Australian teachers’ understandings of the health promoting school concept and the implications for the development of school health

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SUMMARY
The health promoting school has emerged as a comprehensive framework to enhance the health status and health potential of school students. It requires teachers to be proactive in a number of areas beyond the formal curriculum. The success of health promoting schools will depend largely on what teachers know about its building blocks and the likelihood that they will be adopted. A number of teachers were interviewed and surveyed in a sequential study to ascertain their understanding of what constitutes a health promoting school. The findings indicate that teachers think mainly about school health in terms of the curriculum; have little understanding of how community partnerships might work; are very supportive of the concept; and have limited preservice and inservice training in health issues. It is argued that the growth of health promoting schools will be dependent on comprehensive professional development programmes; the production of resources which link teachers’ perceived core business—teaching the mandated curriculum—to the building blocks of the health promoting school; closer collaboration between the health and education sectors; and a recognition by the community that schools cannot easily address (and solve) society’s health concerns.

Key words: health promoting school; school health; teachers understandings

INTRODUCTION
The health promoting school is a concept which has been developed over the last decade to address school health in a more comprehensive way. It represents a settings approach where different aspects of schools are taken into account in efforts to improve the health opportunities for students. The origins of the health promoting school are linked strongly with the work of the World Health Organization (WHO). This appears to be most evident in how the WHO has shaped the parameters of the positive dimensions of health through the Declaration of Alma Ata (WHO, 1978) and the Ottawa Charter for Health Promotion (WHO, 1986a). These broad directional documents have been supported by specific implementation initiatives auspiced by the WHO through its central and regional offices.

The European WHO Regional Office, in collaboration with the Council for Europe and the Commission for European Communities has established a network of health promoting schools in over 37 countries (McDonald and Ziglio, 1994). The Western Pacific Regional Office have produced policies and guidelines for health promoting schools for its 32 member states (WHO, 1996). Parallels exist in the USA where the movement for Comprehensive School Health Education (CSHE) developed during the eighties. Significant impetus for this emerged through The Surgeon General’s Report on Health Promotion and
Disease Prevention (US Department of Health, Education, and Welfare, 1979) and was reinforced by the Healthy People 2000 Report (US Department of Health and Human Services, 1991). The American Cancer Society and the Centre for Disease Control (CDC) also played very significant roles in shaping the direction of and (Allensworth, 1995).

The health promoting school is described differently in various documents (Allensworth and Kolbe, 1987; Young and Williams, 1989; Nutbeam, 1992; McDonald and Ziglio, 1994; WHO, 1996), but usually comprises some combination of actions focused on: (i) school health policies; (ii) physical environment; (iii) social environment; (iv) community partnerships; (v) personal health skills; and (vi) integrated health services. A number of writers argue that the health promoting school produces better health outcomes for students than through a traditional classroom approach using only the classroom curriculum (Lavin et al., 1992; Kolbe, 1993; WHO, 1994, 1996; Allensworth, 1994; Peter and Paulussen, 1994; Collins, 1995; Cohen, 1995; Dommers and Ingolby, 1996). Claims have also been made that integrated and quality health promoting schools/CSHE programmes are very cost-effective (World Bank, 1993; Rothman, et al., 1994).

The health promoting school concept requires teachers to operate in a number of areas in addition to class-based curriculum implementation, e.g. developing appropriate school health policies; enhancing the social environment; linking with relevant community agencies.

The success of the widespread implementation of health promoting schools will largely depend on school teachers’ understandings of the building blocks of the health promoting schools and their capacity to implement it.

A major study was undertaken to ascertain primary school teachers’ understandings of the health promoting school.

**METHODOLOGY**

The research approach used both qualitative and quantitative data collection methodologies. It sought to discover teachers’ understandings progressively by beginning with teachers’ broad ideas of school health; to focus these ideas by ascertaining what teachers believed to be the priorities and actions needed to expand school health activities; to gather information on how teachers rated the importance of the components of the health promoting school; and finally to check findings and clarify uncertainties with teachers.

