; www.das-macht-schule.de). This concept of school quality is used in several federal states and in Anschub.de as well.

Fig. 6.1. Dimensions and criteria of the good school in the SEIS (Self-Evaluation in Schools) quality framework



Aim of work

The aim of the project was to integrate health-related indicators into the framework of an existing school quality system (SEIS).

Description of research

At first we analysed different curricula of the federal states to find the aims for physical education, nutritional education and mental health (aims of health

education). After that we paraphrased the aims into terms related to (indicators of) the good and healthy school. Finally, we assigned the selected indicators to the dimensional framework of school quality of SEIS or we rephrased others to fit in our concept.
Indicators are phrased in a way that they indicate whether a school is using health education or promotion or prevention measures to promote educational aims.

For example: "strategies for learning and teaching" (one criterion of the dimension "learning and teaching process") are the core business of schools. They clearly significantly influence the results and successes of a school. A basic feature of successful teaching and learning is a secure classroom climate. Another important feature is that the school values and accepts the diversity of the students and adapts teaching and learning strategies to the assets the students have. Students should have the feeling that they can cope with the tasks so they can develop self-esteem and self-efficacy. Appropriate indicators from a health perspective are phrased like this:

Improving learning and teaching …

- Teachers develop rules and regulation for social behaviour in the classroom in a participatory way with the students.
- Teachers plan the lessons across the curriculum and practise health interventions such as relaxation and physical activity, eating and drinking.
- Teachers arrange classroom furniture in a way that it offers security.
- Teachers seek to provide fresh air in the classrooms.
- Teachers care about space and time where students can move around during lessons.

Main findings

We were successful in developing a set of indicators that represent the good and healthy school within the framework of the SEIS concept of school quality. In this concept, indicators indicate health interventions as input measures, with educational achievements as outcomes.

Challenges for future research in health-promoting schools projects

The newly developed system of indicators of the good and healthy school consists of over 70 indicators covering all the quality dimensions and its corresponding criteria. This system now has to be tested for validity, reliability and feasibility.

Assessment of the national health-promoting schools situation in Greece

Electra Bada & Katerina Sokou

Introduction

The indicators we chose and used aim at assessing whether health-promoting schools programmes in Greece have achieved the sustainable development of health-promoting schools at the international and national levels and a healthy emotional and social school environment at the school and class levels.

The indicators linked with achieving such sustainable development include issues such as: budget, partnership, involvement of stakeholders and communities, school curriculum and policy development.

The indicators used for evaluating whether a healthy emotional and social school and classroom environment has been attained include issues such as democracy, equity and personal skills development and are grouped in terms of participation, educators' training, empowerment, skills development, teaching and learning methods.

Indicators

Table 6.8 shows how indicators link to specific achievements and how they relate to different levels (international, national, school and class levels) as well as to process or outcome achievements. The indicators are signs that show to which degree goals have been reached. The process achievements refer to how goals are achieved. For example, student dynamic participation in the decision-making related to the creation of an emotionally healthy school environment is a process indicator, as it focuses on how this is being achieved.

The selected indicators are based on concepts of health-promoting schools from the following documents: the Ottawa Charter for Health Promotion (WHO, 1986), the health-promoting schools checklist (Barnekow Rasmussen et al., 1999), the ENHPS indicators for a health promoting school (Pattenden et al., 1999), the resolution from the First Conference of the ENHPS (1997a, b) and the Egmond Agenda (Clift & Jensen, 2005; International Planning Committee, 2002).

We have indicators related to the international, national and regional, school and class levels. The indicators studied are related to the aims of the work, time plan and the limited access to schools.

Table 6.8. Indicators for health-promoting schools in Greece

Aims: what do we want to achieve?	Indicators: we have achieved our aims if:
Sustainable development of health-promoting schools (international and national level)	• Policies are reoriented towards health-promoting schools concepts and aims: mandates for the increase and continuity of health-promoting schools programmes, policies concerning hygiene, safety, access for people with disabilities and healthy food at schools • Budgets for health promotion are increased • Health promotion is integrated into the school curriculum • Health promotion training is implemented • Partnership is attained between international and national health and education organizations
Emotional and social health in school (school and class level)	• Student participation is encouraged both at an everyday class level and in health promotion programmes • Student councils participate in decision-making • Educators participate in health-promoting schools training and are encouraged to implement their training in the school and class • Students and teachers feel that their school promotes their self-confidence and self-esteem • Active learning and participatory methods are used in everyday class teaching and in health promotion programmes • All students participate in health-promoting schools programmes • The community and parents are involved in health-promoting schools programmes

Aim and methods of the research

The aim of the research was to assess progress in the development of the health promoting school programme in Greece by applying the indicators specified.

The methods used include collecting and analysing ministerial documents related to legislation and policies and collecting data on school health promotion programmes from government institutions.

Further, we sent open questionnaires to regional health education officers and to officers in the Ministry of National Education and Religious Affairs and the National Youth Foundation (which took over the technical support and management of some European health-promoting schools programmes) about the policies, budget, number of schools, educators and students participating in national and international health-promoting schools programmes. We conducted semistructured personal interviews with educators, regional health education officers, officers in the Ministry of National Education and Religious Affairs and

the National Youth Foundation and other organizations involved in health-promoting schools in Greece.

We conducted observation during visits at schools and engaged in focus-group discussions and health promotion workshops with high school students and their teachers.

We conducted field research at five high schools with 84 students and their teachers. We used the coat of arms (Weare & Gray, 1995) as a symbol of health-promoting schools. We asked the students and their teachers to brainstorm and write down in each of the four sections of the coat of arms a) what they gain from health-promoting schools programmes, b) what has changed in their class since the health-promoting schools programmes were implemented, c) whether their school contributes to their self-esteem and self-confidence and d) what would they ideally like to change in their school. We used the brainstorming technique with students and teachers participating in health-promoting schools programmes to discuss when they feel good at school and when they feel bad.

We also drew on data from evaluation research on school health education programmes for 2003–2005 and content analysis of best practices among health-promoting schools programmes.

Main findings

International and national levels

Reorientation of policies

The research shows that Greece is passing from the pilot phase to the establishment phase of school health promotion. The state policies related to national and school structure and the organization of school health promotion, officially called health education, show progressive increase since 1992. The indications of this are:

- the implementation of annual health education and health promotion programmes;
- the health promotion training sessions organized for educators;
- the creation of educational guides for health-promoting schools and other information material on specific health topics;
- the introduction of health education as an elective and, in specific types of schools, obligatory subject;
- the introduction of health promotion as a subject in graduate and postgraduate studies;

- the development of partnerships between schools and other educational organizations with disease prevention and health promotion organizations as a prerequisite for funding health education programmes;
- the participation of Greece in international health promotion programmes related to health-promoting schools, research, evaluation, training, post-graduate studies, exchanges and twinning;
- the increase of funds for health-promoting schools; and
- a planned reorientation of health-promoting schools starting in 2007.

During the past decade, the creation of a health education department in the Ministry of National Education and Religious Affairs took place, with the appointment of a health education counsellor next to the Ministry of National Education and Religious Affairs, and regional health education officers and of school health education coordinators. In addition, 58 counselling stations for young people and parents are in the process of being established.

Budget for health promotion

The Ministry of National Education and Religious Affairs estimates that the national budget for health education is increasing by 20%. Regional county councils fund local health education school projects. The budget in Greece increased from €1.0 million in 2004 to €1.5 million in 2005 for Greek (regional) programmes. The European health-promoting schools programmes are funded 75% by the European Commission and 25% by the Ministry of National Education and Religious Affairs. Both the number of international and national health-promoting schools programmes and the budgets allocated to these have increased.

Most national health-promoting schools programmes are short term (2–5 months and a few are 1–3 years).

Health promotion in the school curriculum

Health promotion is an elective course in primary schools and an optional course – outside the school curriculum – in secondary schools. During 2006, the Ministry of National Education and Religious Affairs and Ministry of Health and Social Solidarity planned to cooperate on a seven-year programme of sustainable school development, which incorporates aspects of health promotion. Most school health education programmes are very brief, with no well-structured planning, clear aims, expected results, methods and evaluation. Implementation of international health-promoting schools programmes in Greece is also short term and is not widely integrated in the school curriculum.

Training

The organization of regular national, regional and local health promotion training for educators and health professionals is ineffective and needs to be developed. Training activities have no continuity. There is no awareness of the whole-school approach; teaching methods are not participatory and active learning is not usually used.

Policy encourages educators to offer two hours per week for health-promoting schools programmes. In the secondary school sector, this time does not always coincide with student availability, for it takes place after the official school time. Teachers are paid extra for the two hours as an incentive, but many do not seem to view this as a significant incentive compared with the amount of work. A small minority of educators and health professionals are effectively trained in health promotion principles, concepts and methods.

Most of the above initiatives are fragmentary, discontinuous, cost-ineffective and inefficient. Dissemination of the new health promotion material is limited, and best practices of health-promoting schools programmes are not disseminated. Participation in training and in school health promotion programmes is also limited to a small minority of educators and students. Educators do not really encourage students who need the health-promoting schools programmes the most to participate in them.

The Ministry of National Education and Religious Affairs, educators and scientific and other health organizations involved in health promotion are aware that school health promotion and all related actions urgently need to be reoriented and reorganized.

Partnership

In practice, partnership between schools is limited (even though it is compulsory). In addition, the Ministry of National Education and Religious Affairs functions as a gatekeeper, which makes implementing the research and evaluation programmes introduced by research institutions in schools extremely difficult.

Partnership between national health and education organizations is at an early stage of development. Nevertheless, there has been significant progress during the past decade in terms of partnerships. The Ministry of National Education and Religious Affairs and the Ministry of Health and Social Solidarity are now cooperating to promote the integration of health and health services in the school

system. Other scientific institutions are also participating in planning changes. The Ministry of National Education and Religious Affairs started planning in 2006 the next stage for the years 2007-2014. This includes specific short-, mid- and long-term targets aiming to empower students, use active learning and participatory teaching methods, ensure teachers' systematic training, ensure parents' involvement and focus on health education, human rights, nutrition, physical activity, mental health and other topics.

School and class level

The work undertaken with young people and their teachers showed the following.

- Both students and teachers state that health education programmes improve teacher–student relationships and communication.
- Some students contend that the school as it functions today does not promote equity and democracy (with regard to equal opportunities for participation in decision-making and health promotion programmes) and actually feel disempowered to make actual changes.
- Most students contend that health promotion programmes increase their knowledge in specific health-related topics, improve their communication skills and relationships and their skills for self-care and life management.
- Finally, all schools in Greece have student councils, but this does not necessarily mean that students genuinely participate in decision-making and in school changes.

Main surprises

Process-wise, one of the surprises is that, except for the numbers of programmes implemented, schools, educators and students participating and the budgets of the past few years, the Ministry of National Education and Religious Affairs has no qualitative data for evaluating health education at the national and school levels.

Research institutions have difficulty in gaining access to schools outside a specific programme, which makes evaluation very difficult. The incentives given to educators have been reduced in relation to the time and funding allocated for training.

As a result of training, empowerment of educators and students has increased, but only for a small minority. Active learning methods are a prerequisite for participating in national and international health-promoting schools pro-

grammes. However, only a small minority of teachers have the skills and actually apply student-focused, active and participatory learning methods in health promotion. Only a small minority of educators are aware of existing health-promoting schools training and educational material and have heard of health-promoting schools and understand it. Even a smaller minority practises health-promoting schools. No school fulfils the whole-school approach (Weare, 2000).

All educators and students who participated in an active learning workshop are enthusiastic about this learning and teaching method. What they all appreciate most is the cultivation of good relationships and the communication and exchange of views. The term health education is officially used but most often refers to health promotion and health-promoting schools.

Recommendations

Based on the results of the study using health-promoting schools indicators in Greece, we recommend the following.

- Educators at all school levels should receive regular systematic evaluated training on the concepts, principles and active learning methods related to school health promotion; on issues related to the mental and emotional health of young people; on the major health hazards, national epidemiological data and results from Health Behaviour in School-Aged Children research; and on planning, implementing and evaluating health-promoting schools programmes.
- Policies for a whole-school approach: health promotion should be introduced both as an obligatory school subject in all school grades in which all students and educators participate and as an optional programme in which the priority participants are students with greater need for social inclusion.
- Policies should be implemented to ensure the systematic and regular use of student-focused, active, participatory learning methods in everyday classes.
- School climate and ethos has to be reconsidered in an attempt to reinforce democracy and equity, recognize personal contributions, create a feeling of belonging and of satisfaction with the school, cultivate relationships, good communication and creativity, strengthen the feeling that every member of the school community is valued, respect all sort of differences, empower students and educators and reinforce participation.
- Research on and evaluation of health-promoting schools has to be regular and systematic, and the results should be used for regularly restructuring and reorienting health-promoting schools.
- Partnerships between schools and the educational sector with the health sector as well as with institutions related to health promotion, research and evaluation have to be strengthened.

- Graduate and postgraduate health promotion studies have to be part of the university and to be an obligatory part of the basic studies of all educators.
- Health promotion and health education information material and training guides have to be renewed, cover more topics and be widely disseminated among health promotion professionals and educators.
- The involvement of parents and the community in health-promoting schools has to be strengthened and clarified.
- The budget for health-promoting schools has to increase to cover all school needs.
- Best practices in health-promoting schools programmes have to be collected, evaluated and widely disseminated.
- National, regional and local participation in international programmes has to be continued and strengthened.
- The Ministry of National Education and Religious Affairs should officially recognize health promotion as the umbrella of such programmes as health education, environmental education, cultural education and consumer education. Health promotion has to be understood and practised.

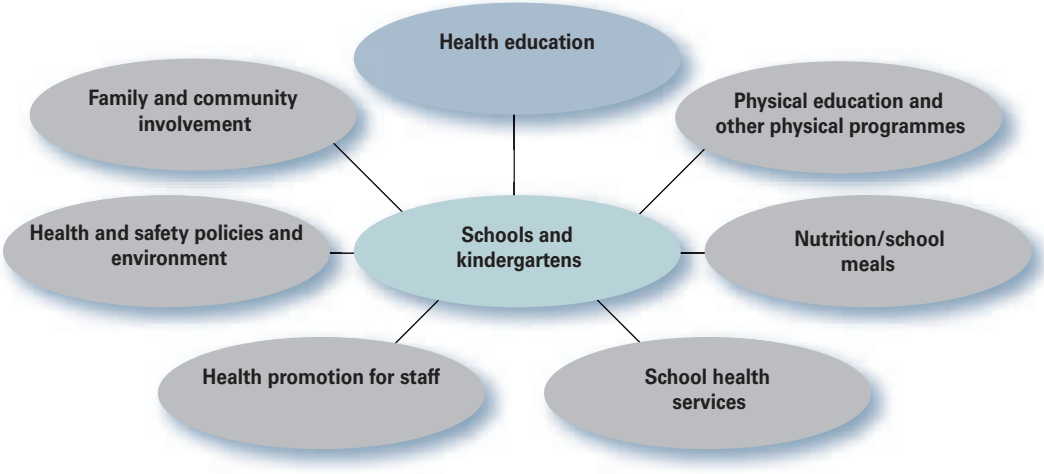
The development of a national health-promoting schools programme in Iceland

Jórlaug Heimisdóttir

Introduction

The health-promoting schools approach in Iceland is to support schools in developing health promotion in its broadest sense. The health-promoting schools approach comprises seven different components or dimensions: family and community involvement, health education, physical education, nutrition and school meals, school health services, health promotion for staff, health and safety policies and the environment (Fig. 6.2). The process entails individuals from every part of the school community being involved in planning ways to improve the school system.

Fig. 6.2. Health-promoting schools approach in Iceland



Critical success factors

The strategy map (Fig. 6.3) contains the critical success factors in increasing the understanding and adoption of healthy lifestyles by children and their families. The critical success factors span four levels: funding, development and growth, process and outcomes.

Paying attention to each of the critical success factors at the individual level should increase the likelihood of achieving the goals outlined in the strategy map (Fig. 6.3).

Fig. 6.3. Strategy map for health education of schoolchildren in Iceland

PHI: Public Health Institute of Iceland
CHS: Centre for Child Health Services

FUNDING	DEVELOPMENT AND GROWTH	PROCESS	OUTCOMES	GOAL
Framework agreement between the PHI and for CHS	School nurses' knowledge and skills School nurses' participation in hte project Cooperation between the PHI, the primary health care sector and the Ministry of Education, Science and Culture	Framework for health education for schoolchildren (related to the 6H) Framewoek for involvement of parents in health education and healthy family lifestyles (related to the 6H) Health education in national curriculum guidelines A national electronic database and regular questinonnaires for process and evaluation	Children's knowledge and skills regarding healthy lifestyle (related to the 6H) Parents' knowledge and skills regarding healthy lifestyle (related to the 6H) School administrators' knowledge and skills regarding healthy lifestyle(related to the 6H)	The promotion and advancement of healthy lifestyles of Icelandic schoolchildren, achieved by faciliting the acquision of relevant knowledge and skills

Theoretical and ideological work for the 6H, which are: (1) nutrition, (2) physical activity, (3) oral hygiene/health, (4) mental health, (5) tobacco and alcohol prevention and (6) sexual education. The ideologgy is based on "learning by doing."

The case study links to the European health-promoting school approach by the development of a framework of health education to coordinate health issues influencing children's health and well-being. The six issues are:

- nutrition;
- physical activity;
- oral hygiene and health;
- mental health;
- preventing tobacco and alcohol consumption; and
- sex education.

The ideology is based on learning by doing. The aim is to increase children's knowledge, influence their attitude and change behaviour and support them in making well-informed choices for health (Fig. 6.3).

The indicators are relevant at different levels. The indicators at the process and outcome levels are measured at the individual and school levels. The indicators at the development and growth levels are measured at the national and individual levels.

Aim

The aim was to measure the effectiveness of the educational materials on health promotion.

Description of the project

The goal of this project is to improve students' educational achievement and their health. The focus is on enhancing children's decision-making skills, self-esteem, goal-setting, stress management and effective communication.

The study is a development project undertaken by the Public Health Institute of Iceland and the Centre for Child Health Services in cooperation with school nurses. These organizations have signed a two-year framework agreement for working on this project.

The time until September 2006 was used to develop materials for six- to nine-year-old children and their parents. The material focuses on information about nutrition, hygiene and oral health, mental health and physical activity to improve the indicators chosen for each subject area. Further, newsletters have been developed aimed at getting parents involved. The newsletters contain information and instructions for parents to improve the family lifestyle regarding the six health issues.

The school year 2006/2007 is being used to develop material for children aged 10–13 years and 14–16 years. The material will focus on the same subject areas mentioned above but additionally on tobacco and alcohol prevention and sexual behaviour. Further, newsletters are being developed to get parents involved. The newsletters contain information and instructions for parents to improve family lifestyle regarding the six health issues.

The professionals responsible for the project include the Centre for Child Health Services (Director of School Health Services), primary health care services (school nurses) and the Public Health Institute of Iceland (project managers and the national coordinator).

Funding will come from the Public Health Institute of Iceland and Centre for Child Health Services. The project will receive additional support from the Prevention Fund for 2006–2008.

