EDITORIAL

The health promoting school: some reflections on evaluation

The *health promoting school* is an offspring of WHO's (1984) creation of the health promotion movement as a whole. While its main elements have been present for many years in suggested blueprints for school health education and in curriculum development more generally, WHO's initiative has added impetus to and popularized the concept. The intention of this Editorial is to locate this initiative within the general framework of a *settings approach*, provide a model encapsulating key features of a health promoting school curriculum, and consider some implications for evaluating its effectiveness and efficiency.

The emergence of the health promoting school

Even 12 years after its launch by WHO, any discussion of the still essentially contested notion of health promotion must be prefaced by some definition. In short, health promotion is firmly grounded in certain ideological principles. The pursuit of equity and its associated attempts to tackle the inequalities which underlie and characterize health status within and between nations is perhaps the central driving force. This goal is to be achieved by the creation of *healthy public policy* designed to influence the socio-structural and environmental causes of health and illness. Furthermore, in accordance with the Ottawa Charter credo (WHO, 1986), an integral principle of health promotion is the development of active empowered individuals and communities—and since traditionally the profession of medicine has had a depowering effect, *demedicalization* and a *reorientation of medical services* form part of health promotion's manifesto. Following Alma Ata's (WHO, 1978) review of *primary health care*, it has been increasingly acknowledged that a wide range of services—other than medical services—have a highly significant contribution to make to the promotion of health. Clearly, the education service must have a centrally important part to play.

Logistically speaking, if a wide variety of services have a potential contribution to make to health, then tactics must be developed to, first, alert these services to their health promotion role, and, secondly, to foster *inter-sectoral collaboration* and establish *healthy alliances* between partners.

The contribution of health education to the broader health promotion goal has provoked some debate (Tones, 1987); indeed, for some, health education would appear to be synonymous with health promotion. After the ringing endorsement provided by Alma Ata, health education was not always accorded the prominence it merits—although the Ottawa Charter did make reference to the importance of people *developing personal skills* which could only be provided by the educational process. Although doubtless simplistic, the 'formula' adopted here places health education centre stage. In short, health promotion is viewed as a synergistic interaction between education and health and social policy:

$$\text{health promotion} = \text{health education} \times \text{healthy public policy}$$

The settings approach

Following the translation of the concept and principles of health promotion into the Ottawa Charter, key conferences in Adelaide (WHO, 1988) and in Sundsvall (Pettersson and Tillgren, 1992) emphasized the importance of healthy public policy and supportive environments, and WHO sought to apply these principles, together with the remaining key features of the Ottawa charter, to a number of settings. Thus, following the *Healthy Cities* initiative, guidelines were developed for a holistic approach to health promotion in institutions and organizations such as the *health promoting hospital* and the *health promoting school*.

The key feature of the settings approach in general and the health promoting school in particular is the imperative to ensure that all of the activities and ethos of the setting in question are mutually supportive. Moreover, each setting should be 'outward looking': those working in the

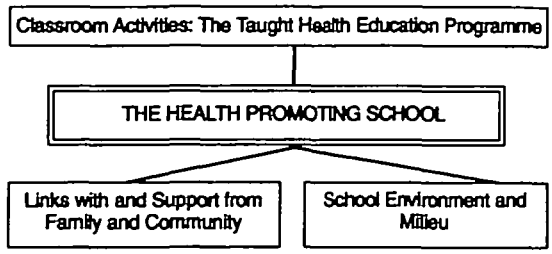

Fig. 1. The health promoting school (Green *et al.*, 1996).

setting should collaborate with the community at large and with other settings in the pursuit of health promotion goals. As may be seen from Figure 1, three complementary contexts are identified in the school setting:

- Teaching in the classroom.
- The school environment and milieu.
- Links with family and community—including health services.

Currently some 39 countries in Europe are part of the European Network and other WHO regions have adopted the concept (WHO, 1996a). I am indebted to Lawrence St Leger for drawing my attention to one of the more recent and comprehensive initiatives in the West Pacific Region which identified six elements for the health promoting school as follows (WHO, 1996b):

- School health policy.
- Physical environment of the school.
- Social environment of the school.
- Personal health skills.
- Community relationships.
- Health services.