Data in the study were collected in four phases. Phase 1 required teachers from three schools who claimed they were addressing school health issues to take photographs which could be used to explain to someone what the school was doing in school health. Two weeks after taking the photos the teachers were interviewed individually and their explanations of the photos were recorded and analysed. A number of preliminary assertions were made which were used to shape phase 2.

Phase 2 involved five focus group interviews in five different schools with groups of teachers. The schools were chosen at random from the eastern suburbs in metropolitan Melbourne. They were asked to cluster and rank 20 photographs to ascertain further their understanding of school health. Here attention was given to: hearing teachers’ views on health outcomes for students; teachers’ top priorities in school health initiatives; and teachers’ reactions to the phrase ‘health promoting school’. Again a set of assertions and emerging issues was identified.

Phase 3 involved using the data of the first two phases, plus components of the health promoting school frameworks from the literature, to design, implement and analyse the results from a questionnaire which was given to a broad cross-section of teachers. Schools were chosen from all primary schools in the eastern suburbs of Melbourne with each fourth school in the alphabetical list being selected. Principals were invited to choose teachers involved in school health programmes to complete the survey.

The final stage, phase 4, was structured around a focus group interview with eight teachers who were chosen from schools which had comprehensive programmes. Major uncertainties from the early phases were put to the group to hear what they said about the issues and interpretations which were still problematic. It also provided an opportunity to check earlier findings.

It is argued that the use of both qualitative and quantitative methods and the shaping of one phase by the preceding one(s), provides opportunities for triangulation of data and accuracy in mapping and explaining teachers’ understandings of a concept, framework or phenomenon (Brotherson and Goldstein, 1992; Robson, 1993). There is also a strong case made in the literature by researchers and evaluators in the health and education fields.
who argue for a closer symbiosis of both qualitative and quantitative frameworks so the phenomena under investigation can be understood to the highest level (Green and Lewis, 1986; Hawe et al., 1990; Glesne and Peshkin, 1992; Tilford and Delaney, 1992; Tones and Tilford, 1994). Similarly, the step-wise discovery approach was used where each phase in a sequence shapes and enriches the questions asked in the next phase, and can lead to findings which might earlier have been tentative and can be substantiated further or eliminated as the research progresses (Patton, 1990; Tesch, 1990; Brotherson, 1994).

Collecting data using qualitative methodology may influence the interviewer in shaping their responses. Robson (1993) argues that the perceived disadvantages of reliability of data from subjects with different opinions and beliefs is outweighed by the potential of the interview to provide rich and illuminating data (p. 229). Guidelines for interviewing suggested by Robson (1993), Morgan (1990), Flores and Alonso (1995) and Duffy (1993) were followed to reduce interviewer bias.

The collation and analysis of the qualitative data in phases 1, 2 and 4 was undertaken to seek progressive insights into teachers’ comprehension of the health promoting school. All interviews were tape recorded and played back regularly to ascertain and understand the points being made by teachers in reference to the variety of stimuli, namely photographs, individual and group tasks and reactions to assertions.

Table 1 summarises the data collection methods.

RESULTS

Phase 1
Nine teachers in three schools took a total of 112 photographs to portray what their school was doing in school health. Teachers individually explained the photographs to the interviewer. Six categories were used to cluster the responses (see Table 2).

Four main themes and issues emerged from phase 1. These were stated as a series of assertions.

Teachers appear to undertake and support both a health education and health promotion focus

Indications from this phase suggested teachers believed school health should be about: (i) achieving health gains through health promotion initiatives, e.g. increased fitness, improved nutritional practices; (ii) health educational learning outcomes, e.g. decision-making skills in safety; and (iii) understanding the benefits of oral health; knowledge of the components of a balanced diet.

Teachers appear to believe that school health can be addressed in diverse ways in school communities

The teachers in phase 1 believed that school health involved a number of action oriented dimensions, e.g. developing school policies in areas such as bike helmets, sun protection (no hat—no play), protective sporting equipment. They also claimed that health was enhanced by the provision of an appropriate physical environment, such as sporting facilities, buildings and vegetation.