Methods

As mentioned above, the project is a development (action) project that will be evaluated rather than a research project. We will use various methods to evaluate whether the process used has been successful.

The project status was assessed in 2005 and 2006, and educational materials are being prepared for children to improve their knowledge and behaviour related

Every fourth year we use the Health Behaviour in School-aged Children questionnaire to survey the children's attitudes, competence and behaviour and to assess the parents' attitude and behaviour regarding the six health issues.

School nurses use a database where they record all their educational activities. This programme will be used as a process evaluation tool and also used to strengthen and coordinate the activity across the country. The school health service or nurses are responsible for the education.

Recommendations for future health-promoting school projects

The effort to enhance the health of children and young people must clearly be based on wide-ranging interdisciplinary collaboration within each school and community. Collaboration is required between the health care system, school administrators, families and the community, teachers, staff and students.

The factors that will be focused on to evaluate the school system are:

- the schools and the child's environment;
- the children's attitudes, competence and behaviour (Health Behaviour in School-aged Children survey);
- the parents' attitudes and behaviour; and
- the dissemination of health education by school nurses.

The main challenge for the project is to find how successful the educational materials are in improving children's health. Another challenge is to use the evaluation of education to change the process where needed.

A national framework for developing and evaluating health-promoting schools in Poland

Barbara Woynarowska & Maria Sokolowska

Introduction

In Poland, the health-promoting schools movement started in 1991 as a three-year project established with support from the WHO Regional Office for Europe. It was part of the initial pilot phase of the ENHPS implemented in four countries – Czech Republic, Hungary, Poland and Slovakia.

In 2006, the regional networks of health-promoting schools existed in all 16 regions with more than 1200 schools. During the past 15 years of political, social and economic transition, many changes occurred in Poland in the education and health sectors. Such changes have created a need for a new framework for the development, dissemination and evaluation of health-promoting schools.

Basic assumptions

Health-promoting schools is a comprehensive concept, implemented within the educational sector, with influence from the health sector, and modified by many cultural factors and specific needs of different schools.

The whole-school approach in health promotion is the basis for the development of health-promoting schools in Poland. This concept needs to be presented in a clear way for various audiences.

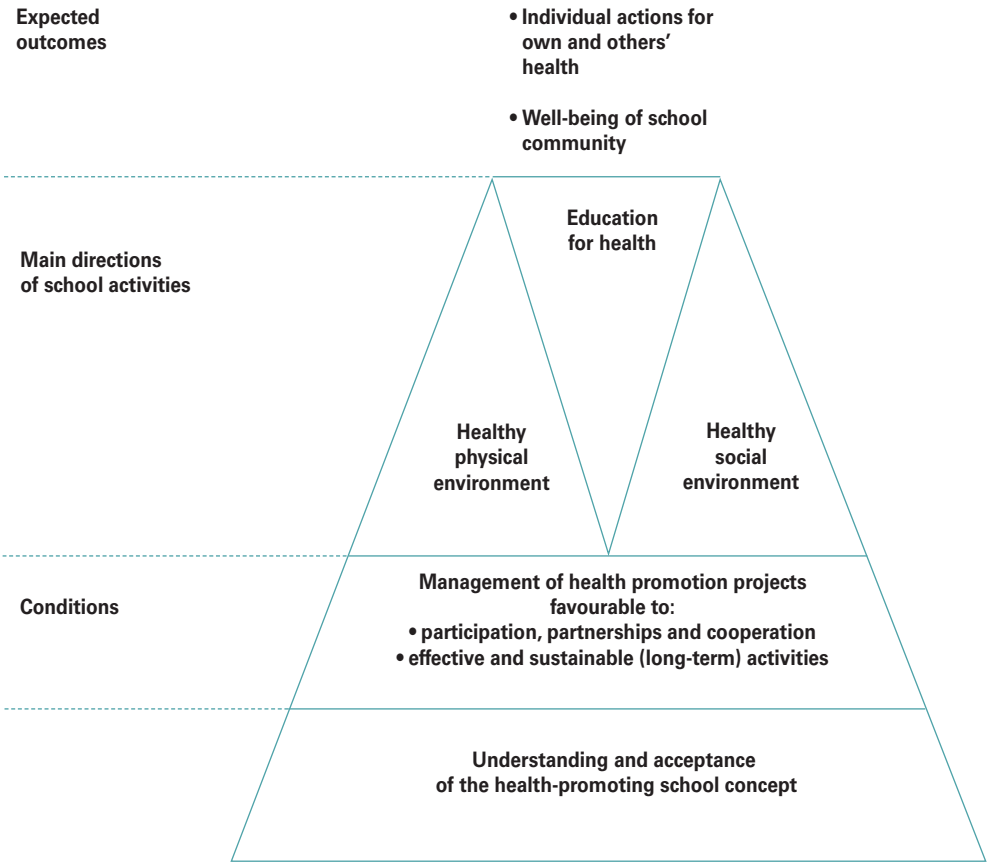
The health-promoting schools framework provides the basis for the development of indicators and tools for their measurement that can be used for self-evaluation by schools.

Model for health-promoting schools in Poland

Health-promoting schools create conditions and undertake activities favourable to the well-being of members of school communities (direct outcomes) and individual actions for their own health and that of others (empowerment – direct and long-term outcomes).

The model of health-promoting schools developed in Poland (Fig. 6.4) is based on Maslow's hierarchy of needs, with an open top. At the bottom of Fig. 6.4 are two levels relevant to conditions required for effective activities within a school context. The middle part of the model presents three main directions of health-promoting schools activities. The open top to the model represents expected and unexpected outcomes of the activities characteristic of health-promoting schools.

Fig. 6.4. The health-promoting school model in Poland



National health-promoting school standards

Poland's model specifies five national principles for health-promoting schools (or standards, as they are called in Poland). Standards 1 and 2 concern conditions, and standards 3, 4 and 5 concern the main directions. A school is assumed to be health-promoting if it:

- helps the members of a school community to understand and to accept the concept of health-promoting schools;
- manages health-promoting projects favourable to participation, partnership and cooperation involving the school community, parents and local community partners;
- implements health education for students and school staff and aims for improving its quality and effectiveness;
- creates a positive school climate that:
  promotes the health and development of students and school staff;
  gives opportunities to achieve success for all and supports their self-esteem;
  provides conditions for participation, partnerships and cooperation among school community, parents and local community; and
- creates a physical environment within the school that supports the health and safety of students and school staff.

Aims of the work

Many discussions, meetings and surveys (with the participation of many people from the national, regional and school levels) on health-promoting schools were carried out in Poland during 2003–2006. The aims of this work were:

- to build a new framework for developing and evaluating the health-promoting schools model and to establish national standards for health-promoting schools;
- to establish sets of dimensions and indicators relevant to each standard and to develop tools for their measurement; and
- to carry out a pilot study in selected schools in order to test the usefulness of these dimensions, indicators and tools.

Methods

Stage 1

The new model and five national standards for health-promoting schools were developed based on discussion and negotiation at the national, regional and school levels (2003–2004).

Stage 2

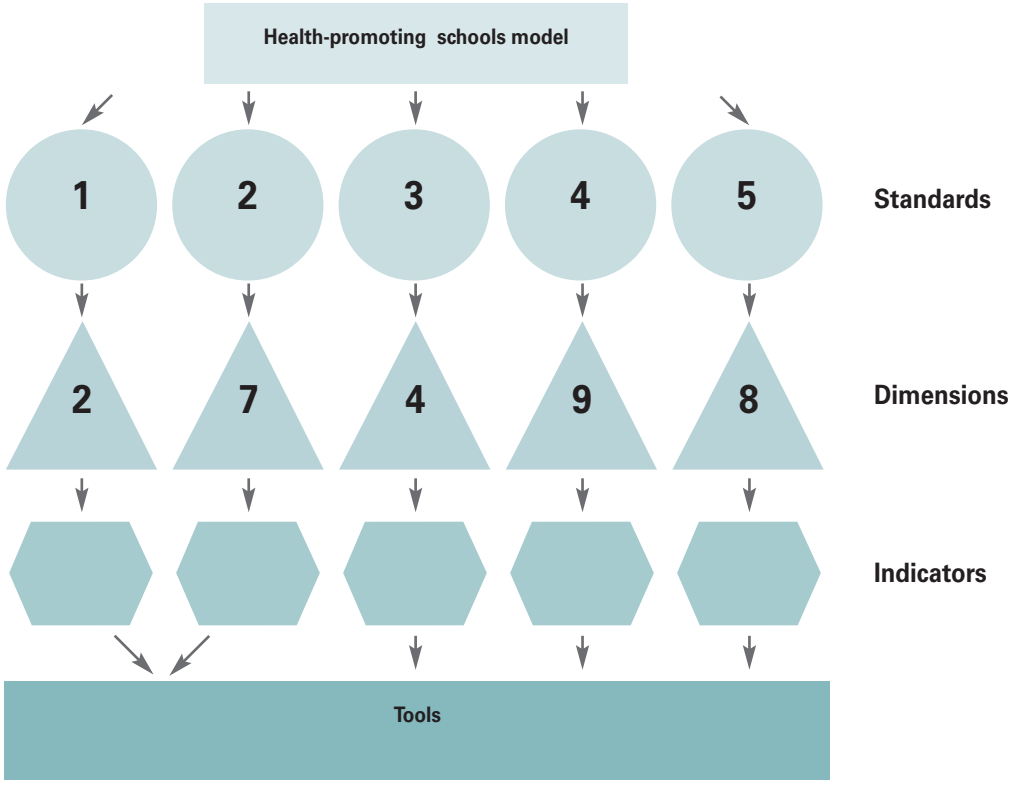
A task force group (three people from the national level and four regional coordinators (volunteers)) was established (2005), which worked to elaborate for each standard a set of:

- dimensions – the most important components describing the content of the standard;

- the indicators for each dimension – characteristics, events and phenomena that can be measured: signs that identify the achievement of each dimension of a given standard; and
- tools – means of measuring each of the indicators.

Fig. 6.5 presents the general scheme developed on the basis of the health-promoting schools model, showing relationships between standards, dimensions, indicators and tools.

Fig. 6.5. Scheme of relationship between standards, dimensions, indicators and tools (the numbers represent five standards and the number of dimensions in each standard)



Stage 3
Stage 3 was a survey carried out in 24 schools in six regional networks (2005–2006).

Stage 4
The data were analysed, leading to modification of indicators and tools.

Results
This case study presents the health-promoting schools model and national standards as well as the example of indicators and tools for the first standard. The first national standard ("a school is health-promoting if it helps the members of the school community to understand and to accept the concept of health-promoting schools") is elaborated here as an example.

Rationale for standard 1
Understanding and acceptance of the health-promoting schools concept within the school community is the basis for participation of its members in its development. Health promotion may be a new idea for a school community, and the creation of health-promoting schools is a long-term process that requires implementing new approaches and methods.
A school community changes every year (new students, parents, staff and local community partners) so each year information needs to be provided about the concept and criteria of the health-promoting schools for the new members as well as additional training for the established ones.

Dimensions and indicators

Table 6.9. Dimensions and indicators

Dimensions	Indicators
1. Dissemination of the concept of health-promoting schools and the feeling of knowing this concept among the school community	• Informing new teachers, other workers, students and parents about the concept and strategy of health-promoting schools • Participation of senior staff members and parents in certain training activities during the past 2–3 years • Access to publications and other materials concerning health-promoting schools
2. Understanding and acceptance of the concept of health-promoting schools among the members of the school community	• Feeling among the members of the school community that their knowledge about health-promoting schools is satisfactory • Acceptance of the health-promoting schools concept and the rules for its development among teachers • Knowledge of the basic criteria (characteristics) for health-promoting schools among teachers • Understanding what health-promoting schools means among parents • Understanding the role of members of the school community in developing health-promoting schools

Evaluation procedures

Table 6.10. Sample and sample size for the survey

Sample	**Sample size**[a]
A. Teachers	At least 60% of the total number of teachers
B. Students: grade 6 of primary school, grade 2 of lower secondary school andgrade 2 of upper secondary school	About 30 students randomly selected (all students in small schools)
C. Non-teaching staff	At least 70% of the total number of non-teaching staff
D. Parents	About 30 parents of children from the grades mentioned in B

[a]The sample size depends on the decision of the school.

Documentation analysis

Documentation analysis included documenting the work of the school coordinator and school team for health promotion, books and other available materials on health education and health promotion.

Organization of evaluation

The school coordinator of health promotion organized and managed evaluation. There are four stages of work.

Stage 1 – establish the evaluation team and divide the tasks

- Invite the representatives of different groups of the school community (including students) and parents to cooperate; there should be 6–8 people in the evaluation team (at least 3 of whom are not members of health promotion school team because the assessment of its activities is included in the evaluation).
- Organize the first meeting of evaluation team. Inform about the concept of evaluation and tasks, which have to be performed. Divide the members of the team into four groups that will carry out the survey among different groups of the school community (using appropriate questionnaire) and calculate and interpret the results: group A – teachers' survey, group B – students' survey, group C – non-teaching staff survey, group D – parents' survey.
- Ask the members of the team to read some parts of the book Health promoting school: ten years' experience – team and co-ordinators handbook (Woynarowska & Sokolowska, 2001). It is necessary for assessing many aspects of school activities as well as teachers' understanding of the health-promoting schools concept and rules for its development.
- Plan for a second meeting of evaluation team (after 7–10 days) for summing up the results of surveys and fill out sheets for evaluation of activities defined in standard 1.

Stage 2 – questionnaire surveys
Groups A–D carry out surveys and analyse their results according to additional instructions. These results are used in the third stage.

Stage 3 – filling out sheets for evaluation of activities defined in standard 1
Organize the second meeting of the evaluation team. The aim of this meeting is to summarize the results of the questionnaire surveys and to fill out sheets for evaluation of activities defined in standard 1 (Annex).
Read each statement (indicator) successively included in the sheet and ask an

adequate group to present the results (arithmetic mean of points) of appropriate positions from the questionnaire. Based on these data and discussion, mark the grade in the sheet (column 3) closest to this statement and fill out together columns 4 and 5 of the sheet.
Discuss within the team the results of the analysis of question 6 in the teachers' questionnaire concerning their understanding about the concept of health-promoting schools and question 3 in the students' questionnaire concerning their knowledge about activities in school for health and better well-being.
The assessment of all indicators should be in agreement with the real situation (some schools tend to increase the grades and assessment). Self-evaluation is the opportunity to create a true picture of the progress (achievements and failures) in the development of health-promoting schools. The school community does this.

Stage 4 – school coordinator summarizing the results of evaluation
Calculate the average number of points in each sheet (annex) according to the instructions. Fill out the evaluation report. Disseminate the results of the evaluation in the school community.

Conclusions

The results of the pilot study on the reliability of some tools and a new national framework for development and evaluation of health-promoting schools were presented and discussed in the group of regional and selected school coordinators in June 2006. A final version of the tools has been prepared and will be published soon in a manual for health-promoting schools.

It was decided to establish a health-promoting school certificate. Schools that receive this certificate will become members of the Polish Network of Health Promoting Schools (currently schools are members of regional networks, and a national health-promoting schools network does not exist). A school will be able to apply for this certificate after three years of membership of a regional network. The application will require the school to present the results of an evaluation based on national standards. Many schools are interested in applying for this certificate.

We hope that implementing this framework will increase the quality of health-promoting schools activities.

Annex: tools

Form No. 1
Dissemination of the concept of health-promoting schools
(filled in by a school coordinator of health promotion in the cooperation with the school team).

1. Passing on knowledge and skills concerning the concept and strategy of health-promoting schools to the new members of the school community

People	Number of people	Ways of passing on knowledge (workshops, meetings, written information, etc.)	How long (hours)	What should be improved?
New teachers				
New school workers				
Students				
Parents				
Other people (such as in the local community)				

a) Are there any materials concerning health-promoting schools (such as a school-prepared leaflet, written information, etc.), that could be passed on to every new member and person visiting the school? (please mark an appropriate answer) YES NO
b) Has there been any training in the past two years aimed at strengthening the knowledge and skills concerning the concept of health-promoting schools? (mark an appropriate answer) YES NO
If YES, for whom? (write in)
c) Are activities concerning passing on the knowledge and skills of health-promoting schools documented? (please mark an appropriate answer) YES NO
d) What should be improved in order to disseminate the concept of health-promoting schools?
2. Access to books, articles and other publications about health promotion and health education in school – make a list and assess who reads these materials
Conclusion: What should be improved in order to have more accessible publication and materials in the future? (write in)

Questionnaires

Questionnaires for students, teachers, non-teaching staff and parents were prepared. Questions concerning all standards were combined. There are questions related to the first standard only. Each of the questionnaires has the following introduction (instructions):

This questionnaire concerns your knowledge about health-promoting schools. Based on the questionnaire results, we will mutually think over what can be done in order for people to be better acquainted with and understand the essence of a health-promoting school and to take part in creating it. The questionnaire is anonymous.

Here is a list of statements. Read each of them carefully and think it over. Please, mark an appropriate number in the column next to each statement.

5 = definitely yes (highest grade)
4 = probably yes
3 = it is difficult to say (I am not sure)
2 = probably no
1 = definitely no (lowest grade)

Students' questionnaire

	Mark an appropriate number
1. In my school I was precisely informed what it means that my school is a health-promoting school	5 4 3 2 1
2. I know how I can take part in the development of health-promoting schools	5 4 3 2 1

3. Specify school activities aimed at students' health and better well-being. (write in)
4. If there are no such activities, what could be done in this field? (write in)
5. Would you like to receive more information in order to better understand the principles of health-promoting schools? (mark an appropriate answer) YES NO – why (write in)

Teachers' questionnaire

	Mark an appropriate number
1. In my school I got plenty of information about the concept and rules for creating a health-promoting school	5 4 3 2 1
2. I accept the concept of a health-promoting school and the rules for its creation	5 4 3 2 1
3. I know what my role and tasks are in the development of health-promoting schools	5 4 3 2 1

4. In the past 2 years I have read at least one publication concerning health promotion (mark an appropriate answer) YES NO
5. In the past 2 years I have taken part in a workshop or other training that strengthened my knowledge and skills in health promotion (mark an appropriate answer) YES NO
6. In your opinion, what are the most important criteria (features) of a health-promoting school? (write in)
7. Would you like to receive more information concerning health-promoting schools and the rules of creating it? (mark an appropriate answer) YES NO

Non-teaching staff questionnaire

	Mark an appropriate number
1. In the school where I work I was informed about what a health-promoting school means	5 4 3 2 1
2. I know what a health-promoting school means	5 4 3 2 1
3. I know what my role and tasks in a health-promoting school are	5 4 3 2 1

4. In the past 3 years I have taken part in a workshop or training that strengthened my knowledge and skills concerning health care (mark the appropriate answer) YES NO
5. I would like to receive more information about health-promoting schools and

Parents' questionnaire

	Mark an appropriate number
1. In my child's school I was informed about what a health-promoting school means	5 4 3 2 1
2. I know how parents should participate in the development of health-promoting schools	5 4 3 2 1

3. In the past three years I have taken part in training or a workshop that strengthened my knowledge and skills of health promotion (mark an appropriate answer) YES NO
4. I would like to receive more information about a health-promoting school and the rules for creating them (mark an appropriate answer) YES NO

Sheets for evaluation of activities defined in standard 1

Evaluation report
(Prepared by a school coordinator in cooperation with a health promotion school team)

Standard 1 (fill in based on sheets I and II)

Dimension	Average
I. Dissemination of the concept of health-promoting schools and the feeling of knowing this concept in the school and local community (sheet I)	
II. Appreciation and acceptance of the concept of health-promoting school in the school community (sheet II)	
Total grade (add number of points I and II and divide by 2)	

The results can be also presented graphically together with the results of other standards.