The English project for evaluating the health promoting school network lists 12 criteria which both illustrate its key principles and which, as we will note later, can also serve as a checklist for evaluation (HEA, 1996).

Ethos and environment

- Provides a safe, secure and stimulating school environment which encourages pupils to be health and safety conscious both in and out of school
- Actively promotes opportunities which develop pupils' self-esteem and self-confidence, enabling them to take initiatives, make choices, and exercise responsibility for their own and others' health
- Fosters a whole-school understanding and sharing of the school's aims for health education, and the contribution that individuals can make through their respective skills and personal qualities
- Creates a school climate in which good relationships, respect and consideration for others flourish
- Promotes the health and well-being of all staff and pupils and considers the role of staff as an exemplar of a healthy lifestyle

Curriculum

- Formulates a range of health-related policies which are in accord with the school's aims, e.g. those concerned with nutrition, physical activity, substance misuse and bullying
- Implements the health-related policies, and monitors any changes in pupils' knowledge, skills, attitudes and behaviour
- Plans and implements a coherent health education curriculum which complies with statutory requirements and is accessible to all pupils
- Ensures that teaching is informed, is of a consistently high quality, and is based upon a positive approach which recognizes the importance of starting with pupils' existing levels of understanding and experience of health matters.
- Provides stimulating challenges for all pupils through a wide range of physical, academic, social and community activities

Family and community

- Develops good liaison with other schools, pupils' parents/guardians and the community on a range of health promoting initiatives
- Makes effective use of outside agencies and specialist services to advise, support and

contribute to the promotion of health, either directly or through the curriculum

Again, these 12 points may serve as a checklist for evaluation purposes.

The curriculum of the health promoting school

The curriculum of a school is a selection from culture: there is an endless variety of content and activities which schools might include in their curricula. However, since they cannot teach everything, a choice has to be made. The result of the selection process thus reflects what a given culture considers to be most important—although according to Benjamin's (1971) classic allegory of the *saber tooth curriculum*—originally produced in 1939—the curriculum tends to reflect what *used to be* important several generations earlier! There is, of course, rarely agreement about what exactly is important and pressure is constantly exerted by various factions seeking to gain access to the captive audience of schoolchildren. At a more fundamental level, the curriculum represents the success of a dominant ideology over competing ideologies. In Europe and, perhaps, worldwide, schools have in recent years been the subject of battles between right and left, between conservative and socialist, between traditionalists and those who espouse so-called child-centred, 'progressive' approaches. Latterly, scuffles over access to the 'secret garden' of the curriculum have been between people of more moderate views and factions which urge schools to 'get back to basics'. This nostalgic journey to what Benjamin might have described as the 'stone age curriculum' places an emphasis on a narrow notion of morality and—on the basis of outmoded learning theory—urges the acquisition of skills deemed necessary by an 'enterprise culture' in order to enhance the economic prospects of the particular nation.

Those who consider health an important issue also compete for curriculum space and frequently become embroiled in broader ideological disputes (of which, teaching about sexuality is a prime example). Furthermore, health and education professionals have their own ideological commitments which are reflected in different curriculum models. For instance, teachers and health workers often have different perspectives on the goals of health education. Teachers may consider the goals of education to be primarily those of providing understanding, developing personal skills and characteristics, and, perhaps, facilitating choice. Health workers will frequently hope that their educational efforts will result in behaviour change. In other words, their guiding principle may be a preventive medical model—rather than a broader social or educational model. Therefore, if we are to consider the question of evaluating the health promoting school we must be quite clear about the values underpinning its philosophy. As we have noted earlier, health promotion adopts a radical stance which centres on empowerment and choice rather than compliance and coercion. The *Sundsvall Handbook* (Haglund *et al.*, 1992) for instance notes that schools have two major goals:

> To educate students in academic or cognitive skills and knowledge; and to help students develop the individual and social skills required for employment and socio-political involvement in society.

Furthermore, education should

> ... provide people with an opportunity to rise above the limitations of the social group in which they were born. (p. 62)

In short, both education in general and health education in particular should have a subversive function. In the rather inelegant but, nonetheless, graphic words of Postman and Weingartner (1981), all students should, '... develop built-in, shock-proof crap detectors as basic equipment in their survival kits' (p. 16). Or, following Freire (1972) a prime function of radical education is that of *critical consciousness raising*.