The content of school health is dominated by five areas, namely physical activity, nutrition, mental health, safety and sun protection

Teachers talked about topics as they described their photographs. Anecdotes and stories were told to explain why the photo was taken and in most cases pride was expressed about how they and the school were tackling the issues of the topic area. Only five topic areas were mentioned in explaining the photos. These five areas are part of the stated health curriculum. Not mentioned was sexuality education and drug education, which are also part of the curriculum.

The understanding of the notion of local school community in the context of school health, is perceived by teachers in terms of resources

The teachers viewed the local community as a resource which could provide speakers to both students and parents about health topics. There was no evidence presented in this phase to indicate that teachers perceived local community members and agencies as partners in planning, implementing and reviewing school health programmes.

Phase 2
Five focus groups were undertaken with teachers \((n = 31)\) from five different primary schools. Twenty photographs, reflecting the five areas of the Ottawa Charter and which depicted school health, were used as stimulus material for the groups. Teachers were asked to: (i) cluster the photos into groups which made sense to them and explain the clusters; (ii) choose the photographs which would produce the ‘best health
<table>
<thead>
<tr>
<th>Phase</th>
<th>Purpose</th>
<th>Methods</th>
<th>Recording of data</th>
<th>Processing and analysing of data</th>
<th>Form of findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>to ascertain how teachers constructed ‘school health’</td>
<td>task explained to Principal photographs taken by individual teachers</td>
<td>photographs (various) (numbered at interview) taped interview</td>
<td>tapes played back and data recorded in tables and under headings tentative assertions formed</td>
<td>series of themes and assertions based on commonalities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1:1 debriefing interviews two weeks later</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>to ascertain the priorities teachers have for school health</td>
<td>5 focus group interviews with separate schools</td>
<td>all interviews taped teachers categorisations of photos noted at interview</td>
<td>tapes played back and reasons for categorisations recorded all photos and their placements noted and collated groupings developed for comment about health promoting schools</td>
<td>a set of data reflecting frequency of responses assertions made based on data (photo choice and narrative)</td>
</tr>
<tr>
<td></td>
<td>to explore how teachers viewed health outcomes for students</td>
<td>20 numbered photos used to stimulate discussion teachers asked to respond to 4 main tasks/questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>to gain some early understanding of how teachers saw a ‘health promoting school’</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>to check how a wider group of teachers viewed health promoting schools</td>
<td>questionnaires distributed to schools and teachers chosen at random open ended, rating, and ordering responses</td>
<td>data entered on to SPSS</td>
<td>open-ended responses grouped into clusters statistical tests undertaken to determine frequency, correlations and patterns</td>
<td>a set of quantitative data assertions based on the questionnaires</td>
</tr>
<tr>
<td></td>
<td>to determine teachers priorities for the buildings blocks of health promoting schools</td>
<td></td>
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<tr>
<td></td>
<td>to identify the factors influencing health promoting schools</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>to check perceived anomalies and unclear assertions</td>
<td>focus group with 8 teachers responding to certain issues and questions</td>
<td>taped interviews</td>
<td>tape played back comments noted and explanations made</td>
<td>a set of tentative conclusions identification of areas of uncertainty</td>
</tr>
</tbody>
</table>

**Table 1: Summary of the structure of the study**
outcomes for students’; and (iii) explain what the phrase ‘health promoting school’ meant to them. The interviews were taped and the discussions analysed.

Four key themes emerged from Phase 2. These are presented as assertions.

**Teachers think about school health from a categorical stance**

When talking about priorities and outcomes of school health, teachers constructed their conversations based on health topics. Three dominated: physical activity, food and nutrition, and safety.

**Experience and participation with the health promoting school concept influences teachers’ understandings of what a health promoting school is, how it works and what it might achieve**

Some teachers had actually started to develop a more holistic approach to school health and to adopt health promoting school concepts without knowing the framework existed. These teachers showed greater appreciation of the diversity and complexity of school health than teachers who saw health as classroom based.