People who would like to receive more information about health-promoting schools (fill in based on the questionnaire for students – question 5; questionnaire for teachers – question 7; questionnaire for non-teaching staff – question 5; and questionnaire for parents – question 9:

Students %
Teachers %
Non-teaching staff %
Parents %

Conclusions

The main problems that should be solved

Sheets for evaluating activities defined in standard 1

I. Dissemination of the concept of health-promoting schools and the feeling of knowing this

Max. <---------> Min.

No.	Indicators (statements)	Rating *(mark it)*
1.	In this school year new teachers, other school staff, students and parents have been informed about the concept of health-promoting schools *(use data from form 1, p. 1)*	5 4 3 2 1
2.	There are many publications concerning health promotion and education *(use data from form 1, p. 2)*	5 4 3 2 1
3.	Members of the school community have obtained lots of information concerning the concept and rules of health-promoting schools *(explain it by giving the results of the questionnaire for students, teachers, non-teaching school staff and parents, question 1)*	5 4 3 2 1
4.	In the past two years, most of the teachers have read at least one health promotion publication *(use the results of the teachers' questionnaire, question 4)*	5 4 3 2 1
5.	In the past two years, most of the teachers have taken part in training that strengthened their knowledge and skills in health promotion *(explain it by giving the results of the teachers' questionnaire, question 5)*	5 4 3 2 1
6.	In the past three years, most of the non-teaching school staff have taken part in workshops that strengthened their knowledge and skills concerning how to take care of health *(explain it by giving results of the questionnaire for non-teaching school staff, p. 4)*	5 4 3 2 1
7.	In the past three years, most of the parents have taken part in lessons that strengthened their knowledge and skills in health promotion *(explain it by giving the results of the parents' questionnaire, p. 3)*	5 4 3 2 1

Sum up the marked numbers in particular rows Total =.....points Divide this sum by number of indicators (rows)

concept among members of the school community *(sheet completed by evaluation team)*

Explain the grade *(write in the number of points from questionnaire or arguments)*	**What should be improved?** *(write in)*

Average = ...points

II. Understanding and acceptance of the concept of health-promoting schools among members

No.	Indicators (statements)	Grade (mark it)
1.	Teachers accept the concept of health-promoting schools and the rules for developing them *(explain this by giving the results of the teachers' questionnaire, question 2)*	5 4 3 2 1
2.	Teachers know the basic criteria (characteristics) of health-promoting schools *(use the answers to question 6 in the teachers' questionnaire, assess them critically and categorize them and explain them by giving arguments)*	5 4 3 2 1
3.	Teachers know their own role and tasks in developing health-promoting schools *(explain them by giving the results of the teachers' questionnaire, question 3)*	5 4 3 2 1
4.	Students can give examples of activities conducted at school for health and better well-being *(use the answers to question 3 in the students' questionnaire, assess them critically and explain them by giving arguments)*	5 4 3 2 1
5.	Students know how they can participate in developing health-promoting schools *(explain this by giving the results of the students' questionnaire, question 2)*	5 4 3 2 1
6.	Members of the non-teaching school staff have a feeling of knowing what health-promoting schools means *(explain this by giving the results of the questionnaire for non-teaching school staff, question 2)*	5 4 3 2 1
7.	Members of non-teaching school staff know their own role and tasks in developing health-promoting schools *(explain this by giving the results of the questionnaire for non-teaching school staff, question 3)*	5 4 3 2 1
8.	Parents know what health-promoting schools means *(explain it by giving the results of the parents' questionnaire, question 2)*	5 4 3 2 1
9.	Parents know what should be their own part in developing health-promoting schools *(explain this by giving the results of the parents' questionnaire, question 3)*	5 4 3 2 1

Sum up the marked numbers in particular rows Total =.....points. Divide this sum by the number of indicators (rows)

s of the school community (sheet completed by the evaluation team)

Max. <---------> Min.

	Explain the grade (write in the number of points from a questionnaire or arguments)	**What should be improved?** (write in)

Average = …….points.

Proposed assessment of the national situation of health-promoting schools in Portugal

Gregória Paixão von Amann

Introduction

Portugal entered the ENHPS in 1994 with a pilot project. In 1997 it was agreed to enlarge the network in the country. The Ministry of Health and the Ministry of Education developed a partnership focusing on health promotion. A National Support Centre was established and priorities for the work were established.

In 2001 the health-promoting schools projects, implemented in 3407 schools and 265 health centres, were evaluated, showing well-established partnerships at the community level and good health-promoting schools developments in schools. In 2005, the government considered health promotion a priority, and a protocol based on the existing legislation concerning the sectors of education and health was drawn up.

In February 2006, the Ministry of Health and the Ministry of Education signed a protocol agreeing to develop standards of partnership, mainly by establishing support structures at national, regional and local levels. The protocol also anticipates the elaboration of a national strategy on implementing the principles and dimensions of a health-promoting school as well as evaluating this implementation and its impact on the educational system, health system and the community. The evaluation will also focus on the contribution of the implementation of health-promoting schools principles to the ongoing process of improving school effectiveness.

The results of the evaluation will assist in redefining the health promotion strategy in school settings.

Indicators for the health-promoting school

The indicators to be used are as follows:

- percentage of schools with a management structure and policy on health promotion: organizational dimension, project team, management, policy, budget and students', parents' and teachers' involvement;
- percentage of schools with a health education curriculum (curricular dimension – with themes of health promotion included and tackled in different areas and projects);

- percentage of schools with a good ethos (psychosocial dimension – with participatory methods, good relationships and friendly atmosphere);
- percentage of schools that consider that they have a good physical environment (ecological dimension – security, hygiene, good nutrition, sports and health examinations of students, teachers and others);
- percentage of schools with partnerships (community dimension – partnerships and involvement of the community outside the school in the process);
- percentage of schools working with the health-promoting schools concept;
- proportion of children attending a health-promoting school;
- proportion of teacher training courses including the health-promoting schools concept;
- percentage of staff, students and parents actively involved in implementing the health-promoting schools concept; and
- percentage of members of the local community actively involved in implementing the health-promoting schools concept.

Methods
The methods used were:

- proposing the project evaluation to the Directorate-General of Innovation in Curricular Development, representing the Ministry of Education;
- analysing the legislation and supporting documents of both ministries;
- discussing the questionnaire survey on evaluation of health promotion in the school setting with partners;
- getting the Ministries of Education and Health to commit on the use of the questionnaire and treatment of the results; and
- preparing a report on the evaluation.

Table 6.11 shows the questionnaire designed for the survey. Health and education staff will complete this separately.

Main findings
Analysis of documents and existing legislation concerning the education and health sectors confirms that health promotion is a priority for the government. The government considers schools as an important health promoter of children and their families. This analysis supports the protocol referred to above. The second element of the work using the questionnaire is still a project in progress.

Our goal is to verify whether the partnership of education and health is working for the implementation of health promotion and whether it is effective.

Table 6.11. Questionnaire for the evaluation of health promotion in the school setting

To what extent do you consider that:	Always 5	Very often 4	Occasionally 3	A few times 2	Never 1	Do not know 0
1. A project team has been designated to develop health promotion in the school environment						
2. The management board of the school or health centre is involved, assuring that activities for the health promotion are contemplated in the educational school project or activities plan of the health centre						
3. Students, parents, teachers are involved in defining the health-promoting schools activities of the projects						
4. There is a policy of promoting healthy lifestyles, clearly defined by the school or health centre						
5. On behalf of the school or health centre, there is a budget for health promotion in the school						
6. The school curriculum includes all the themes of health promotion						
7. The themes of health promotion are tackled in various branches and throughout several school years						
8. The relevant themes of health promotion (nutrition, safety, alcohol, tobacco, drugs, etc.) are developed in the project area or other non-educational area						
9. The curriculum projects in class include self-esteem, personal and social competencies, besides the themes of health promotion, etc.						
10. The school's extracurricular practices are in accordance with the health promotion developed in class						
11. The school uses active and participatory methods for developing health promotion						
12. The whole educational community (teachers, parents, staff, etc.) is involved in the health promotion projects of the school						
13. A good relationship exists between students, between students and teachers and between students and staff (school promotes a belonging atmosphere)						

14. A good understanding exists between the school and the families

15. The school has a friendly atmosphere

16. Security of students, teachers, staff and other elements of the school are given priority (rules, procedures, plans of security, etc.)

17. Hygienic rules exist and are implemented in the school (cafeterias, buffets, WC, patio, etc.)

18. There is a focus on students' eating at school and providing balanced meals

19. The school spots are pleasant and promote well-being at school

20. There is preoccupation with the effect on health of the actions of students, teachers and other staff members (examinations, vaccines, response to specific difficulties, etc.)

21. Other partnerships, beyond health and education, are involved in the health-promoting schools projects

22. The community outside the school intervenes in defining the activities of the project

23. The community outside the school participates in evaluating the health-promoting schools projects

24. Resources are shared on behalf of the community's institutions (spaces or technicians) for carrying out extracurricular activities concerning health promotion in the community

25. The community outside the school collaborates in resolving problems detected at school

26. The educational professionals of your school or health professionals of your health centre are involved in health promotion in the school setting

27. The students are involved in the health promotion projects of the school

28. The parents or the educational tutors are involved in the health promotion projects of the school

29. The community institutions are involved in the health promotion projects of the school

30. The educational or health professionals have been trained in health promotion

Which five areas of health promotion were given most attention by the school or health centre during the school year 2004/2005?
(Use a scale of 1 to 5, in which 1 is the theme given most attention and 5 the least attention)

	Kindergarten	Primary schools	Lower secondary schools	Upper secondary schools
1. Development of personal and social competencies				
2. Prevention of abandonment				
3. Mental health				
4. Oral health				
5. Body hygiene				
6. Healthy nutrition				
7. Physical activity				
8. Safety promotion				
8.1. Traffic education				
8.2. Accident prevention				
8.3. Evaluation of the school's safety and hygiene conditions				
9. Prevention of illicit consumption				
9.1. Prevention of alcohol and tobacco consumption				
9.2. Prevention of alcohol consumption				
9.3. Prevention of tobacco consumption				
10. Prevention of illicit consumption (drugs)				
11. Sex education				
12. HIV and AIDS prevention				
13. Violence prevention at school				
14. Cardiovascular disease prevention				
15. Obesity prevention				
16. Cancer prevention				
17. Others: which?				

In your opinion, what can your school or health centre do to enhance health promotion in the school in the future?

Health-promoting schools – the development of quality indicators within a partnership model in Scotland

Anne Lee & Ian Young

Background

Developing the school as a health promotion setting has been an area of focus and discussion for over 20 years in Scotland (Young, 2005). In 1986, 150 delegates from 28 of the 32 Member States of the WHO European Region attended the first health-promoting schools conference hosted by the Scottish Health Education Group in Peebles, Scotland. The discussions and debates from this formed the basis of *The healthy school* (Young & Williams, 1989).

Scotland's commitment to this area of work was formalized in 1993 when it joined the ENHPS. With the United Kingdom joining initially in 1993, the Health Education Board for Scotland became the networking agent for Scotland (Crosswaite et al., 1996); separate programmes were set up for Wales, Northern Ireland, Scotland and England.

To strengthen the evidence base for health-promoting schools, close links were established with Edinburgh University from 1993, which assisted in evaluating health-promoting school case studies (Inchley et al., 2000). Strong links were built with the Health Behaviour in School-aged Children (HSBC) study and the Child and Adolescent Health Research Unit at the University of Edinburgh. The outcomes of the HSBC study (Currie et al., 2004) continue to influence health-promoting school policy today in 42 countries, with the Child and Adolescent Research Unit at the University of Edinburgh playing an international coordinating role.

Aim

This review traces the development of quality indicators for health-promoting schools in Scotland during the past decade. It describes the process of change and demonstrates how these measures have become embedded within government policy and practice in the education sector.

Description

Developing indicators

From the early developments described above, it was gradually realized that

getting the health-promoting schools approach to be sustainable in Scotland required a strong partnership between the health and education sectors, recognizing and acknowledging the contribution of each and building developments into existing education structure, policies and practice.

In the 1990s in Scotland, the education sector, led by the government agency for school standards (HM Inspectorate of Education), was developing innovative methods of monitoring school effectiveness. This led to the production of a document (updated three times since 1992) entitled *How good is our school?* (HM Inspectorate of Education, 2002, 2004).

How good is our school? is designed to help head teachers and teachers with school self-evaluation and to assist education authority officials in discharging their responsibilities for quality assurance. The continuing strength of this set of indicators is that it is uses both external evaluation by the national inspectors as well as self-evaluation by schools and local authorities in quality assurance procedures. As a result, it provides an opportunity to continue the partnership at all levels of the education system. The third edition (HM Inspectorate of Education, 2002) uses the term "quality" rather than "performance" indicators to reflect the qualitative nature of the judgements to be made and to distinguish them from quantitative or statistical measures.

The indicators are generic and can be used in primary, secondary and special schools and by groups within these sectors. A range of approaches can be taken to quality assurance and improvement, and the report recognizes that there is no single model for self-evaluation. The approaches suggested in *How good is our school?* incorporate the direct experience of schools, education authorities and HM Inspectorate of Education, and this partnership approach has been a feature of developments in Scotland.

Those working in health promotion in Scotland in the 1990s found that, as the education system was developing its own effectiveness or quality indicators, it would be important to link any health promotion indicators to the mainstream indicators of quality in the education system. The thinking behind this was that health education and health promotion should be fully integrated into the education system. Setting up a separate system of quality measurement was likely to encourage the idea that health promotion was not part of the mainstream work of schools. Getting busy teachers to set up a parallel system for health promotion would also have been difficult, and this would have increased resource requirements and bureaucracy at a time when teachers were already being asked to undertake more internal assessment, with its associated administrative burden.

This led to the publication in 1999 of *A route to health promotion – self evaluation using performance indicators* (Scottish Executive et al., 1999). It was a partnership production between the national health promotion agency (Health Education Board for Scotland), Aberdeen City Council and the Audit Unit of the HM Inspectorate of Education. Its aim is to assist teachers in pre–five years old, primary, secondary and special schools to evaluate and improve the quality of their health promotion. In providing a framework for a structured audit, this document built directly on the national approach to self-evaluation set out in *How good is our school?*

The approach is based on school management asking three questions:
- How are we doing?
- How do we know?
- What are we going to do now?

Schools are encouraged to take a broad look by initially scanning how the school promotes students emotional, physical, mental and social health, then they are asked to take a closer look at key areas. *How good is our school?* outlines 33 performance indicators; of these, 10 have been selected as being particularly relevant to health promotion within the school setting:

- structure of the curriculum;
- quality of courses or programmes;
- meeting students' needs:
- pastoral care;
- personal and social development;
- ethos;
- partnership with parents and the school board;
- links with other schools and agencies, employers and the community;
- provision of accommodation and facilities; and
- organization and use of resources and space.

Those engaged in self-evaluating are asked to evaluate their practice against four levels of performance, again in the same way as How good is our school? (Table 6.12).

Table 6.12. Four levels of performance in self-evaluation

Level		
4	Very good	Major strengths
3	Good	Strengths outweigh weaknesses
2	Fair	Some important weaknesses
1	Unsatisfactory	Major weaknesses

For example, for the performance indicator on the extent to which "the school accommodation and facilities promote the health and well-being of staff and pupils", the report offers features to look for and provides a written illustration of what a level 4 (very good) award would mean. Here is the level 4 illustration in relation to the performance indicator on school accommodation and facilities.

The accommodation and facilities provide a safe, pleasant and stimulating environment well suited to supporting the curricular activities of pupils, the work of staff and social and leisure activities where applicable. There are, for example, safe and secure bicycle storage facilities for pupils who cycle to school, good social provision for pupils, a suitable medical/rest facility and an attractive canteen area. The grounds of the school provide a safe, yet stimulating, area for pupils to relax or play. Accommodation is in a very good state of decoration and repair and equipment, such as sporting equipment, is of high quality and in good condition. School toilets are hygienic and properly maintained. Access is suitable to the needs of all users.

A detailed illustration is also given for a level two award, and levels one and three can be judged by whether they are lower than level two or between levels two and four. Subsequently this has been revised and extended to six levels of performance (Table 6.13).

Table 6.13. Six levels of performance in self-evaluation

Level		
6	Excellent	Excellent
5	Very good	Major strengths
4	Good	Important strengths with areas for improvement
3	Adequate	Strengths outweigh weaknesses
2	Weak	Important weaknesses
1	Unsatisfactory	Major weaknesses

In revising this four-point evaluation scale to a more finely calibrated six-point scale in school inspections, a new top level of excellence was incorporated, which reflects the philosophy of the report *Ambitious, excellent schools* (Scottish Executive, 2004).

Updating developments

With the health-promoting schools approach gathering momentum both nationally and regionally within schools and preschool establishments, HM Inspectorate of Education (2004) produced a new document: *How good is our school? The child at the centre: the health promoting school.* This document for self-evaluation selected key clusters of quality indicators for schools and performance indicators and care standards for pre–five years old centres were selected. In evaluating against these, schools and centres are encouraged to use the measure that best helps capture the key features of the schools or establishment.

Policy context – the Scottish Health Promoting Schools Unit

At this same time that this evaluation using performance indicators was being developed, the policy context for health promotion in schools was entering an important phase, and it is incorporated in several Scottish Executive documents, which span both health and education. Critically, *Towards a healthier Scotland: a white paper on health* (Scottish Executive, 1999) and the *New community school prospectus* (Scottish Executive, 1998) provided fresh impetus for the further development of health promotion in schools.

Towards a healthier Scotland demonstrated the government's commitment to this area of work, as it stated, "Working with [the Convention of Scottish Local Authorities] and Learning & Teaching Scotland [the national agency for curriculum development], Health Scotland will establish a specialist unit to develop health education and health promotion in schools." As the partnership created the Scottish Health Promoting Schools Unit, a key aim was to embed the health-promoting schools approach within the education sector at both the strategic and operational levels.

Working with partners in education and health both locally and nationally, the Scottish Health Promoting Schools Unit (2004) produced *Being well, doing well,* a framework for health-promoting schools. This report offers national guidance on several key aspects related to the development of health-promoting schools and is aimed at those who have responsibility for planning and implementing young people's policy in health education and promotion, children's services and community development within:

- councils, education departments of local authorities, schools, preschool centres and communities; and
- health promotion departments and other health agencies.