Figure 2 provides an analysis of the curriculum of the health promoting school, and incorporates the policy dimension relating to the provision of a supportive environment and the schools liaison with home and community.

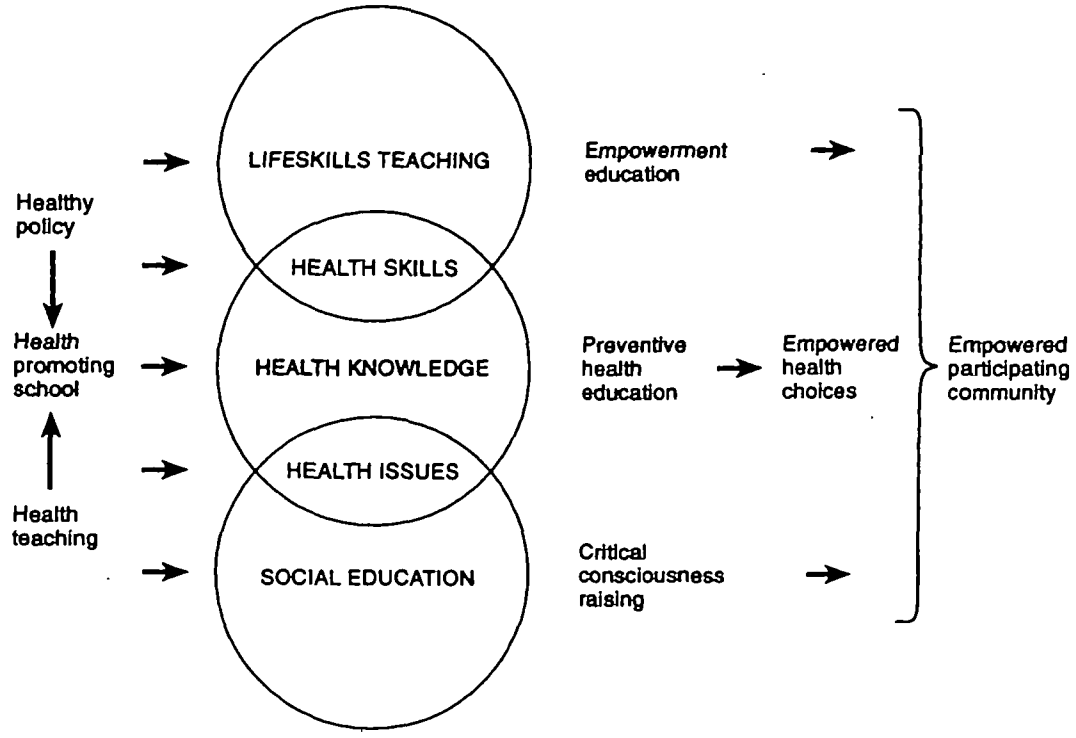

Fig. 2. The health promoting curriculum.

The term *social education* is used here to describe the consciousness raising function of education within the health promoting school, whereas *lifeskills teaching* refers to the importance of providing competences which might contribute to individual empowerment. Figure 2 also acknowledges the traditional health education function of providing health-related knowledge and understanding. It will also be apparent that the health promoting school does not lose sight of the preventive goals espoused by the medical model. Indeed, it is assumed that an empowerment approach is more rather than less likely to facilitate the achievement of those preventive goals while emphasizing its prime concern with enhancing feelings of control, facilitating choice and contributing to the development of *active participating communities*. Accordingly, healthskills teaching borrows from the repertoire of general lifeskills and applies these to specific 'medical problems'—such as resisting pressure to have unwanted sex. Similarly, social education would address both general issues, such as poverty, and health issues related to these—such as the social class gradient in illness.

The health and lifeskills approach—sometimes described as Action Competences (Tones, 1994)—has a parallel in the recommendations of WHO's (1993) mental health programme which listed 10 important lifeskills: *decision making, problem solving, creative thinking, critical thinking, effective communication, interpersonal relationships, self awareness, empathy, coping with emotions* and *coping with stress.*

Classroom activities, ethos, environment and community

The importance of supportive environments and community links has already been emphasized, and a more complete and detailed discussion is beyond the scope of this paper. However, because

of a common tendency to assume that the school curriculum consists only of the taught element, it is worth comparing and contrasting the three elements shown in Figure 1 above and noting some of the basic requirements for success.