**Professional development programmes for teachers about school health is a strongly expressed need**

Only one of the 20 photos depicted teachers. This one was of a group of teachers undertaking a professional development programme. It was the second most popular photo when teachers were asked to ‘choose four pictures which give you the best outcomes for students in a health related program’. Teachers stated they needed more knowledge and skills if they were to work successfully in school health.

**Teachers wish to engage more with the local community but appear not to know why**

Some of the photographs (four of 20) depicted school community health-related activities. These produced an enthusiastic response from teachers, e.g. ‘yes, we should do more of that’ but when pushed to explain why, there was little or no response which gave insights into their selections.

**Phase 3**

The questionnaire used in this phase was constructed using the findings of phases 1 and 2 and the frameworks and guidelines from organisations and countries who were using the health promoting school concept.

Teachers \( (n = 102) \) were asked to respond to the question ‘what does the term health promoting school’ mean to you. Responses appear in Table 3. The respondents were also asked to rate 16 statements ‘which you believe reflects their importance [of the statements] for enhancing students’ health’. The rating line had 0 at one end with the words ‘not important’, and 10 at the other with the word ‘essential’. They placed a cross on the line at points which they deemed appropriate. Responses are shown in Table 4.

Teachers were asked ‘If your school was to become more active as a health promoting school, what are some factors which would enhance or inhibit your school’s programs.’ Results are shown in Tables 5 and 6.

**Phase 4**

The results and analysis from phases 1 to 3 were re-read and the data were re-examined to identify which components were difficult to explain and interpret. A series of assertions were put to eight teachers in a focus group lasting 90 min. These were the following.
Primary school health is shaped by five content areas, namely physical activity, nutrition, safety, mental health and sun protection.

All teachers believed this was the case in their schools—past and present. They believed the curriculum guidelines emphasised physical activity and nutrition and claimed that the area of safety was underpinned by government policies relating to road safety, ‘stranger danger’ and the regulations governing the use of bicycles. Mental health was explained as permeating all activities in primary schools.

Table 3: Categorisations of teachers’ responses to the question—What does the term health promoting school mean to you?

<table>
<thead>
<tr>
<th>Categories</th>
<th>Percentage of total no. of teachers making the response</th>
<th>Percentage of responses in this category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum</td>
<td>90</td>
<td>33.1</td>
</tr>
<tr>
<td>Resources</td>
<td>33</td>
<td>12.5</td>
</tr>
<tr>
<td>Policies</td>
<td>32</td>
<td>12.1</td>
</tr>
<tr>
<td>Environment</td>
<td>26</td>
<td>9.9</td>
</tr>
<tr>
<td>Staff</td>
<td>20</td>
<td>7.4</td>
</tr>
<tr>
<td>Students</td>
<td>20</td>
<td>7.4</td>
</tr>
<tr>
<td>Community</td>
<td>20</td>
<td>7.4</td>
</tr>
<tr>
<td>Parents</td>
<td>17</td>
<td>6.3</td>
</tr>
<tr>
<td>Professional development</td>
<td>11</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4: Results of teachers’ responses to 16 statements about health promoting schools

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>Empowers children to think critically and analytically about social and health issues</td>
<td>8.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Possesses comprehensive and suitable resources for both students and staff</td>
<td>7.7</td>
<td>2.6</td>
</tr>
<tr>
<td>Focuses on the school as a caring community</td>
<td>7.7</td>
<td>2.5</td>
</tr>
<tr>
<td>Possesses a comprehensive health curriculum which engages all pupils</td>
<td>7.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Acknowledges staff well-being and health-related activities</td>
<td>7.4</td>
<td>2.7</td>
</tr>
<tr>
<td>Attempts to integrate external health services, e.g. local government, health care professionals into the school’s health programme</td>
<td>7.4</td>
<td>2.6</td>
</tr>
<tr>
<td>Recognises the significance of staff as role models in health-related issues</td>
<td>7.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Recognises the wide range of influences on pupils’ health</td>
<td>7.1</td>
<td>2.7</td>
</tr>
<tr>
<td>Provides ongoing professional development for staff</td>
<td>7.0</td>
<td>2.9</td>
</tr>
<tr>
<td>Develops regular parental support and cooperation</td>
<td>6.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Takes account of students health beliefs, values and attitudes</td>
<td>6.4</td>
<td>3.0</td>
</tr>
<tr>
<td>Demonstrates the integration of the physical, social, mental and environmental aspects of health</td>
<td>6.2</td>
<td>2.8</td>
</tr>
<tr>
<td>Acknowledges the importance of school policies as integral of health</td>
<td>6.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Recognises the socio-economic determinants of health</td>
<td>6.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Demonstrates a focus on the school’s physical environment</td>
<td>5.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Demonstrates student participation in decision-making and policy development</td>
<td>5.2</td>
<td>3.0</td>
</tr>
</tbody>
</table>
It’s self esteem, feeling, feeling good about yourself and really what goes on in the whole school to make it a healthy environment for students. (Shirley)