In creating a focus for this development, the Scottish Executive set the target that every school in Scotland should become a health-promoting school by 2007. With this target came a number of key questions, such as:

- How will we know whether all schools are health-promoting schools?
- How will we ensure consistency and coherence in approach across Scotland?
- How do we ensure that this is seen as an integrated and ongoing part of school life?

As a result of these questions being debated, a national accreditation framework for health-promoting schools was developed to support a consistent and coherent approach.

The national accreditation framework operates based on the following.

1. The local and regional accreditation process is nationally endorsed.
2. This depends on the local process meeting nationally agreed core criteria.
3. Nationally agreed core criteria for evaluating local health-promoting schools accreditation processes focus on broad aspects, rather than more detailed ones, in order to allow for local flexibility (linking to the HM Inspectorate of Education self-evaluation tool *The health promoting school*);

4. A national multidisciplinary team will assess local arrangements against the core criteria set out below.
5. There will be one level of recognition for national accreditation. However, councils and National Health Service (NHS) boards have discretion to identify targets as they feel appropriate and include as many levels of recognition as they wish in their local arrangements.
6. National endorsement of local accreditation arrangements is based firmly on existing planning, evaluation and reporting procedures of local authorities, their schools and NHS boards.
7. Local authorities and NHS boards are strongly encouraged to evaluate all their schools for national accreditation by the end of 2007 through their local arrangements.

The national accreditation framework identifies these seven key principles, at the centre of which was the use of the published HM Inspectorate of Education (2004) self-evaluation tool, *How good is our school? The child at the centre: the health promoting school.*

Conclusions and future challenges

WHO recognizes that health-promoting schools having become embedded in the policy statements of both the education and health sectors at the national level is a significant achievement in Scotland and considers this a prerequisite for the sustainable development of health promotion in schools in Member States.

The health-promoting school has been useful as a unifying concept to build partnerships between the health and education sectors, and indeed with other key contributors such as those from sport and research institutions. The innovations in health education and health promotion are viewed within the established conceptual framework of the health-promoting school.

Translating policy into good practice that is effective and sustainable requires skill, persistence and an understanding of the barriers to progress. In Scotland, we recognize that we still have much to achieve. We have developed indicators for health-promoting schools in a partnership between education and health and also between the national and local levels. We have set a target for all schools to adopt this model, and many education departments and area health promotion departments are working towards this goal. We still have much to do to spread this good practice to all schools across Scotland. Nevertheless, we are confident that this can eventually be achieved because of the political will and the fact that health promotion is gradually being built into the daily business of schools rather than being perceived as a peripheral issue, as it was over 20 years ago at the start of this movement.

Development of a national programme for self-evaluation of health-promoting schools in Slovenia

Vesna Pucelj

Introduction

The Slovenian Network of Health Promoting Schools has existed since 1993. Currently 130 schools are involved in the project (100 elementary schools, 25 secondary schools and 5 secondary boarding schools). The purpose of the health-promoting schools approach in Slovenia is to transfer experiences and examples of good practice from health-promoting schools to every school in the country. One of the most important goals of including health topics in the curriculum is to promote knowledge about health as well as creating a school climate that enhances opportunities for healthy living. The issue of the hidden curriculum is relevant. Acknowledging health equity and the action competence of children is also very important.

Everyday lifestyle is influenced by different attitudes and behaviour relating to health. Preliminary conditions for responsible daily choices are knowledge, individual differences, the effects of society and establishing personal responsibility for one's own health. All these conditions influence the choices and behaviour concerned with health. Health in the school environment therefore needs to be addressed in an integrative way for students, teachers and other school staff. Further, all health-promoting tasks have to be carefully planned, monitored and evaluated.

We have chosen to work on three levels. At the national level, we are implementing the health concept into the school environment.
At the school level, we strive for health promotion principles to be recognized in the school environment and increasing the effectiveness of the project in particular schools.
At the individual level, we are strived to ensure that health promotion has meaning for the students.

The aims of this project were:
- to discover the opportunities for including health promotion in the school environment;
- to determine the effectiveness of the project in specific schools of the Slovenian Network of Health Promoting Schools;

- to discover how well the schools included are acquainted with health promotion concepts;
- to acknowledge the participation of students; and
- to set indicators of effectiveness of the health-promoting schools project.

Description of research

Table 6.14. Framework followed in the research project

What	Who	When
Health concept in the school environment Implementation	National Institute of Public Health Multisectoral working group	Accepted in 2004 Continually since 2004
Self-evaluation activities in schools	Project teams in schools	Continually since 1994
Introductory meeting with health-promoting schools team leaders	Team leaders and national team	March 2006
Preparation of questionnaire and workshops for pupils	National team and other experts	July and August 2006
Application of the questionnaire in schools	Team leaders	October 2006
Workshops on chosen schools	Team leaders	November and December 2006
Analysis of data	National team	January 2007
Research report	National team	March 2007

Methods

The methods for the national and school levels include:

- organizing introductory meetings with team leaders, where they will be informed about the research; and
- preparing a questionnaire for assessing the level of inclusion of health promotion principles in the school environment (team leaders will also monitor school activities during the school year and then report to the national team, which will gather and analyse the data).

The method for the individual level includes workshops – draw and write. We will use the diamond method: students will rank specific elements of health promotion in the school environment by priority.

Main findings

During 2004/2005, we received reports from 67% of the schools included. Most activities carried out were in mental health, healthy nutrition, variation of school lessons, physical activity and addiction. Most activities were held for students and some also for teachers and parents. Most activities were planned for a longer period (one year or more).

Team leaders were mainly satisfied with the activities performed and rated 25% of all performed activities as successful.

Introductory meetings with team leaders were held in March 2006 to plan future evaluation work. In order to successfully carry out any project in the school environment, leaders believe that this requires:

- a project team (with support from the principal);
- cooperation with parents and the local community;
- acceptance of certain policies in school (prohibiting smoking and drinking alcohol, encouraging healthy nutrition and drinking water etc.);
- including students in the process of planning, implementing and evaluating projects in school;
- ensuring expert guidance from appropriate institutions (for the Slovenian Network of Health Promoting Schools, this is the National Institute of Public Health); and
- acceptance of health promotion principles as part of the everyday functioning of a school.

Recommendations for future health-promoting schools projects

During 2007 we plan to focus on the evaluation of the Slovenian Network of Health Promoting Schools and to undertake research on individual projects in schools.

Development of a national programme for multi-level evaluation of health-promoting schools in Spain

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Introduction

In Spain, a case study analysed the current situation of health promotion in schools based on nine sets of indicators that have been developed. The case study also focused on involving the regional coordinators in the Spanish Network of Health Promoting Schools.

The aims of the work were:

- to analyse the situation of health promotion in schools, focusing on: the commitment and collaboration between health and education; health education in the curriculum; in-service training; the health-promoting environment; policies and participation; and using the agreed set of indicators; and
- to increase the involvement of the regional coordinators in the Spanish Network of Health Promoting Schools.

Set of indicators

The following indicators have been formulated at the national, regional and school levels.

National indicator

- Statements that are supportive of the health-promoting schools approach are found in official documents.

National and regional indicators

- The health-promoting schools approach is integrated into strategic planning and policies.
- Regular contacts or meetings are taking place between the national coordinator and regional coordinators.
- Health education in the curriculum is supported by legislation.

Regional and school indicators

- Percentage of schools or school communities that have given increased time and resources to health promotion and education.

- Regular contacts or meetings are taking place between regional coordinators and their schools.
- The way health promotion or education has been implemented in schools (such as health issues debated in school councils; support for health promotion activities from parents' associations, etc.).

School indicators
- Number of teachers attending in-service courses on health promotion and education
- Environmental indicators in each school: provision of healthy food, canteen, water, school dining room, supervised diets, etc.

Description of research
The Coordinator of the Spanish Network of Health Promoting Schools and the Ministry of Health and Consumer Affairs agreed on a work plan.
On 2 March 2006, the Ministry of Education and Science and the Ministry of Health and Consumer Affairs convened a meeting together with all regional coordinators. During this meeting the outline of the work was agreed. Two different questionnaires were developed to send to the regional coordinators and school coordinators.
Questionnaires were sent out and the data were analysed. Further, official documents and records were analysed. The results of the questionnaire survey were compiled and official documents analysed into a final report with recommendations.

Methods
Of 17 communities and 2 autonomous cities, 6 autonomous communities belong to the Spanish Network of Health Promoting Schools, and not all their schools belong to the Network. During the 2006/2007, two more autonomous communities are planned to be included in the Network.

The report includes data and information from a variety of sources:
- data from questionnaires completed by the regional coordinators;
- reports sent in by school coordinators;
- information collected in the meeting that took place on 2 March 2006;
- contributions made by the health and education administrations of the autonomous communities;
- contributions from the Ministry of Health and Consumer Affairs;
- a report from the national coordination of the Spanish Network of Health Promoting Schools; and
- analysis of official documents: agreements and legislation.

Main findings

The autonomous communities have many different perceptions concerning the necessity and advantages of belonging to the Spanish Network of Health Promoting Schools.
On the negative side, considerable paperwork is involved, and teachers are expected to undertake the work without fair compensation. On the other hand, it is an important source of information, provides resources and social recognition

It is therefore important to work on strengthening health-promoting schools at the regional, national and international levels.
Based on our findings, we decided to undertake further national research, which is intended to be completed soon.

Recommendations for future health-promoting schools projects

The work undertaken so far suggests the following recommendations.

- Projects should establish contact with other health-promoting schools
- Projects should be adapted to the school reality and to the environment related to health education and promotion by undertaking a situation survey.
- The teaching and administrative workloads of teachers and others involved in health-promoting schools projects should be acknowledged.
- The involvement of the health sector in health-promoting schools projects should be increased.
- The local community and parents should be involved in health-promoting schools projects. For example: when parents register their children in a school, they could be given information about the health promotion activities of the school and be invited to be involved.
- The visibility of project outcomes should be raised through publication and dissemination activities.
- Cooperative projects should be undertaken with networks of health-promoting schools in other European countries.

Challenges for future research in health-promoting schools projects

The challenges for future research include:
- increasing the number of health-promoting schools in each autonomous community;
- widening the range of schools belonging to the Spanish Network of Health Promoting Schools, including private and public and primary and secondary; and
- furthering the integration of health education and health promotion into daily school life.

Assessment of the national health-promoting schools situation in Sweden

Bengt Sundbaum & Jörgen Svedbom

Background

The Swedish National Agency for School Improvement is responsible for ENHPS membership in Sweden. The health-promoting schools approach is closely linked to the educational dimension of health-promoting schools and is labelled health-promoting improvement of schools. The important perspectives are the participatory perspective, the gender perspective, the health perspective, the cross-curricular perspective and the whole-school approach.

This report is based on a task the Government of Sweden delegated to the Swedish National Institute of Public Health to disseminate effective methods of strengthening school-based prevention of alcohol and drug misuse. The task is to be carried out in partnership with a number of other agencies and organizations, such as the Swedish National Agency for School Improvement and the Swedish National Agency for Education.

Today the main component of school-based prevention of alcohol and drug misuse is traditional information. But current research shows that traditional, informative education on alcohol, drugs and tobacco does not have the anticipated effect on student's behaviour. Feeling happy and functioning well at school, however, provide students with fundamental protection against developing problems and alcohol and drug misuse.

The effective methods on which the task from the Government of Sweden is based can be categorized in four cornerstones, all closely linked to health promotion in a broad perspective: educational measures in the classroom, cooperation with parents, students' health and young people's use of leisure time.

Relevant policy plans for preventing bullying and truancy are also important school-based factors known to reduce risk behaviour among young people.

Indicators selected

The indicators for health-promoting schools are linked to Sweden's compulsory school curriculum to emphasize that a health-promoting perspective is an obvious part of the responsibility of school. The indicators selected are:

- educational measures to create a safe and encouraging classroom environment;
- cooperation and dialogue with parents;
- student health services in close cooperation with the school staff;
- meaningful and organized leisure activities; and
- active work against bullying and truancy.

Each of these is discussed in greater detail below.

Educational measures to create a safe and encouraging classroom environment

The importance of good classroom management

"The school shall strive to be a vibrant social community that provides security and the will and desire to learn." Excerpt from Sweden's compulsory school curriculum

Teaching and learning are difficult if the atmosphere in the classroom is noisy and unsettled. Maintaining peace and quiet is a key factor. This is particularly true for students who find it difficult to fulfil established educational goals. Students who cannot concentrate and have externalized behaviour problems risk being excluded from school and led astray. A calm atmosphere in the classroom is also important for quieter and more reserved students, who are easily neglected, to be able to flourish and do well.
Research shows which methods are effective in enabling the teacher to create structure and peace and quiet in the classroom. Several schools are already successfully using existing educational tools to improve teachers' classroom management skills. The teacher must formulate clear rules of the social game in partnership with the students to create an atmosphere of security and trust in the classroom. Everyone must be aware of the rules and the consequences of breaking them. The most successful approach seems to be to praise the students when things are going well instead of dwelling excessively on negative behaviour. Research also shows that repeated reprimand and punishment do not alleviate disturbance and noise problems in the classroom in the long term but instead intensify different types of problem behaviour.

The same research tells us that praise and appreciation help to motivate students to work harder and follow agreed rules. If the teacher can praise and encourage rowdy and vulnerable students in a well-considered and consistent manner, the risk of these students being excluded will be reduced and their decline into failure, truancy and abuse will be halted.

Knowledge for life
"Schools shall promote understanding for other people and the ability to empathize."
"Their task is to convey fundamental values and promote learning among students to prepare them for living and working in society."
Excerpts from Sweden's compulsory school curriculum

Similar to reading, writing and arithmetic, the ability to interact and cooperate well with other people is also of fundamental importance. The teacher can work methodically to promote a friendly atmosphere in the classroom and strengthen students' ability to interact. There are now evaluated educational methods to help students to understand and deal effectively with their own feelings and those of others. Students can develop their ability to solve problems and conflicts. They are also given tools to help them make sensible decisions and are trained in foreseeing the consequences of various actions. It is important for young people to learn how to show solidarity, empathy and consideration and to be familiar with how to establish friendships and relationships of mutual respect. Experiences from schools that work systematically with developing the social and emotional skills of students find better school attainment, a friendlier school climate and a reduction in students' risk behaviour. The earlier such interventions are implemented, the better the results.

Education on tobacco, alcohol and other drugs
"The school principal has a particular responsibility to ensure that interdisciplinary knowledge areas are integrated into the teaching of various subjects. Knowledge about tobacco, alcohol and other drugs represents one such interdisciplinary area."
Excerpt from Sweden's compulsory school curriculum

Several surveys have indicated that education on alcohol, drugs and tobacco increases students' knowledge and awareness of risk but does not have any proven preventive effect on smoking, binge-drinking or other types of risk behaviour. Further, substance-oriented information and scaremongering methods can, in a worst-case scenario, aggravate the problems and even entice vulnerable and insecure adolescents into experimenting with such substances.

Even if education about alcohol, drugs and tobacco does not noticeably influence student behaviour, teaching about alcohol, drugs and tobacco and their role in society is a key component in a long-term and broad preventive strategy. Prevention is not just about scope in schools for conveying knowledge, but also to a high degree about how the education should be designed. The most effective form of

education is a combination of discussion, dialogue and role-play with the students about tobacco, alcohol and drugs. A particularly valid approach seems to be rectifying the misunderstanding of the majority among 12- to 13-year-old students.

Cooperation and dialogue with parents

"Schools shall provide support for families regarding their responsibility for the upbringing and development of their children. They must work together with the students' families to achieve this."

"The school principal is responsible for the school's results and has hence, within a given framework, a special responsibility for improving cooperation between the school and the home ..."

Excerpts from Sweden's compulsory school curriculum

Parents are an important, but often undervalued, resource in creating a positive and secure learning environment at school. Schools and teachers have a lot to gain from developing close cooperation with students' parents.

If the school takes the initiative to increase parents' involvement and presence, students perform better, attendance improves and there is a calmer climate in the classroom. Teachers and parents can do much to inspire children in their schoolwork.

There are successful methods of simple cooperation with parents to combat alcohol and drug problems. One method that has been successfully evaluated in reducing binge drinking and norm-breaking behaviour among adolescents is for parents in a class to agree on a restrictive approach to adolescent drinking.

Some schools have arranged courses for parents in cooperation with the social services. Research has proven that this intervention benefits students considerably. Parents meet and are given support to be able to effectively deal with various everyday parent–child conflicts. Situations and problems that are common to all families are discussed and new approaches tested.

Student health services in close cooperation with the school staff

"Schools are responsible for every student, after completing her or his compulsory schooling, possessing fundamental knowledge about the prerequisites of good health."

Excerpt from Sweden's compulsory school curriculum

The psychosocial environment in schools is crucial to the well-being of students, and it also affects the degree to which girls and boys attain established educational goals. The school health service staff members have an important role to play in the efforts to create a secure work environment in the school since they not only have close contact with the students but also have expertise on the social development and health of children and adolescents.

The school health service uses health consultation as a method. Asking open and interested questions and listening carefully and nonjudgementally is an effective way of encouraging thoughts and giving support. A discussion method that has been evaluated with positive results in many contexts is the motivational interview. This technique demands understanding and respect for adolescents' frequent insecurity and resistance and ambivalence to change. The basic structure of the dialogue is about acknowledging the student and listening actively and carefully, asking open and exploratory questions and considering and reflecting on what the students say. The method, which has been shown to be very useful, helps students to take a constructive step in the right direction regarding several health problems.

Meaningful and organized leisure activities

"Schools shall promote the harmonious development of the students."
Excerpt from Sweden's compulsory school curriculum

Several studies have shown that such problems as alcohol and drug misuse and crime increase when adolescents susceptible to risk behaviour gather in recreational environments where they just "hang out" together and have no meaningful contact with their friends. This is particularly true in economically and socially disadvantaged areas, where the students often have less access to stimulating and absorbing leisure activities.

In contrast, having the chance at an early stage to develop an inspiring interest together with close friends can act as a protective factor. Clubs and societies with the school acting as a base or cooperation partner can be a good way of working preventively.

Active work against bullying and truancy

"No one shall be subjected to bullying at school. Tendencies towards harassment shall be actively combated."
"Schools shall have a special responsibility for students who, for some reason or another, have difficulty in reaching the educational goals."
Excerpts from Sweden's compulsory school curriculum

A good school with positive expectations, warmth, care and clear knowledge requirements is particularly important for the weaker students. A fundamental task of school staff members is therefore to ensure that all students attend lessons. Truancy is a serious wake-up call and a measure not just of how the individual student feels but is also an indication of the health status of the entire school. Truancy is often an expression of students not feeling happy at school. It may also indicate a student having serious problems and hence running a greater risk of smoking or drinking excessively.

It is a challenge for schools to improve school attendance and immediately seek out any truant students. In-depth knowledge and methods of improving attendance need to be developed.

Bullying at a school is a sign that it needs to improve its working climate in general. Research shows that, to be effective, anti-bullying efforts must involve all school levels: school management, teachers, school health service staff, students and parents. Anti-bullying regulations must be well publicized and emphasized. The entire school must jointly and in no uncertain terms renounce bullying. Bullying often affects anxious and cautious students who find it difficult to assert themselves. Being subjected to insults and other types of bullying seriously damages a person's self-esteem, but students who bully also get into difficulty of various kinds. The same students who bully are often truant as well. Students who bully also have high risk of alcohol and drug misuse and crime, and identifying them at an early stage is important.