The classroom

As we will observe later, unless the taught element of the curriculum is appropriately structured, we cannot expect efficient results. Health education may figure in the curriculum in various ways—as a regular timetabled 'slot' or in the context of other subjects (such as biology, home economics, art or literature); it may appear in the pastoral curriculum; it may be included through health projects or topics. What is important is that the pattern of provision is planned and, ideally coordinated across the curriculum and, utilizing the notion of a *spiral curriculum*, forms part of a health career approach from primary to secondary schooling. Clearly the use of teaching methods appropriate to the learning task is a *sine qua non* for successful results.

The school milieu

As we observed earlier, a key feature of a settings approach is the provision of a supportive environment. Accordingly the health promoting school must actively develop policies which not only try to ensure state of the art teaching but which also stimulate the development of physical and social environmental conditions which 'make the healthy choice the easy choice'. Thus, school policies on nutrition, smoking and bullying should ensure that the school ethos and environment reinforces classroom learning through direct experience.

The following examples from the Western Pacific Region's list of checkpoints WHO (1996b) illustrate the particular importance of the *social* environment in empowering pupils and creating a sense of concern which is central to a healthy school life. They also provide a ready made checklist for '*rapid appraisal*' of the school's progress towards the creation of a fully fledged health promoting school! The seven examples listed earlier of the criteria for English health promoting schools could be put to a similar use.

The school ethos is supportive of the mental health and social needs of students and staff.

- Teachers do not use harsh discipline and are supportive of and respectful towards students
- Students are encouraged to participate in school decision-making processes

The school creates an environment of care, trust and friendliness which encourages student attendance and involvement.

- The school actively discourages physical and verbal violence, both among students and by staff towards students

The school provides a fully inclusive environment in which all students are valued and differences are respected.

- The school provides opportunities to celebrate cultural, religious and tribal diversity e.g. through food, costume, dance, craft, displays, festivals and exhibitions.

Links with family

The family is, of course, the primary socializing influence on children. The support and encouragement of parents have always been recognized as prime determinants of children's success at school. However, the health promoting school is charged with greater proactivity—to involve parents maximally in school matters and to seek to influence parental health status by using the often quite substantial influence of the child. For instance, parents might be asked to volunteer to become involved in the development of school nutrition policies; they might be encouraged to help children adopt a more balanced diet and, in the process, introduce changes into family eating practices.

Community liaison

The school should be an important part of its local community. It should not only seek and expect community support but might also have an impact on community norms and practices. It might also expect support from community health services. Both aspects are illustrated by the West Pacific Region initiative (WHO, 1996b)

- The school informs the local community of its health initiatives e.g. through the use of local media, school open days, students providing 'healthy school' displays at community functions
- Counselling and support services are available for socially and emotionally distressed students and those with medical problems
- Health service agencies are active in approaching schools with offers of support to them in their work on health promotion

One additional example may be offered to illustrate children's potential for initiating change in their community and, in the process, acquiring empowering skills. A major cancer organization in Portugal, La Liga Contra O Cancro, has enrolled some 47 000 pupils into its 'Smokebuster Club' (Os Caca Cigarros). Smokebusters is an international initiative which seeks to offer a variety of incentives as part of an initiative designed to prevent the recruitment of young people to smoking. Although this is not school-based, the Portuguese club has recruited from schools and has emphasized the importance of children's community involvement. Amongst other activities, school children made a presentation of the work of their organization on local radio. In the course of doing so it seems they indulged in active lobbying for the non-smoking cause with the result that a no smoking policy was established in the radio station (L.Lima, personal communication).

Measuring the success of the health promoting school

This paper makes no claim to provide a review of the effectiveness of school health promotion programmes (for further discussion, see Green *et al.*, 1996). It may, however, be useful to provide a brief reminder of (1) the meaning of success, (2) the appropriate choice of indicators of success, and (3) criteria for judging effectiveness and efficiency.

The first of these points requires little further discussion. Evaluation is concerned with assessing the extent to which valued objectives have been achieved. As we noted above, health promotion has its own particular value base and ideology which may or may not conflict with the values of competing models of health education and/or convictions about the purpose of the school curriculum. In short, the health promoting school should be judged *primarily* by its contribution to such health promotion goals as equity and empowerment—or by the success of initiatives contributing to such long-term goals.