The existing evaluated methods of combating bullying have also been shown to improve the climate in the classroom, reduce risk behaviour and improve school attendance.

Work in progress on alcohol, drugs and tobacco prevention in schools

Aim of work

The aim of this work is to strengthen and vitalize the disease-preventive and health-promoting work in school and to bridge the gap between everyday work at school and the research community by promoting a research-based perspective among school staff and municipalities.

Description of the research

The project is based on a report to the government in 2002 about effective, school-based methods for preventing alcohol and drug use among young people. These methods are, however, considerably much more general and health-promoting than only focusing on preventing high-risk behaviour.
The project about informing the school community about effective methods in school-based alcohol and drug prevention started in March 2005 and will finish in December 2007.
During the first phase (March 2005–June 2006), the project focused on developing competencies and written materials, establishing cooperation with authorities and local and regional levels and initiating various measures in 11 pilot municipalities. The second phase of the project is focusing on the national dissemination of competencies and knowledge to municipal school administrations, principals and school staff and also to make available training courses in various methods for school staff.

Two evaluators are continuously monitoring the project. The methods used are mainly document analysis, scientifically based reviews, interviews and questionnaires. Indicators were selected based on scientific articles and reviews. Interviews with headmasters and staff at municipal school administrations and national questionnaires will be used for evaluating the dissemination activities.

Main findings

A national pre-survey indicates that teachers and principals are very interested in effective methods of preventing disease and promoting health. Today about half the schools seem to have measures aiming at improving their psychosocial environment. Further, about half the responding schools answered that they had some form of programme for parents aiming at preventing alcohol and drug misuse among children. Schools in the pilot municipalities have shown great interest in introducing new methods in disease-preventive and health-promoting school-based work, and many teachers have registered for training courses.

Recommendations for future health-promoting schools projects

Implementing health promotion and disease prevention measures takes time. The process of getting support for the implementation must be carefully carried out among policy-makers and decision-makers, administrators at the municipal level and school staff.

A self-evaluation tool for linking health-promoting schools with school development in Switzerland

Edith Lanfranconi

Introduction

Studies have provided evidence showing that health promotion influences the quality of a school and learning. Health promotion and improving the quality of schools therefore need to be combined. The Government of Switzerland requires all schools to work to develop their quality in accordance with a national framework aiming to ensure that all schools are both good and healthy. Three main aspects of good, healthy and effective schools have been identified, and high levels on each are assumed to lead to high well-being, high achievement and good processes:

- the health quality of school and teaching;
- the quality of school and teaching processes; and
- the quality of effects and achievements of school and teaching.

In April 2007, the networks on education and health of Switzerland, North Rhine–Westphalia and Hessen will publish a handbook for good and healthy schools by Gerold Brägger and Norbert Posse. This publication will help schools to combine school quality and health quality in a profound and professional way. The main feature of this handbook will be the presentation of a sophisticated scheme of quality dimensions:

- living space: state of health of teachers and students, learning spaces, day structures, working conditions and cooperation with external partners of health promotion;
- teaching: school programmes for health promotion and disease prevention, organization of teaching, guiding the class, accompanying the teaching and courses and programmes in health promotion;
- learning: self-regulated health learning, cooperative learning, learning with all senses, orientation towards needs and individual care;
- school climate: school community, culture of feedback, cooperation and teamwork, participation of parents and students and the school climate of health promotion;
- school leadership: educational leadership, intelligent distribution of tasks, decision-making processes, school organization and health promotion as a task of the leadership;

- staff development: specific staff development, progressive development of competencies, management of resources, recognizing quality deficits and social support and workplace health promotion;
- quality management: quality objectives, controlling the quality processes, individual feedback, evaluating school development, managing the quality of health promotion and disease prevention; and
- effects: mandate of education, competencies, success of schooling and career, satisfaction of everybody involved and health and well-being.

Each aspect identified in this scheme will be specified in greater detail by means of concrete indicators. For example, the aspect "participation of students" under "school climate" could be assessed using the following indicators.

- The teachers know how they can promote self-responsible working and participation among the students.
- Democratic structures are lived actively.
- Each class has a class council.
- School rules are developed in a participatory process with all school members.
- The school has a good reputation for participation in public.
- Participation is mentioned in the school's guidelines.

Description of school self-evaluation processes

Health-promoting schools should analyse their situation and find their own way of developing quality according to their needs. To be able to measure their success in health promotion (resolution from the First Conference of the ENHPS (1997a, b)), schools need to know their aims and be aware of appropriate indicators to determine when they have reached these aims.

Asking the schools to specify their programmes in health promotion is relevant at the national level, but it influences the school level and also has effects on the classroom level.

Since July 2005, all new schools in the Swiss Network of Health Promoting Schools were asked to give a more detailed version of their programme to become a member of the Network. From February 2006, all schools that became members of the network Education and Health Switzerland within the past two years were asked to give the same detailed information about their programme on the web site of the Swiss Network of Health Promoting Schools. The procedure for documenting the programme is described in a guide "on the way to a health-promoting school".

Schools have been asked to provide information under the following headings:
- needs for development;
- vision for the school as a health-promoting school; and
- programme for the next three years.

Table 6.15. Questions on evaluation for schools

	What do we want to change? (quality aim)	How do we see the change? (indicators)	How do we want to achieve the aims? (actions)	When and how do we measure the change? (evaluation)
Aim 1				
Aim 2				

Main findings

The 15 schools that have become members of the Swiss Network of Health Promoting Schools since July 2005 have completed the agreement in this new way. Another 10 schools described their programme in the new, more detailed way on the web site.

Many schools have difficulty in stating their objectives and in seeing the connection between school quality and health quality; they often state a number of activities but cannot say what exactly they would like to change and how they would recognize that it has changed.

However, some schools are very advanced in combining school quality and the quality of health promotion. For example, Table 6.16 shows how Schulen Utzenstorf completed the grid given above.

Table 6.16. How Schulen Utzenstorf completed Table 6.15

	What do we want to change? (quality aim)	How do we see the change? (indicators)	How do we want to achieve the aims? (actions)	When and how do we measure the change? (evaluation)
Aim 1	Participation of students and parents	Students are in decisions Parents have an official delegation	Install a school council or parents' meetings	At the end of the school year, the work of the student council will be evaluated In summer 2007 it will be clear how the parents' meetings work
Aim 2	Avoiding violence – meet conflicts and difficult situations in a constructive way	Students meet difficult situations through dialogue, perhaps with the support of a third neutral person	Peacemaker project	Monthly evaluation at the meetings of the peacemaker kids and written evaluation after two years

Source: Netzwerkschulen Schulen Utzenstorf (http://www.gesunde-schulen.ch/html/netzwerkschulen.html?ID=2891, accessed 21 November 2006).

Recommendations for future health-promoting schools projects

- Give clear instructions on what the schools are asked to do – how, when and why they should do it.
- Schools need to understand the connection between school quality and health quality.
- Give schools as much support as they need.
- Electronic messages are still not the best way of communication for everybody.

Development of a national health-promoting schools programme at the school level in Ukraine

Oleg Yeresko & Viktor Lyakh

Introduction

Ukraine became independent in 1991. Along with other newly independent countries in the region, Ukraine experienced dramatic and far-reaching political, social and economic changes. These changes have brought major transitions in many aspects of life including substantial change in financing and the provision of health care and the structure of the education and health care systems. Reform is underway in all sectors, and each one is experiencing challenges. The health sector reform is working to overcome old Soviet attitudes and practices of a curatively oriented health care system in which disease prevention and health promotion messages were delivered using approaches of blaming the victim and addressing lifestyle issues as messages to the population.

In recent years, the Government of Ukraine has recognized health promotion as a strategic priority. Several national policies and documents have been issued to facilitate the cooperation of the health and public sectors and to introduce health education to Ukraine's population in general and to young people in particular. The key concern of health care reform is therefore to strengthen the potential of education and other public sectors to start and contribute to active community-based health promotion, especially among young people. Hence, developing indicators for health-promoting schools at the national level can contribute to improving the system of primary disease prevention in Ukraine.

In 2004, Ukraine's Ministry of Education and Science of developed and approved a national health education course Basics of Health for students in grades 1–9, which is to be obligatory in all general schools. Later in 2004, a system for preparing and training teachers to deliver the course was introduced. Using the cascade model of training, the Ministry of Education and Science would like to provide schools with trained personnel. According to the Ministry, about 15% of schools have personnel prepared for delivering this particular course.
In accordance with introduction of the national course, the Ukrainian Centre for Monitoring and Evaluation of Health Education was created in February 2006. A national system of monitoring and evaluation based on agreed indicators is being developed. This is being guided by ENHPS principles and previous work on indicators.

The Centre plans to assess existing indicators and to collect the data using them soon. The set of existing indicators used before will be tested. Indicators developed within this case study will be used to strengthen the existing ones at the national level.

In accordance with the nationally recognized training course for teachers, various other organizations and projects have developed several other courses. These include: a life skills–based education course developed by Christian Children's Fund Ukraine with support from the United Nations Children's Fund (UNICEF), and the Schools against AIDS project, developed by Health through Education, supported by WHO, UNICEF and the International HIV/AIDS Alliance, Ukraine. These courses could complement the existing national course, and the schools' administrations will decide about using complementary courses available through other organizations.

The key element of the health curriculum is the nationally recognized mandatory course – Basics of Health – approved by the Ministry of Education and Science. The scope or research undertaken in this case study was conducted with the involvement of the Ministry of Education and Science. Our research concentrated on analysing existing health education courses developed and run in schools either by the Ministry of Education and Science or by other organizations with further revision by and recommendation of the Ministry.

Level of indicators

The work on developing the indicators was conducted at the school level. Given that the Ministry of Education and Science accepted the national course on health education (as a key element of the health education curriculum and a key element of health-promoting schools) as a mandatory subject for all schools in Ukraine, the study was expanded to take in the national level as well.

Aim and objectives of work

The aim of the research was to develop Ukraine-specific lists of indicators for health-promoting schools at the school level.

The objectives were:

- to revise the existing ENHPS indicators: adding, changing, commenting and excluding some if necessary;
- to check the list of indicators in the other agencies and institutions within the countries (school inspections, hygiene inspections etc.);
- to finalize the list of the indicators for health-promoting schools at the school level;

- to obtain data based on the developed indicators (added later);
- to liaise with the national coordinator on the final list; and
- to share findings between countries (June 2006).

Description of research

Table 6.17. Timetable for research activity

Year	Month	Activities	Remarks
2006	April–May	Sending the lists of indicators to the Technical Secretariat Sharing findings between countries* Finalizing the list of the indicators for health-promoting schools at the curricular level (Ukraine) and ethos (Bulgaria) at the school level Testing selected indicators at the school level using a ationwide study	
	March	The Ukrainian Centre for Monitoring and Evaluation of Health Education in general schools and other educational establishments was created. The set of the ENHPS indicators (including the indicator on curricula at the local level) was accepted as a basis for development of the national system of monitoring and evaluation of the health promotion and disease prevention activities. The Centre plans to assess the existing indicators and to collect the data using them soon. The set of developed indicators at previous stages will be tested during that time.	Testing will be organized dur-ing the national assessment
	November	Liaising with the national coordinator on the final list	Additionally – interim meeting (March 2006) of the representatives of Ukraine and a WHO expert (David Rivett) to check the interim results
	February	Development of the preliminary lists	Done; testing will be organized soon
	January	Checking the list of indicators existing in the other agencies, institutions within the countries (school inspections, hygiene inspections etc.)	Done
2005	December	Revision of the existing ENHPS indicators on the curricula(Ukraine) and ethos (Bulgaria) at the school level	Done; the set of indicators were developed on the curricular (Ukraine)

Methods

The methods included analysis of documents (such as policies, national legislation and statutory orders of the Ministry of Education and Science), observations (at the school level), interviews (with teachers and school administration staff), pre- and post-class questioning for students and consultations.

Main findings

Three main indicators related to a health-promoting school curriculum at the school level were elaborated (and informally tested in a selected number of schools):

- a national curriculum for health education, which is in accordance with health-promoting schools policies and requirements for students in grades 1–9 (including content, educational materials and illustrative materials) is in place in 27 regions by the end of 2009;
- the number of teachers trained on the accredited course who have delivered the curriculum in schools in the past nine months by the end of May 2007; and
- the number of students receiving the national curriculum by the end of May 2007 delivered by those receiving accredited training.

An additional or optional indicator is:

- the number of schools running health promotion courses by end of May 2007 that do not follow the national curriculum.

Although the national policy on health education in schools was elaborated to comply with the requirements of health-promoting schools policies, we noted during the research that there is no component on the building of supportive environments in schools for health education. Data for the additional indicator are unexpectedly high, which could be explained by the limited number of tools used for research (interviews with directors).

Recommendations for future health-promoting schools projects

The national system of monitoring and evaluation of health education needs to be improved: the set of indicators should be broadened and extended to various levels, including indicators for the local and school level. Further, the set of tools for gathering data should be improved to include participatory measures for gathering data.

Challenges for future research in health-promoting schools projects

Considering the school curricula component (and at the national level), we found that the following key issues need to be addressed:

- preparing teachers for delivering the course; and

- improving the system of preparing specialists dealing with health education in schools delivering the nationally recognized course, including the system of follow-up and hands-on support, certification, training, for self-education etc.

The Ministry of Education and Science plans to create and launch nine regional centres for monitoring of health education for 27 provinces. These centres will play a considerable role in providing data for analysing the effectiveness and of health education in schools. However, this number is not enough for the proper training, support and monitoring activities of specialists dealing with health education at the school level.

The quality of training for specialists (especially using the cascade model of training) should be ensured. While using the cascade model for preparing teachers, the Ministry of Education and Science (and other institutions that could be delivering the course) needs to ensure the system of supervision, support and further education for teachers.

National health education curriculum and connections with other subjects

The national course still has not been tested. The course will need to be changed and improved after the first round of implementation.
Various courses exist other than the nationally accredited teacher-training course. No procedure for licensing these courses exists, which means that they are not included in the national system of monitoring and evaluation.
Some elements of the nationally recognized curriculum will be revised. The sections for grades 5–7 are due for revision. The curriculum for primary school students (grades 1–4) has already been revised. Teachers and class supervisors are encouraged to integrate the curriculum into the other subjects (such as biology, literature and history) to address health issues in accordance with the existing curriculum.
The component on building supportive environments in schools should be added to both the training process for teachers and specialists and to the system of national indicators as well.

Place of health education in health promotion activities

The national curriculum Basics for Health (and other complementary courses) should be presented to and discussed with parents and the wider public.
The Ministry of Education and Science needs to establish a coordination and compatibility process for programmes run by other organizations and ministries (such as the Ministry of Health, Ministry of Family, Youth and Sport, nongovernmental organizations and international agencies).

B. Development of indicators for regional strategies and support structures

Development of a regional strategy to support health-promoting schools in the Czech Republic

Tomáš Blaha

Introduction

Two sets of health-promoting schools indicators are already available in the Czech Republic: one set for kindergartens (12 indicators) and one set for primary schools (9 indicators).

The coordinating team of the Czech Network of Health Promoting Schools developed sets of tools for self-evaluating these indicators at schools:

- INDI MS for kindergartens; and
- INDI 9 + INDI 12 for primary schools.

The results from research using these tools were presented on posters at ENHPS evaluation workshops in 2004 and 2005.

The issue chosen for this case study is the regional strategy of the Czech Network of Health Promoting Schools, as this is currently an important component in the programme of work. It has been necessary to delegate part of the coordination of the Czech Network of Health Promoting Schools from the national level to the regional level for a number of reasons.

- The Czech Network of Health Promoting Schools has approximately 200 schools, and this number will increase. The guidance and support for health promotion in so many schools cannot be effectively managed at the national level.
- Government is currently being decentralized in the Czech Republic, and many government functions have been delegated to regions, especially in the education sector.
- The development of health promotion in every school can be better supported through closer contacts between schools and strategic partners at the regional level.

There are two main directions in the regional strategy of the Czech Network of Health Promoting Schools. The coordination of networks includes:
- establishing regional networks of health-promoting schools;
- certifying new applicants for a network of health-promoting schools; and
- coordinating regional teams.

The dissemination of health-promoting schools and practical support for schools includes:
- introducing health promotion and health education in the educational programmes of every school; and
- training teachers in health promotion and health education.

The indicators that are the focus of this case study are closely connected to this regional strategy.

Indicators

The regional strategy has developed two kinds of indicators. The quantitative indicators are the numbers of: partners involved, contacts and activities and schools in the Czech Network of Health Promoting Schools. The qualitative indicators include the needs of partners in the context of every region, the satisfaction of partners within the team, the satisfaction of schools in regions with contacts and the activities of the team in every region.

The aim of these indicators is to monitor and evaluate the regional strategy process in the Czech Republic. This strategy is a part of the whole approach of the Czech Network of Health Promoting Schools and is supported by the Ministry of Health.

Aim of the work

The aim is to facilitate and support the regional strategy process in establishing 14 regional coordinating teams. This involves assessing the needs of partners involved, identifying the risks associated with the process and evaluating its effectiveness.

Description of the research

The original idea and timeline of the project was as follows.

Step 1

- Arrange meetings with the national coordinator of the Czech Network of Health Promoting Schools and strategic partners in every region to gather information and consult on the process to be adopted.

Step 2
- Develop questionnaires for regional partners and for schools in the Czech Network of Health Promoting Schools to be completed by school coordinators.
- Send the questionnaires, gather the responses and analyse the results.

Step 3
- Send preliminary case study outcomes to the ENHPS Technical Secretariat at the WHO Regional Office for Europe by May 2006.

Step 4
- Send final case study outcomes to the ENHPS Technical Secretariat by the end of 2006.

The first version of the regional strategy of the Czech Network of Health Promoting Schools was designed for direct cooperation with the education sector through education centres in every region (providing teacher training). However, the Ministry of Education, Youth and Sports eliminated these centres (delegating these competencies to regional authorities and regional councils), so another partner had to be found to take responsibility for the regional strategy for health-promoting schools: the health sector.

In pursuing this, however, several changes and problems occurred.

- Even though the grant request was accepted, there was a delay in the release of funding to the health-promoting schools programme team to realize the regional strategy and the planned project.
- The health sector (regional public health authorities and public health institutes) has the competencies to directly support schools in health promotion at the national and regional levels, whereas the education sector has competencies only at the regional level (through regional authorities – departments of education, regional councils and school inspectorates).
- The National Coordinator of the Czech Network of Health Promoting Schools had three meetings with representatives of the regional public health authorities and public health institutes at the Ministry of Health during 2005 to cooperate on developing the regional strategy.
- Work is still required to establish the regional networks of health-promoting schools and create the regional coordinating teams.

The steps in the timeline given above can be realized after regional health-promoting schools coordinating teams are created in every region and regional representatives identified.

Main findings

Ten regional health-promoting schools networks have been established of the planned 14. The analysis of needs produced the following findings.
Regional partners need from the coordinating team of the Czech Network of Health Promoting Schools:

- a clear outline of the regional health-promoting schools strategy; and
- a specific statement on the roles and objectives of every partner institute involved.

Health-promoting schools counsellors need from the coordinating team of the Czech Network of Health Promoting Schools:

- experiences from other regions;
- greater involvement by the Ministry of Education and regional authorities (departments of education); and
- publicity for the health-promoting schools programme

The success of the whole regional strategy mainly depends on specific individuals and their motivation. We also faced some obstacles in accomplishing the planned schedule from institutions that had to sign key letters and individuals, since the health-promoting schools counsellors are very busy volunteers.

There have also been challenges in motivation. Institutions (the Ministry of Education, Youth and Sports and the regional authorities (departments of education)) still have little motivation to support the regional health-promoting schools strategy. Further, there are some unclear matters in competencies between the staff of regional public health authorities and public health institutes.

Recommendations for future health-promoting schools projects

It seems to be necessary to find the proper motivation for those involved and to give more publicity to the health-promoting schools programme to both professionals and the wider non-professional public.

It is also necessary to find more sources of funding and not rely on only one (although it was approved several months ago).

Challenges for future research in health-promoting schools projects

The regional health-promoting schools strategy is still being developed, and satisfactory progress may be achieved soon.

Research on the regional implementation of health-promoting schools in the Netherlands

Christine Hekkink, Goof Buijs & Zeina Dafesh

Introduction

Regional public health services play a key role in developing the national health-promoting schools strategy in the Netherlands. The Netherlands currently (2006) has 36 regional public health service divisions. Each regional public health service division has a department of youth health care and a department of health promotion that facilitate the development and implementation of health promotion programmes. For the youth target group (4–18 years), there is particular emphasis on school-based programmes. Evidence supports the focus on school settings in accessing this target group (Buijs & Busch, 2005).

The regional public health service divisions play a role in coordinating school health policy in their region, preferably in close collaboration with other regional organizations that are supporting schools in health and care. The regional public health service divisions offer support to schools to help implement school health policy. However, it is not known how these regional public health service divisions work to support health promotion in schools, hence the current project.

Aim of the work

The aim of the research is to give insight into the approaches that regional public health service divisions in the Netherlands use to help schools take steps towards promoting better health and well-being. Attention is given, in particular, to provision of information, resources and advice on evaluation.

Issues for research

The health-promoting schools approach in the Netherlands is based upon the resolution from the First Conference of the ENHPS (1997a, b). The indicators have a direct link to the Egmond Agenda (International Planning Committee, 2002) focusing on partnership, long-term planning and evaluation.

The issues focused on here operate on a regional level. In undertaking the study, we were guided by three elements of the health-promoting schools method in the Netherlands (Buijs, 2005). First, we were interested in the extent to which regional public health service divisions adopted a demand-oriented approach in supporting health-promoting schools.

Demand-oriented approach

The strategy of the regional public health service divisions for supporting schools includes:

- theme-oriented versus demand-oriented approach;
- incidental versus structural support;
- isolated versus comprehensive activities;
- incidental versus planned research data;

The factors that influence the strategy used by public health service divisions are:

- local or municipal policy; and
- demands from schools.

The factors that describe how the public health service divisions have organized the school support include:

- the internal work plan of public health service divisions; and
- systematic evaluation of school support: within public health service divisions and in schools

Communication with schools comprises:

- letters and personal contact;
- web sites;
- an information centre for schools; and
- a regional (digital) newsletter.

Secondly, we wished to assess the extent to which regional health-promoting schools involved themselves in six steps for school policy development with respect to health promotion.

Six steps for school policy development

- defining the health needs: for example, the number of public health service divisions that identify the school's specific health needs, number of public health service divisions making reports on the school's specific health needs, sources of information used describe health situation in schools such as: epidemiological data on students' health behaviour or screening data, absenteeism data and truancy, quick scan on health promotion and care, occupational health data and academic achievements;

- defining the priorities of the school: for example, the number of public health service divisions consulting schools for setting priorities, the number of schools that receive consultancy by public health service divisions on setting priorities, strategies used for setting priorities (such as meeting with the school team, discussing research results on school health or using a SchoolBeat priority workshop);
- defining the activities and strategies: for example, the number of schools that receive support deciding on activities and strategies, methods used to select activities and strategies (such as own research data, overview of regional or national programmes, web sites, healthy school model in the Netherlands and the results of the SchoolBeat quality checklist);
- establishing a school health plan: for example, the number of public health service divisions supporting schools in establishing a school health plan or public health service divisions playing a consulting role or coordinating role);
- carrying out the plan: for example, public health service divisions taking an active role in carrying out the plan and ways public health service divisions support schools (such as giving lessons, training, providing teaching materials and regular meetings); and
- evaluating the plan and its implementation in the school policy: for example, registering health-promoting school activities (such as health issues, use of materials, education, electronic school file and work plan or annual report), process evaluation and effect evaluation.

Thirdly, we wished to gather evidence on the extent to which regional health-promoting schools were involved in collaboration with local, regional and national organizations involved in health promotion.

Level of local or regional collaboration

Examples include describing collaboration with local or regional organizations, level of collaboration (none, incidental, regular meeting, joint activities and policy agreements), creating a regional network and (level of) collaboration with national organizations.

Methods

This study used a questionnaire on health-promoting schools. This will serve as a monitor for the Ministry of Health, Welfare and Sport and national institutions in the Netherlands to achieve a current view of how the regional public health service divisions contribute to health promotion in schools. The scan could be carried out every four years, to monitor progress at the regional level in relation to health promotion in schools.

The questionnaire was sent to the heads of the departments of health promotion and youth health care of all the 39 regional public health service divisions (in 2005) in the Netherlands.

- The research studied the three dimensions of the health-promoting school method in the Netherlands. The basis for the questionnaire was the demand-oriented approach, the six-step plan for health-promoting schools (Buijs, 2005) and the level of local and regional collaboration. The six-step plan (outlined above) is a systematic method to work towards health promotion in schools. The regional public health service divisions could play a vital role in supporting schools in these steps.

Other aspects that are included in the questionnaire are: expertise and staff of the regional public health service divisions. Also, questions on background information of the public health service divisions were included, such as the number of schools and students in the region and how support provided for health promotion in schools is embedded in their organization.

Main findings

Response

The questionnaire was sent out in October 2005. Thirty-two of the 39 public health service divisions (85%) participated in the study. Ten of the participating public health service divisions are members of the Healthy School Network. Seven public health service divisions did not participate in this research. The reasons for this were: lack of time, questionnaire was difficult to fill in, unclear significance of the study and reorganization of the public health service divisions.

Embedding the support of the schools in the regional public health service divisions

Most regional public health service divisions (78%) have embedded support for schools in their departments of health promotion as well as youth health care. More than half the regional public health service divisions have established a project group within their organization focusing on health promotion in schools. Most of the public health service divisions (91%) offered extra training for their employees in health promotion in schools. Further, the public health service divisions have different functions (for example, an epidemiologist and school doctor) working in health promotion in schools.

Approach of the public health service divisions to promoting health in schools

Approximately 40% of the regional public health service divisions define their strategy according to a demand-oriented approach and support schools in a structural way. Moreover, 70% of the public health service divisions make use of systematic research data and incorporate integrated activities in relation to health promotion in schools. Only 44% of the public health service divisions have an annual action plan (including hours, budget and activities) for health promotion in schools. Further, only 38% of the public health service divisions systematically evaluate their approach in relation to health promotion in schools. The five health issues to which the public health service divisions had paid the most attention during the past year in primary schools were: obesity, healthy nutrition, sports and physical exercise, dental care and bullying. The public health service divisions paid most attention to the following five health issues in secondary schools: sexuality and relationships, smoking, alcohol, drugs and obesity.

Local public health policy and demands from schools have the most influence on the choices public health service divisions make on the health issues addressed in schools.

Role of the regional public health service divisions in supporting schools on health promotion

Steps 1–3: defining the health needs, priorities, activities and strategies of the school

The public health service divisions mostly support schools in defining their health needs and report these back to the school (step 1). This is especially the case for secondary schools. The public health service divisions also support schools in establishing the priorities and focusing on health issues (step 2). Again, this happens more for secondary schools than primary schools. The public health service divisions offer less support to schools in choosing the activities and strategies for implementation in the school (step 3).

Step 4: establishing a school health plan

Table 6.18. Role of the regional public health service divisions in step 4 – establishing a school health plan (n = 32)

	Primary school		Secondary school	
	Yes	No	Yes	No
Involved in establishing a health plan	59%	41%	69%	31%
Advisory role	47%	53%	50%	50%
Supervisory role in establishing a health plan	9%	91%	3%	97%
Advice or support depends on the school's culture	9%	91%	31%	69%

Most public health service divisions play an advisory and supportive role rather than a supervisory role in establishing school health plans.

Step 5: carrying out the plan
More than half the public health service divisions support schools in implementing their activities and strategies for health promotion.

Step 6: evaluating the plan and implementing it in the school policy
More than 70% of the public health service divisions have been involved in evaluating health promotion activities in schools (75% in primary school and 72% in secondary school).

Table 6.19. Role of the regional public health service divisions in step 6 – evaluation of health promotion programmes by the regional public health service divisions

	Primary schools					Secondary schools				
	Never (1)	Occasionally (2)	Sometimes (3)	Mostly (4)	Always (5)	Never (1)	Occasionally (2)	Sometimes (3)	Mostly (4)	Always (5)
Process evaluation	9%	16%	19%	38%	19%	9%	25%	22%	28%	16%
Effect evaluation	29%	29%	26%	16%	0%	35%	35%	21%	7%	3%

Process evaluation has been conducted for more than half the health programmes in primary schools and for almost half the programmes in secondary schools. However, almost 30% of the public health service divisions had never performed an effect evaluation for primary school health programmes and 35% had never performed an effect evaluation for secondary school health programmes.

Communication with schools
The regional public health service divisions mostly use letters, personal contact and their web site as tools to communicate with schools.

The public health service divisions intend to use a digital regional health-promoting school newsletter (schoolSlag nieuwsbrief) as a vehicle for communication in the near future.

Cooperation with other organizations
Most of the regional public health service divisions cooperate with regional rganizations, mainly with respect to policy agreements and implementing activities. At the regional level, the public health service divisions mostly cooperate with municipal authorities, institutions for addiction care, youth care authorities, local sports authorities and mental health care authorities. Three quarters of the public health service divisions have established a regional network with one or more of the cooperating institutions. There are hardly any policy agreements between the public health service divisions and national organizations concerning health promotion in schools. Cooperation with national organizations is mostly incidental.

Conclusions
Most regional public health service divisions are beginning to use a more demand-oriented, integrated and structural approach to support schools in health promotion and care. This creates a promising base to further disseminate and implement the national healthy school method in the Netherlands. Regional public health service divisions mainly support schools in steps 1 and 6 of the six-step plan for health-promoting schools: defining the health needs and process evaluation.

Municipal policy and demands from schools have the most influence on the choices of the health issues addressed in schools.

Most of the public health service divisions play an advisory role in establishing the school health plan.

More than half of the public health service divisions support schools in implementing healthy school programmes.

The response rate of the regional public health service divisions was 85%. This shows that public health service divisions are clearly committed to the health-promoting schools method in the Netherlands.

The support to schools is embedded in the policy of the regional public health service divisions, but in more than half this was not systematic. Interestingly, one quarter of the public health service divisions are intending to use the tools and instruments that have been developed as part of the health-promoting schools method in the Netherlands.

Recommendations for future health-promoting schools projects

The regional questionnaire will be used as a baseline measurement (benchmark) for the dissemination of the health-promoting schools method in the Netherlands. Based on the outcomes of the regional questionnaire, further developments in national policy for health-promoting schools can be clearly defined. It is also recommended that a regional survey be carried out at least every four years.

Challenges for future research

Challenges for future research include:

- including in the questionnaire requests for information from public health service divisions about successes and perceived barriers in working more collaboratively across all the six steps for developing school health promotion; and
- including questions about the successes and challenges in collaboration between local and regional organizations.

C. Using indicators at the school and classroom levels

Method for developing and assessing indicators for students' participation: an example from Denmark

Jeanette Magne Jensen

Aim of work and links to basic health-promoting schools values
The project focuses on indicators of students' participation and ownership of school health promotion.

In Denmark the health-promoting schools approach has been focusing on participation and ownership as crucial elements in strengthening children's engagement in health issues and the development of children's competence to take action for the promotion of their own health and that of others. This study explored how to define and support elements of participation in school health promotion, since participation has been proven to be a difficult concept (a) to integrate in teaching and education at the school level and (b) to evaluate because sustainable and controllable indicators are lacking.

The indicators presented are relevant at the classroom level.
The aims of the project are:

- to develop indicators of students' participation that are congruent with the health-promoting schools approach; and
- to describe appropriate methods for assessing these indicators.

The project is working with the following research questions.

- In which ways can students' participation be put into operation in the form of indicators?
- How do students understand participation?
- How does students' participation affect the classroom and school?
- How is participation correlated with students' learning?

The indicators of participation are being developed and discussed based on a development project in two regions of Denmark embracing seven different primary schools involving 14 different classes in grades 4–8. This project is aiming

at developing new methods of teaching to involve students and create students' ownership of school health promotion. The aim of the development project is to encourage teachers to work with students' participation on the topics of food and culture and physical activity in various school-based projects. One of the challenges is to link students' participation to the specific content of the two topics and thereby to strengthen students' learning by participation.

Networks across schools among teachers and students have been established and are used as a unique approach to assure elements of participation in the school-based projects. The aims of the networks are a) to create space for teachers to discuss how to integrate students' participation and action in class and b) to allow students to exchange experiences from the projects in school. Educational consultants facilitate the networks.

The evaluation of the development project will:

- clarify the conditions for students' participation in class and their ownership of school health promotion; and
- develop indicators that can be used in evaluating future projects within health-promoting schools projects.

Description of research methods

The author is conducting the evaluation in cooperation with the National Coordinator of the Danish Network of Health Promoting Schools, four educational consultants and a representative of Denmark's Ministry of Education.

We collected data during spring 2006. The data are now being analysed and will be published in an evaluation report. Based on the evaluation, a resource book will be prepared aimed at inspiring teachers to use methods in teaching that emphasize elements of participation.

The methods in the project comprise a mix of observations, focus-group interviews, individual interviews and document analysis.

- Observations in students' networks: what is crucial for students' engagements in the networks?
- Observations in teachers' networks: which questions concerning the work in class are crucial for teachers to discuss with each other and the consultants?
- Focus-group interviews with six students: how have the students experienced their own participation in the development project? How do students consider participation important for their involvement and ownership?

- Focus-group interviews with 6–8 teachers: how have the teachers experienced working with students' participation in class? Is students' participation important for strengthening students' learning?
- Focus-group interview with educational consultants: what do the consultants consider crucial for integrating students' participation in class? What are the major obstacles to students' participating in class?
- Teachers are preparing diaries to describe the different projects carried out within the development project, and they are being read to understand teachers' reflections.

This case study primarily draws on observations of collaboration between teachers and students in the schools involved as well as focus-group interviews with students.

Students' views on participation

Participation is an important prerequisite for students' ownership of school health promotion. A few examples of quotations from the interviews with students illustrate this fact:

When you participate and are able to decide how to work in class, you have to think in another way than when the teachers tell you what to do. You have to use your brain more, and this is much more fun than listening to the teacher. [boy, 6th grade]

You learn a lot more from deciding yourself how to work and what to work with. When the teacher stands at the blackboard and tells you stuff, you pay no attention after 5 minutes because it is tiresome. When you have decided yourself what to work with then it is fun to work in school – you are much more part of it. [girl, 7th grade]

It is okay that the teachers decide that we will work with health, but we should decide for ourselves which health topics we want to work with. This makes schoolwork much more pleasant and interesting. It is a very nice feeling when you are able to express how you think and feel instead of just listening to the teacher. And in a way you learn more from deciding yourself because you feel more responsible for the work. [girl, 5th grade]

Indicators of participation

The study demonstrates that participation is a complex concept that different teachers often interpret differently. It also shows that participation is not only one thing – in fact it can be practised in many ways. Participation therefore needs

to be thought about in more operational and sophisticated ways. Based on the empirical data, it seems reasonable to view participation as consisting of at least three different categories or versions:

- students' own initiatives (taking action);
- students' demonstrating influence within a framework (taking part); and
- students' commitment (showing motivation).

Initiatives

Students take initiatives when they take action to change the conditions of teaching, the school environment, the conditions in class or the conditions in their family. Thus, initiatives comprise action independent of encouragement by the teacher – students do something of their own accord.

Examples of students' initiatives include:

- suggesting changing the topic of teaching or learning;
- advocating for changing the conditions in the class or school;
- approaching other people in the school or community (such as interviewing); and
- propose new methods of learning or teaching.

Influence

When students demonstrate influence in their class or school, the teacher has often provided some space in the class for students' participation. The teacher has invited or encouraged the students to participate actively and raise their voices on various matters related to classwork. Creating space for participation differs from initiatives, in which students independently contribute in class without having been encouraged or asked to do so.

Examples of students' influence include:

- choosing the health topic for learning from a range of possibilities given by the teacher;
- influencing aspects of a topic chosen by the teacher;
- influencing with whom, where and when to work in dialogue with the teacher;
- participating in teacher-facilitated reflection and discussion in class; and
- expressing personal opinions and experiences in class.

Commitment
Students' commitment is strongly linked to students' ownership of and dedication to health promotion projects in the class or school. This case study shows a strong relationship between students' experience of participation in class and their devotion to school work.

Examples of students' commitment include:

- using time after school for project work;
- demonstrating that they are highly motivated;
- telling family or friends about project; and
- remembering the work or project after a certain period of time.

Since the study of indicators is ongoing, the set of indicators might still be expanded and modified. The indicators have been developed in schools in Denmark and are therefore probably useful in similar cultural and educational settings. Studies in countries in which participatory teaching methods are either more or less developed than in Denmark might very well produce different and additional indicators of participation.

The study clearly shows that participation should not be understood as solely a bottom-up process in which students decide everything in class and the teachers have a passive role. The case study shows that participation can take place even though the teacher is in charge and has a say in the process. But the teacher needs to create room for students' influence for genuine participation.

How can the indicators be measured?

Table 6.20 illustrates various methods for evaluating or capturing the indicators of participation in health-promoting schools projects.

Table 6.20. A system of signs or indicators and methods

Participation: outcomes	Indicators: signs to look for	Methods
Initiatives on their own	• Approaching other people (such as interviews) • Proposing new ways of learning or teaching • Suggesting changing the topic of teaching • Suggesting changing the way of working in class • Advocating for changing the conditions in the class or school	• Observations • Focus-group discussions (teachers and students) • In-depth interviews (teachers and students) • Questionnaire (teachers and students)
Influence within a framework	• Participating in reflection and discussion in class • Expressing personal opinions in class • Deciding how to work with health • Deciding the health topic to work with • Influencing different aspects of a given topic • Deciding and choosing with whom, where and when to work	• Observations • Focus-group discussions (teachers and students) • In-depth interviews (teachers and students) • Document analysis
Commitment	• Using time after school for project work • Having a strong sense of motivation • Telling family or friends about the project • Remembering the work or project	• Observations • Focus-group discussions (teachers and students) • In-depth interviews (teachers and students) • Document analysis

In an evaluation of participation, using triangulation and combining methods to capture the different indicators or signs of participation is useful. This case study showed that qualitative methods such as interviews and observation work very well in depicting and describing signs of participation in class. Consequently, questionnaires should not be the dominant instrument of measurement let alone the only one.