A closely reasoned discussion of the remaining two issues is not possible here and so a number of assertions will be made which might serve the purpose of stimulating discussion!

Indicators of success

It is useful to conceptualize indicators of programme success in relation to a proximal–distal chain which originates with some 'input' and ends some time later with measures of 'output'. A further discussion of this notion and the points made below may be found in Macdonald *et al.* (1996). Output would be assessed by outcome indicators. These might, for instance, comprise policy implementation or the adoption or change of behaviours such as reductions in recruitment to smoking or the adoption of food choices which contribute to a balanced diet. For reasons discussed elsewhere (Macdonald *et al.*, 1996), the use of more distal policy changes—such as a reduction in unemployment—would be considered impractical, while the use of traditional epidemiological indicators—such as mortality and morbidity would be considered not only impracticable but undesirable as measures of *health promotion* interventions. Accordingly, *intermediate indicators* of effectiveness and efficiency would most usually be used to assess success. These would include such measures as the acquisition of knowledge and understanding, evidence of successful values clarification, the efficient performance of healthskills, the enhancement of self esteem and changes in self efficacy beliefs—and the like.

Frequently, though, we need to evaluate initiatives which contribute indirectly to pupil gains. For instance a checkpoint from the Central Pacific

Region's list of 'personal health skills' argues that 'training sessions should be made available for parents, key health and education personnel and local community members...'. The assumption is that successful training will contribute to successful teaching which will, in turn, contribute to effective pupil outcomes. Accordingly such initiatives should be assessed using *indirect indicators*. As we will note later, indirect indicators are essential to successful process evaluation.

Judging effectiveness and efficiency: avoiding Type III error

We have suggested using a number of checklists as a basis for deriving indirect, intermediate or outcome indicators of the success of the health promoting school. Clearly such checklists would need refining and developing in the interest of enhancing reliability and validity. It is also accepted that Type I error should be avoided wherever possible, and competing explanations for any changes in environment or pupil characteristics and competences should be excluded. However, the health promoting school is a complex organism: success depends on multiple activities and interactions. Perhaps, therefore, we should be more concerned to avoid Type III error! Type III error is not uncommon in health promotion. In other words health promotion interventions are judged to have failed despite the fact that the programme in question may have been grossly deficient. We cannot expect to achieve success unless a certain number of key conditions prevail. We have already emphasized one important requirement: health education must be supported by healthy public policy—the taught curriculum must have its supportive physical environment and ethos. As observed by Green *et al.* (1996), The School Health Education Evaluation (Connell *et al.*, 1985) demonstrated that success—as measured by knowledge acquisition and changes in attitude and behaviour—depended on an adequate educational intervention. There was an association between numbers of classroom hours devoted to health education and evidence of change in pupil competences and characteristics. The programme impact was also influenced by the provision of teacher training, the provision of appropriate support materials and programme 'fidelity' (i.e. teacher's adherence to recommended guidelines).

Allensworth (1994), cited by Green *et al.* (1996), provide a more comprehensive list of requirements to avoid Type III error. These reflect more closely the philosophy and practice of the health promoting school:

- Use a number of complementary theories and models as a basis for the programme.
- Use a combination of educational strategies.
- Use appropriate teaching methods and encourage active pupil participation.
- Focus on priority health related behaviours.
- Address common skills which are relevant to a number of health issues.
- Have effective coordination throughout the school.
- Expand the scope of school health programmes by integrating all aspects of school activities which relate to health.
- Gain family support and involvement.
- Achieve coordination between school and community.

Evaluating process

Reviews of the literature on the effectiveness of health promotion in general constantly lament the lack of formative evaluation. Whether programmes have or have not achieved significant changes, it is usually impossible to determine what particular aspects of the programme have been responsible for success or failure. This series of observations on the health promoting school will, therefore, conclude with a plea for process evaluation. The application of the simple 5W + H checklist may be all that is necessary. *Who* did *What* with *Whom*? *Where* did it happen and *Why? How* did it work? In short, the purpose is to provide *illumination* (Parlett and Hamilton, 1978). In the words of these authors, relying solely on outcome indicators is: '... rather like a critic who reviews a production

on the basis of script and applause meter readings, having missed the performance'.

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