Nevertheless, questionnaires might provide valuable and additional information after qualitative methods are used to describe the indicators of participation (in class). These methods will provide the evaluator with cultural and contextually

embedded signs that are needed for developing a questionnaire that is suitable for the target group in question. This is important to keep in mind since participation is manifested differently in different cultural settings.

Other findings from the study

- Students' participation plays a crucial role in their ownership of school health promotion.
- Students say that they are much more engaged in school health promotion and teaching if they are allowed to influence and affect decisions in class.
- Students can be very innovative in pointing out pathways to health if they are allowed to go beyond the more individualistic and behaviouristic model towards living conditions and the environment.
- Students are very keen on discussing health matters with their peers and learning from each other. The eagerness to discuss is viewed as an element of ownership.
- Sustaining students' participation in their work with children is challenging for teachers.
- Teacher networks seem to be a very effective method of strengthening teachers' focus on students' participation in class.
- The ethos of a health-promoting school should be part of the curriculum in teacher training and education since this could strengthen teachers' understanding of student's participation in class.
- Support from school management and teacher colleagues is viewed as crucial for sustaining participation-oriented techniques in the classroom.

Challenges for future research in health-promoting schools projects

The following questions are important for future research:

- How can teachers be supported in using and sustaining participation-oriented techniques in the classroom?
- How can the ethos (such as participation, ownership and action competence) of health-promoting schools become part of the school setting?
- How can the wider community outside the school recognize and acknowledge the need for participation-oriented teaching in school and support these methods in school?

Research on using health-promoting schools indicators on a school level in Finland

Kerttu Tossavainen & Hannele Turunen

Background for developing indicators in the Finnish Network of Health Promoting Schools

As part of the ENHPS, the Finnish Network of Health Promoting Schools has carried out a quantitative follow-up study every three years since 1997 to evaluate goal attainment and the possible changes in health promotion practices in the schools in the Finnish Network of Health Promoting Schools. The indicators that have been measured in the follow-up evaluation based on the model for health promotion in the school community of the Finnish Network of Health Promoting Schools are:

- general infrastructure;
- clarification of the mission;
- active participation;
- curriculum development, planning and evaluation skills; and
- implementation and networking.

The indicator on the general infrastructure consists of subindicators such as a healthy, safe and secure teaching and learning environment. These include physical and mental safety and security during lessons and breaks. For example, healthy nutrition, opportunities for physical education and adequate health services should be available.

The indicator on clarification of the mission of health promotion includes subindicators related to joint discussions about the values, attitudes, commitment and resources related to health promotion.

The indicator on participants' active and collaborative participation comprises subindicators such as in-service training for staff and the use of collaborative methods and learning strategies and networking.

The indicator related to the development of curriculum planning and evaluation skills recognizes that if the school community considers health an important issue, it should also be visible at the curricular level. This requires systematic planning and collaboration between several fields of health promotion actors. Thereafter, the aims of health promotion and networking can be expected to be implemented in order to share experiences.

Selection of indicators

In Finland, a complete set of indicators has been developed for the Finnish Network of Health Promoting Schools (Box 6.2). The indicators have been selected for evaluating health promotion of schools in the Finnish Network of Health Promoting Schools at the school level and at the individual level.

Box 6.2. Overview of health-promoting schools indicators in Finland

International level

Key area: dissemination

- Health-promoting schools is on the agenda of supranational organizations
- Support from the Technical Secretariat to national coordinators
- Number of publications and conferences
- Expert meetings convened and output

Key area: structures

- Technical Secretariat provides relevant information
- Members regard ENHPS as a successful project
- Countries maintain commitment to ENHPS membership
- Technical Secretariat functions in a participatory, democratic, empowering and consultative way

Key area: impact

- Impact on policies at the European level and national programmes

National level

Key area: dissemination

- Dissemination of the ENHPS concept
- Collaboration between health and education ministries
- Health-promoting schools integrated into strategic planning
- Records of regular meetings and contacts
- Annual meeting for school coordinators organized by the national coordinator and steering group
- Dissemination of methods of good practices reported by school coordinators
- Support of the national coordinator for school coordinators in the evaluation process

Key area: structures
- Meetings at the national and regional levels

Key area: impact
- Schools offer children the opportunity to attend a health-promoting school
- Influence of the ENHPS is visible in the school curriculum (national and local)
- Schools increase time and resources for health education
- Health education is supported by legislation in the curriculum
- The health-promoting schools concept is included in teacher training and in-service courses
- Participants perceive the training as useful and of high quality
- The core values and principles of the health-promoting schools are evident in both the initial teacher training institution and in-service training

School level

Key area: dissemination
- Staff members are involved actively in implementing the health-promoting schools concept according to the objectives and content of the compulsory national curriculum
- Students are involved actively in implementing the health-promoting schools concept according to the objectives and content of the compulsory national curriculum
- Parents are involved actively in implementing the health-promoting schools concept according to the objectives and content of the compulsory national curriculum
- Local community agencies (school health care, youth work, sports, police etc.) are involved actively in implementing the health-promoting schools concept according to the objectives and content of the compulsory national curriculum

Key area: structures
- The policy on health education is visible in the curriculum
- Relevant policies exist on aspects of ethos and environment, such as school meals, safety, bullying, nonsmoking school policy and health education

Key area: impact
- The curriculum covers a wide range of topics related to health-promoting schools objectives
- Teachers use active or experiential learning methods
- Students, teachers and parents respect health and health education
- Positive relationships between students, and staff and students are observed in practice

Individual level

Staff
- Occupational health and well-being of staff are organized and supported systematically

Students
- The school is a nice place for students
- Students report and demonstrate action competencies including value clarification, goal settings, decision-making, communication skills, self-esteem and stress management

Families and community
- Members of the school and student welfare services and families collaborate according to the principles of the basics of the national as well as the school curriculum
- Members of the school health care services act according to the national recommendations of school health quality and act as a visible partner for students and the school community and parents
- Schools and agencies of local communities collaborate according to the joint objectives

Aims of the work

This case study focuses on describing the format of the quantitative follow-up study and some main results of one three-year study period.

The aim of the study was to investigate teachers' assessment of the achievement of and possible changes in health promotion practices between the beginning and the end of the three-year period during which the participating schools belonged to the Finnish Network of Health Promoting Schools. The purpose was to establish the level at which the schools in the Finnish Network of Health

Promoting Schools promote health in relation to the specific indicators. The specific objectives were to determine how the general infrastructure, clarification of mission, active participation, curriculum development, evaluation skills, implementation and networking related to health promotion are achieved in the schools in the Finnish Network of Health Promoting Schools and the possible changes that occurred during the three-year period.

Data and methods

For the evaluation of the schools in the Finnish Network of Health Promoting Schools, a questionnaire was formulated based on the model for health promotion of the Finnish Network of Health Promoting Schools. The model was developed using knowledge of health promotion in the school community, health policies concerning schools and more general knowledge concerning society. The data were gathered from 24 teachers who acted as coordinators at the school level and responded both at the beginning and at the end of the three-year period.

Main findings

The teachers who also worked as health-promoting schools coordinators at the school level assessed that many issues related to health promotion had been attained well in the participating schools. However, more detailed examination revealed evident developmental tasks for health promotion, especially from the viewpoint of the participation of the whole school. The results concerning the infrastructure for health promotion indicated that the safety of the learning and working environment was emphasized more, including lessons and breaks.

The teachers assessed the issues related to clarifying the mission to have been positive overall, but negative changes had also taken place. Discussion of the values related to the health-promoting schools programme was more positive at the end of the three-year period. However, some unexpected results appeared. Negative changes emerged in the attitudes of other school staff members towards the health-promoting schools programme, the school community's support for participation in the health-promoting schools programme and discussion of the school's own aims related to the health-promoting schools programme. The reason for the "unsatisfactory change" in the clarification of the mission may be that the participants of this study were coordinator teachers, who had begun to understand the meaning of the concept of health-promoting schools more deeply and critically and were hence not satisfied with the prevailing practices in their schools. Additionally, this might also reflect the situation prevailing in the participating schools: at the beginning of the project many people may be keen on the idea of creating a health-promoting school, but as the project progresses,

less interest and commitment may be shown.
The teachers reported improvement in the use of participatory teaching and learning methods in the schools in the Finnish Network of Health Promoting Schools. This is a favourable development in line with the principles of the health-promoting schools programme as well as modern teaching and learning approaches. However, only 54% of the teachers said both at the beginning and at the end of the three-year period that students participate actively in health-promoting activities. The same number of teachers felt that health promotion is part of every teacher's teaching. Health promotion as whole-school participatory action should clearly be developed further.

The results show the need for ongoing efforts to support health promotion within the school community, given that the staff developed some negative attitudes towards it. Some teachers may have been unsure of their competence related to health promotion. On the other hand, one can consider very positive the more critical attitude towards health promotion that the coordinators had at the school level at the end of the follow-up period. Coordinators probably became more aware of the challenges of health promotion in the community and the competencies needed.

Recommendations for future health-promoting schools projects
Based on our experiences of the schools in the Finnish Network of Health Promoting Schools and on our research results, we have recommendations. Achieving, maintaining and improving a healthy school action culture requires a well-maintained healthy school policy and whole-school action plan as well as concrete strategies to achieve the objectives of the plan. The action plan should be developed collaboratively with the staff, maintaining a clear connection to the healthy school standards at the national level. Healthy school action should be a part of the school quality management system with its specific indicators. Our experience as educators in national training programmes for health promotion for comprehensive schoolteachers shows that educating teachers about both the contents of the health curriculum and the use of effective methods in teaching health knowledge to children and young people is essential.

Additionally, at the national level a national coordinator is needed who supports and helps healthy schools and maintains the national network. Correspondingly, an international network continues to be needed for sharing experiences, knowledge and support between national actors. Further, academic evaluative research to assess the progress of health promotion in schools and the issues included in it is fundamental to find evidence and to disseminate best practices for health promotion work at schools.

Challenges for future research in health-promoting schools projects

Funding to implement follow-up studies by academic research staff is absolutely necessary to establish research findings and possible changes that emerge during a longer time period and thus produce an evidence-based knowledge basis for health promotion in schools. These evidence-based findings are needed to influence political decision-making, such as developing the national curriculum. In Finland the specific topics for further research could be:

- how the schools are supported in planning their own health and welfare policy;
- how the competence related to health promotion in the schools in the Finnish Network of Health Promoting Schools will be disseminated to other schools in Finland; and
- how collaboration with the schools in the Finnish Network of Health Promoting Schools and organizations will be improved to foster health and well-being in the school communities.

2. Monitor the behaviour (frequency, context and intensity) to find the best way to change the behaviour. Methods: observation and a questionnaire for children and parents. Sometimes, only monitoring is required for improving behaviour.
3. Analyse and evaluate the actions taken.
4. Create and apply the programme for behaviour change with appropriate rewards, sanctions and modelling.

Methods and activities used to implement the strategies
Many methods and activities were used in implementing the intervention.

1. Establish rules in the classrooms – the children proposed, debated and accepted rules. Respecting or not respecting the rules resulted in receiving either a white or black ball. Three black balls means 1 point minus at conduct, 1 white ball cancels 1 black, and for 3 white balls a student receives a reward.
2. Classroom's mirror – a book with teacher's notes about students' behaviour during the class.
3. The secret friend contest – by drawing lots, everyone becomes a secret friend for another child in the class. The secret friend must care for their protégé, without her or him realizing who the guardian angel is. It is a good contest that promotes kindness, generosity, discretion and modesty.
4. Playing part – someone describes a situation and stops the story at an interesting point. Every child receives a part and continues the play according to his or her feelings, customs, etc. Discussions are focused on finding positive solutions for the debated problem.

Methods used to monitor and assess the intervention
Observation – teachers, parents and colleagues register students' behaviour, attitudes and values and provide information for monitoring behaviour.
A questionnaire was formulated together with the school's psychologist (counsellor). The questionnaire was useful to assess students' own views of their aggression levels and for an indication of how the students manage their aggression. The questionnaire was completed by all children and was processed with the aid of statistical diagrams.

Main findings
As a result of the interventions, the behaviour problems became less frequent and less serious, but there is a long way to go before such problems disappear entirely. Children had more of a feeling of active participation in school life, in cooperation with other children.

However, the study had some limitations. The other teachers in the school did not participate as much in the activities as I would have liked (maybe because one of them is temporary in our school). The parents were also less involved than I had hoped for.

Two surprising results from the intervention are worth recording. In collaboration with the children, class rules were established and rewards and sanctions adopted (that is, the use of black or white balls). The surprise was when some students came and demanded a black ball for their mistakes. They learned to assume responsibility for their actions.
Another pleasant surprise was when a girl from the class ran away from school, because her father beat her for getting a poor grade. The whole class mobilized to help the police find her, which was surprising because the girl did not have any friends in our class.

Recommendations for future health-promoting schools projects
Involving teachers, parents, students and others in the evaluation process is important. Further, involving many health professionals and parents in all activities is important.

D. Involving teachers and students in developing indicators

Method for developing health-promoting schools indicators at the school level: an example from Cyprus[1]

Soula Ioannou & Olga Kalakouta

Introduction

This case study proposes a participatory and collaborative method of identifying and agreeing on key areas of impact and associated indicators of the ENHPS with a multidisciplinary and intersectoral working group. The use of participatory, collaborative and creative methods are in line with the principles that underlie the Egmond Agenda (International Planning Committee, 2002) and the resolution from the First Conference of the ENHPS (1997a, b), which focus on partnership, democratic practices and participation.

The study presents a set of key impact areas and related possible indicators of the role of ENHPS on students, educators, school and community and parents.

The working group agreed on various indicators for each key impact area of ENHPS for students, educators, community and parents and school. These indicators of effectiveness require combining qualitative and quantitative research tools. Quantitative measurements allow for useful comparisons, and qualitative information offers an understanding of the impact of the ENHPS.

The process followed in this study can be applied to all levels of the ENHPS (classroom, school, regional, national and international). The process suggested in this study can be seen as a valuable method that can lead to identification of and agreement on key impact areas among and across many possible working groups.

[1] *The group of people working on this indicators project included Tasoula Hoplarou, Socratis Ktistis, Eftychia Parla, Loukia Kouta, Christiana Menikou, Andri Loizidou, Panagiotis Pittakas, Panagiota Neophytou, Yiola Demetriadou, Elpida Mala, Agni Stylianou and Amalia Evripidou.*

Indicators

This report presents a workshop in Cyprus on the development of key areas of

impact and associated indicators related to the ENHPS. The participants of the workshop (nine teachers and three staff members of school health services) arrived collaboratively at key impact areas of the ENHPS on students, educators, schools and community and parents and suggested corresponding indicators. In the future, the development of a research tool is planned that can gather data related to the suggested key impact areas.

The Cypriotic Network of Health Promoting Schools promotes active participation, collaboration and creative methods in the process of organizing and implementing health-promoting activities in schools. In parallel, this study used team self-review as a method to provide a group of teachers and health workers the opportunity to reflect, collaborate and creatively arrive at some conclusions constructively regarding the ENHPS.

This report presents key impact areas of the ENHPS on students, educators, schools and community and parents and corresponding indicators as developed by a group of teachers and health workers. Tables 6.21–6.24 relate mainly to the individual, classroom and school levels.

Table 6.21. Impact of the ENHPS on students and the indicators developed

No.	Key area: impact	Indicators
1.	Students' understanding of health as a holistic concept	• Number of school activities that promote the holistic understanding of health • Activities reported by the students as protecting health
2.	Students' self-awareness and promotion of their self-esteem	• Number and type of opportunities provided in school life for activities to raise self-esteem • Proportion of students reporting participating actively in school life • Opinions of teachers and parents regarding the self-esteem of the students during their participation in the health-promoting school programme
3.	Relationships between students and between staff and students	• Observation of positive relationships between students and between staff and students • Reported satisfaction in school life • Incidence of reported bullying • Incidence of isolated students (those who cannot participate in schooling relationships)
4.	Participation of students in the decision-making process and programme implementation	• Number of school activities in which students participate in the decision-making processes and their implementation • Number of school activities students initiated • Degree of knowledge of the aim and the processes of the programme
5.	Dissemination of health concepts and attitudes related to the health-promoting school	• Number of contacts (announcements and meetings) with families and the community • Number and type of activities that actively involve parents and other agencies of the community
6.	Satisfaction from participation in the ENHPS	• Proportion of students reporting and demonstrating satisfaction from the programme • Proportion of students who participate voluntarily in ENHPS activities

Table 6.22. Impact of the ENHPS on teachers and the indicators developed

No.	Key area: impact	Indicators
1.	Teaching using active methods of learning	• The reports of teachers relating how and to what degree the ENHPS supports their teaching methods • Proportion of teachers using active learning methods
2.	Attitudes and beliefs of the educators regarding health education and health promotion	• Number and type of activities that contribute to the motivation of teachers on health topics • Self-evaluation of teachers concerning the development of their relationship with health education
3.	Networking between collaborating agents (parents, community and nongovernmental organizations)	• Frequency and type of positive contacts between families, community and schools • Number of complaints • Participation in extracurricular activities • Implementation of shared activities
4.	Stimulation for further action regarding health promotion at the school level	• Number and type of activities stimulated and implemented by teachers • Extent of cooperation between schools • Proportion of teachers who participated in the ENHPS in each school
5.	In-service training on the health-promoting schools concept	• Proportion of teachers who attending annually in-service training • Proportion of participants finding the training useful
6.	Satisfaction from participation in the ENHPS	• Teachers' self-evaluation of the impact of their participation in the ENHPS

Table 6.23. Impact of the ENHPS on schools and the indicators developed

No.	Impact: key areas	Indicators
1.	Engagement and dissemination of good practice to other schools	• Number of presentations in seminars • Production of relevant material • Number of contacts with other schools nationally or internationally • Contribution to the national web site • Contribution to informal and formal newsletters and journals • Degree of knowledge of the school project at the level of Ministry of Education and Ministry of Health
2.	Cooperation between school, parents and community	• Number of organized groups that participate in the disseminating the health-promoting schools concept within the school • Extent and type of cooperation between school, family and community • Number of organized groups that could participate in the school health–related programme
3.	Action planning on health promotion	• Existence of an action plan • Number of activities implemented as an outcome of the health promotion action plan
4.	School environment	• Changes in the school environment • Decrease in vandalism • Provision of a safe and clean environment • Control by the school nurses
5.	Development of school policies that promote health	• Number and type of policies developed as outcome of the ENHPS (such as food, safety, bullying, discipline and recess) • School announcements aiming at developing a school culture that promotes health • Including the health-promoting schools concept in school activities

Table 6.24. Impact of the ENHPS on the community and parents and the indicators developed

No.	Impact: key areas	Indicators
1.	Attitudes towards and awareness of health promotion issues	• Reported positive attitudes towards health promotion issues • Reported awareness of the community and the parents of their role on health promotion issues
2.	Involvement in relevant school activities	• Relevant school policies that stimulate the participation of the community and parents on health promotion issues at school • Number and type of activities in which community and parents participate in the framework of health-promoting schools
3.	Energizing their potential for action on health issues	• Number of voluntary contacts for health promotion action • Number of contacts initiated for health promotion action
4.	Developing partnerships with the school	• Number and type of activities undertaken collaboratively between the school and the community and parents
5.	Awareness and acknowledgement of health promotion activities	• Reported satisfaction relating health promotion action undertaken in the schools or community, respectively • Proportion of parents acknowledging that the school health promotion input is valuable

Aim and objectives of the work

Aim

The aim of the workshop was to identify key areas of impact and related indicators through an active and collaborative process in which the experiences of educators and health professionals were seriously considered. This was used to evaluate the Cypriotic Network of Health Promoting Schools at the school level. The aim of the workshop was specified into four objectives.

Objectives

The objectives of the workshop were:

- to identify and agree on the key impact areas of the ENHPS on students, educators, schools and parents and community;
- to develop indicators of success based on the selected key impact areas;
- to develop and introduce a participatory, collaborative and creative method; and
- to establish a national multidisciplinary and intersectoral working group.

Description of research

The workshop was organized in Nicosia on 13 April 2006. The National Coordinator of the Cypriotic Network of Health Promoting Schools and the adviser on health-promoting schools for primary education developed the workshop and acted as facilitators.

The participants of the workshop were nine educators representing all levels of education who are actively involved with the Network at the school level and three members of school health services (one school doctor and two health visitors).

Activities during the workshop

The workshop started with an icebreaker activity to make the participants feel relaxed with one another. Then the participants were asked to sit in three groups. The facilitators ensured that each group consisted of two teachers from primary education, one from secondary education and one health professional.

The adviser for health-promoting schools for primary education started to set the scene by a short presentation concerning the background, the aim, the steps to be followed and the expected outcomes of the workshop. The steps followed for the development of key impact areas for each area (students, educators, teachers and parents and community) and the related indicators are described below.

- The participants individually had 30 minutes to brainstorm on key impact areas of the ENHPS on students, educators, teachers and parents and community.
- The participants of each team prepared a list, which included all the suggested key impact areas of the ENHPS for students.
- The participants were asked to agree and select maximum six key impact areas of the ENHPS on students. Each team was asked to write the selected key impact areas on a flipchart.
- All groups in a plenary discussion agreed upon six key impact areas of ENHPS of students.
- Each group suggested possible indicators for the six key impact areas related to students, which were agreed with the whole group.
- These steps were repeated for the other key impact areas (educators, teachers and parents and community)

The workshop ended with acknowledging and thanking the participants for their contribution to the workshop. They were also informed that the results of the workshop would be shared in a follow-up meeting.

Methods

Team self-review was used as a method. This can draw from the experiences of teachers and health workers the key impact areas and corresponding indicators relating to the role of the ENHPS at the school level. The workshop as a setting for team self-review consists of interactive methods, which enables the participants to share opinions and personal feelings but also to challenge their assumptions and realize common and different practices.

Team self-review with the use of interactive methods was found to be appropriate for developing indicators for a complex and dynamic system such as a health-promoting school. This approach gave the participants space to work together and arrive through reflection (as an interpersonal and intrapersonal activity) at a deeper understanding of the processes that belong to health promotion. The facilitators used techniques and procedures to encourage the group to work creatively and arrive collaboratively at shared conclusions. These are described in the following section.

Main findings

The participants of the workshop acted as a dynamic group, exchanged ideas and developed their thinking as a group regarding the impact of the ENHPS on themselves as teachers but also on students, on school and on community and parents. They were asked to develop indicators that can "measure" the role of the ENHPS on the agreed key impact areas. Tables 6.21–6.24 present the key

impact areas on students, teachers, school and community and parents that were agreed with the whole group. Each table includes also the suggested indicators from the participants for each key impact area.

Schools in the Cypriotic Network of Health Promoting Schools develop an annual health promotion action plan based on the needs and interests of each school as identified by a coordinating team (teachers, students, parents, school doctor and nurse etc.). Since this is locally driven, schools have different action plans or programmes. Interestingly, at the workshop the participants easily agreed on key impact areas relating to the role of the ENHPS on students, parents, educators and community and parents.

Recommendations for future health-promoting schools projects

The workshop was successful in exploiting the experience of professionals who have been involved in developing the Cypriotic Network of Health Promoting Schools at the school level. The recognition of teachers' experiences as a valuable resource for selecting indicators was found to be rewarding for their past and current dedication and efforts for health-promoting schools. Most participants spontaneously expressed their satisfaction with the process followed in the workshop and their willingness to support such efforts in the future. The active involvement of the participants seems to have ensured their future commitment. We therefore suggest to any future health-promoting school projects to incorporate school stakeholders (teachers, health workers, students and others) in the process of developing research tools.

Challenges for future research in health-promoting schools projects

The workshop was successful in arriving at key impact areas of the ENHPS through a collaborating and interactive process. The participants had the opportunity to discuss and develop further their understanding of the ENHPS. The processes of the workshop included steps that forced the participants to analyse their initial thoughts relating the impact of the ENHPS and arrive constructively at shared conclusions. Consequently, the coordinating group of the Cypriotic Network of Health Promoting Schools has available 5–6 key impact areas of the ENHPS for four areas: students, parents and community, teachers and school. These outcomes have not been used so far. The facilitators plan to present the outcome to the coordinating group of the Cypriotic Network of Health Promoting Schools at the central level and ask for their reflections. Their experiences from a different perspective can also be fruitful in further developing the indicators. Hereafter, the main challenge for the future is the development of a research tool (or a set of research tools) that incorporates the suggested key impact areas for students, educators, schools and community and parents.

Finally, the success of the method in gaining commitment and motivation suggests an engaging and participatory means of working with key stakeholders at all levels.

Development of a method for improving student's participation in Ireland

Siobhan O'Higgins, Elena Nora Delaney, Miriam Moore, Saoirse Nic Gabhainn & Jo Inchley

Introduction

The aim of this research was to demonstrate how effective a participatory research method that adheres to health-promoting principles and the health-promoting schools approach can be. The achievements on which this research focused were student empowerment and participation. Empowerment is the third of ten principles established by the Egmond Agenda (International Planning Committee, 2002) and identified in the resolution from the First Conference of the ENHPS (1997a, b).

- The method described in this research was an attempt to integrate a health-promoting process with health promotion research.
- This research method is an example of how to capture sets of indicators for a health-promoting school from the student's perspective.
- The participatory research method can be applied in any school to inform the development of policies and school plans that will then adhere to health-promoting schools principles.
- The indicators identified by this group of students are relevant to their own school but could also be applied to other school settings if all the stakeholders agreed that they are relevant indicators of a health-promoting school.

The research presented here was undertaken in schools in Ireland as part of a larger national study.

Indicators

In Ireland, there was a focus on working with students in the classroom to develop indicators of a health-promoting school. The philosophy of health promotion emphasizes community participation as integral to the success of all health-promoting interventions. An aligned step could be to develop, disseminate and adopt methods that enable all members of a community, such as a school, to participate in developing appropriate health promotion indicators. By participating in the process of this research, the students may be empowered through the experience that their voices are being heard by adults and may then be acted upon. In Ireland, the National Children's Strategy (National Children's Office, 2000) outlines as the first of its three key goals that "Children will have a voice".

This research fits into this national goal, using participatory techniques to facilitate students to have their views heard by teachers, legislators and other adults in positions of power.

This research focused on enabling students to identify indicators pertinent to them and their health within their own school. Once identified by students, the indicators could be used to explore the extent to which their school may be considered a health-promoting school. The indicators identified by the students are relevant to the individual, classroom, and the school.

Aim of work

The aim of this research was to facilitate students to iterate the indicators they feel best reflect a health-promoting school. It employed participatory methods in which students are seen as social actors rather than research objects.

Students are active and vital members of school communities, and their voices need to be listened to and recorded in ways that honour them. Children in Ireland are not accustomed to having their views being taken into account either at home or at school. Thus, in order to facilitate students to communicate their views in totality, the protocols used need to be child-centred and age-appropriate.

In engaging with students we, as researchers, gain valuable insights into their perspectives; it is therefore important the students also gain from the process. This is achieved through student empowerment, both by having their views valued and enjoying the process; having fun is viewed as an important aspect of being and staying healthy. If a truly reciprocal relationship can be developed, the process will have honoured the students. Further, in this process, students are not excluded from either the data analysis or data reporting phases of research, and thus remain in control of their data for an extended period.

This research adapted protocols first developed in Ireland in 2004. In order to include students' perspectives on well-being in the process of developing a national set of well-being indicators for Ireland, a study design that attempted to honour students while eliciting rich data was developed. That protocol involved individual students creating data and groups of students analysing and reporting on both analysis and synthesis of the data originally collected. Subsequent investigations revealed that the perspectives of parents, teachers and students on the datasets differed substantially. All groups shared the understanding that family and friends are very important for students' well-being, but there were differences in many other areas. These differences emphasize the value of involving students directly rather than accessing their views through adult proxies.

Description of the research

The current research was conceived by Saoirse Nic Gabhainn in conjunction with Jo Inchley (Scotland) and conducted by researchers Siobhan O'Higgins, Elena Nora Delaney and Miriam Moore. Students from three different types of schools in Dublin City were involved in the process during the spring term 2006. All student groups were in their fourth year of postprimary education and were approximately 16 years old.

Three schools were selected to represent single-sex and coeducational establishments, although the schools were otherwise broadly similar. The school principals were contacted and parental consent requested in advance. Three workshops were held in each school with three different class groups. The protocols for the workshops with the students were standardized, although variation inevitably arose due to the participatory nature of the workshops.

- Students in the first group were asked to respond to a single question: "If you went to a new school, what would it need to have for it to be a healthy place?". They wrote their responses on flashcards, which were subsequently collected by the researchers. Thus, workshop 1 focused on data generation.
- Students in the second group were given the cards generated by those in the first group and asked to place them into categories. Students used as many categories as they felt were appropriate and also added to the responses as they wished. Thus, workshop 2 focused on data analysis.
- Students in the third group were given the categories developed by those in the third group (along with the content of the categories). They also added cards as they wished. This group organized the categories into schematic representations on large posters; the students decided the format and presentation within their groups. Thus, workshop 3 focused on data synthesis and presentation.

The rationale and format of the workshops were explained to the students before their own consent to participate was requested. In order to honour the students and their willingness to give their time, energy and opinions to the researchers, the protocols were devised to be as student-friendly as possible, and games were played at the end of each workshop. Students in each school then produced schemes that represented what the students in that school felt were relevant indicators of a school that would be good for their well-being (that is, a health-promoting school).

Main findings

In all three workshops the students were active participants and worked hard to generate rich data, which they analysed and presented as schemes that they felt

would be well received by adults. Each student group produced similar indicators. All aspects of the health-promoting school concept emerged, particularly around the physical and psychosocial environment. Student groups highlighted aspects of the school physical environment: this included aspects of building safety, hygiene, student space and facilities for sport and exercise. Access to healthy food and nutritional issues also emerged as being of particular importance. Interpersonal relationships featured strongly, particularly those between students and school staff. Students in two of the schools also emphasized the concept of discipline and authority for the school to operate effectively: for them to learn in class and to create an atmosphere of mutual respect.

This research verified how willing students are to become involved in such participatory activities and their enthusiasm to present their ideas to adults who are willing to listen. Of particular importance are the holistic nature of the views they shared about how schools affect their health and their ability to creatively articulate what they believed would be indicators of a health-promoting school.

Enjoyment was a key aim of the research process. The researchers conveyed this to the students at the beginning of each workshop and attempted to foster an environment that would support this aim. This was achieved in the way the researchers communicated with the students, in the playing of games and most importantly in listening nonjudgementally to all that the students had to say. It was very gratifying how seriously the students engaged with their tasks and how much they enjoyed the creative process. There was very little messing around within the workshops. Previous work had shown how important it is for the researchers not to try and control the students' behaviour: for example, friends were allowed to work together.

All the student groups stated that they were not interested in participating in the decision-making processes within the school; they felt it was a waste of time. School councils were perceived as just another form of tokenism. Most, if not all, of their interactions with adults in power are based on adult concepts of how to engage and communicate. The students do not consider such attempts to engage with students to be empowering and consider them only nominally participatory.

Recommendations for future health-promoting schools projects

The main implications for the evaluation and development of future health-promoting schools projects fall under three headings.

- This particular protocol as a way of collecting rich and valid data from students has been clearly demonstrated as being effective and incorporating elements to

and use indicators at the level of schools and classrooms and in relation to concrete educational and health issues is also essential. Reports from Denmark, Finland and Romania are of particular interest here.

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Using indicators at the classroom level to assess the effectiveness of an intervention to reduce aggression and violence: an example from Romania

Livia Teodorescu

Introduction

Many children in Romania use an aggressive and vulgar manner of speaking or writing in public places, at school and at home, and verbal aggression can lead to physical violence.

During 2005, national television frequently covered harassment and fights between schoolchildren filmed by the children. Therefore, the Ministry of Education and Research together with the Ministry of Health and others launched a national campaign in April 2006: Be Intelligent, Don't Be Violent! I anticipated (by chance!) this acute problem, since I decided as far back as in November 2005 to undertake research on aggression and violence in classroom and school settings.

In this study I have attempted to find practical solutions to diminish manifestations of violence between children in the classroom setting and to educate them in a friendly, collegial way.
I decided to use the number of violent actions in the classroom as the indicator for assessing the success of implementing strategies within the classroom to create a more health-promoting ethos. Additional criteria for success were:

- reduction in the number of conflict situations;
- increased self-esteem among children;
- increased mutual respect between students (how they speak, what they do); and
- more positive relations between the students and between the students and the teacher.

The selected indicators relate to health-promoting schools principles, because they relate to children's abilities to take action and to generate change. Students are viewed as active change agents in their group; they are helped to be conscious of the problem of aggression and to deal effectively with violent acts in the classroom. Working on this indicator promotes the development of the ability to

work in teams, promotes acceptance of rules of fair-play rules and respect for democratic principles, equity, etc.

Description of class group and strategies implemented

My class is small (22 children, 11–12 years old) composed of students from different classes in my school or from other schools. It is a new class, not a united and cohesive group.

In order to achieve the aim of reducing violence between students, I planned two strategies, a preventive strategy and a strategy for changing behaviour.

Preventive strategy

This strategy had several key elements.

1. Establish rules.
- Clearly communicate the rules on social behaviour at the beginning of the school year. The children are helped by the rules to supervise the impulsive behaviour. The rules were established together with students and reflected the classroom's specific situation. In this case, the children's acceptance of the rules increases.
- Rules are respected when there is group pressure. Self-discipline is an outcome of many factors: the existence of clear rules and well-specified consequences as well as the external pressure of parents, teachers and colleagues.

2. Create a classroom with its own character.
- Select a specific decorative element: in our case flowers (my students like to cultivate them).
- Select a name for each class: we use names of different types of fireworks, because we are noisy and agitated quickly.
- Select a motto, such as "All for one and one for all".

3. Be familiar with children and show interest in them.
- The teacher's respect for schoolchildren is demonstrated by the attention offered.

4. Resolve any problems that take place immediately.
- Use rewards for good behaviour and work to increase the interest for learning and for engaging in tasks

5. Create time and space for positive interactions between children.

Strategy for changing behaviour

I have used several strategies for changing behaviour.

1. Identify the three components of the behaviour: antecedents, behaviour and consequences.

help increase the degree to which participants are honoured as part of the process.

- The participatory method facilitates students to express their views in ways that are accessible and understandable to adults. The process attempts to empower students to express their views and thus can be used to strongly advocate that students deserve (and can rise to deliver) an equal role within policy-making alongside the other stakeholders in education.

- The voice of students in schools in relation to their needs deserves to be creatively iterated and explained to the adults within the system.

Challenges for future research in health-promoting schools projects

Based on this research project, the challenges for future research related to health-promoting schools projects involves researchers going back to basics. As the main stakeholders in the education system, students' views need to be elicited using methods that honour them as full and active participants. The empowerment of the student needs to be at the hub of all research efforts, using health-promoting research methods to inform our health-promoting schools initiatives. Indeed, empowerment is one of the ten concepts of the resolution from the First Conference of the ENHPS (1997a, b). Future research needs to include the development of ever more creative and empowering protocols that allow the voice of the child to be truly heard and faithfully represented.

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Comments on the national reports

We conclude this chapter with some remarks on the reports on health-promoting school indicators resulting from the ENHPS workshops on evaluation and indicator development.

The reports give an up-to-date account of the development and implementation of school health indicators on several levels in countries across Europe.

Some reports (section A) give a complete picture of the health-promoting schools framework and look back on the historical development of school health in their country.

Many of the countries represented have made considerable progress in developing indicator systems and associated tools for assessment and evaluation. In some cases, these systems provide a basis for awarding health-promoting school status to individual schools. Other countries are at an earlier stage in this process.

The reports show that indicator development has proceeded separately within each country, reflecting different national policies and structures; but that this process has been usefully supported by key documents and guidance produced through the ENHPS (such as the resolution from the First Conference of the ENHPS (ENHPS, 1997a, b)) or arising from European health and education conferences (such as the Egmond Agenda). The series of workshops organized through the ENHPS for national coordinators and researchers and evaluators has also played a substantial role in helping to build a shared conceptual understanding of the nature and value of indicator frameworks in taking forward the health-promoting schools project.

One important development, illustrated particularly by the reports from Germany, Scotland and Switzerland, is the attempt to integrate the development of health promotion indicators with approaches to conceptualizing and assessing the educational quality of schools.

It is probably unrealistic to imagine that a set of agreed core indicators could be established as benchmarks for assessment across all national systems, but the joint report from Estonia, Latvia and Lithuania illustrates interesting steps in the direction of cross-national collaboration and agreement in the specification and application of indicators.

The reports in sections B, C and D are more focused and inform on more specific and local aspects of school health indicator development in a country. The reports from the Czech Republic and the Netherlands show a shift in some countries from centralized to regional systems of support for school health promotion.

International and national frameworks undoubtedly have their place in supporting the development of good health-promoting practices within schools, but key principles of the health-promoting school concept involve notions of participation, democracy, empowerment and ownership – and these ideas may get lost in centralized systems of monitoring and assessment. It is encouraging, therefore, to see that several reports emphasize processes of active consultation with teachers and students in clarifying useful indicators for health-promoting schools (such as Cyprus and Ireland). Demonstrating how teachers and students can formulate

and use indicators at the level of schools and classrooms and in relation to concrete educational and health issues is also essential. Reports from Denmark, Finland and Romania are of particular interest here.

European Network of Health Promoting Schools

http://www.euro.who.int/ENHPS