Teachers think about health in terms of the curriculum and topics
This statement produced common agreement among all participants. They believed that what primary schools traditionally do when it comes to addressing a health issue is to try and locate it in different areas of the curriculum to maximise its integration.

If we have to do nutrition we try and link it to science, english and any other area which is relevant. (Tammy)

Teachers believed that the weekly work programme commonly used by many primary teachers as their way of planning their curriculum for their own class, encouraged them to see how certain health themes could be interconnected to the regular areas. However, their belief about what was important in health appeared to be interpreted on an issue basis where there was widespread community concern. There appeared to be a willingness by teachers to accept those health problems and issues which relate to children and are part of community debate, as legitimate for schools to address.

Professional development in school health, particularly for teachers is a strongly expressed need
All respondents claimed they didn’t receive enough in-service education and training in health. Most had been to only one or two workshops or conferences on health-related issues in the last 3 years.

Teachers rate the social environment higher than the physical environment when comparing them but only emphasise the physical environment in unprompted responses
This assertion was put to the group to ascertain why teachers only focused on physical environmental components when asked to portray a health promoting school, yet rated the social environment much higher than the physical environment (3/16 with a score of 7.7/10; to 15/16 and 5.3/10—see Table 4) when asked to compare them.

It’s easy to explain—because you can talk about buildings and trees and classrooms without much emotion but the social environment involves people and their behaviours and it’s harder to talk about and describe. (Tammy)

The teachers discussed how the word environment has physical connotations in everyday ways—pollution, ozone layer, noise, water contamination, roads—and asked whether it could be this which shapes peoples responses. The physical environment was identified exclusively when teachers were asked to describe what is meant by a health promoting school in question 1 in phase 3 (see Table 3). There was no prompting here of the word environment.

No one was able to offer an explanation about why the social environment did not emerge in the unprompted responses in phase 3, and only minimally in phases 1 and 2.

You can’t give money to it, you can’t launch it and you can’t see it—we take it for granted. (Mary)
The ranking of the 16 health promoting school components in phase 3

The result of the ranking of the 16 statements describing health promoting schools was given to the focus group (see Table 4). The table was explained and participants were asked to explain why teachers may have rated selected items in the order they did.

They were asked to clarify why ‘empowers children to think critically and analytically about social and health issues’ was clearly at the top of the rankings.

This statement reflects the emphasis of sciences and maths on a school’s curriculum and our strong focus on the left brain to the detriment of the right brain and its more creative side. Oh—its also about the dominance of universities on the school curriculum which encourages analysis. (Jan)

No one would put it anywhere else—the word ‘empowers’ is powerful and it is what we are supposed to do as teachers and it is what is expected of us—empowerment is ‘in’! (Fiona)

The impression gained from the group was that this statement should be at the top of the 16 statements and it is what schools are attempting to do in health and other areas of the curriculum. It reinforces earlier findings that teachers see their role in school health as emanating from the curriculum and focusing on life skills, rather than health knowledge gain or changes in health practices.

The overall order of the other statements in Table 3 was supported by the group.

DISCUSSION

The study was a progressive discovery of how teachers understood the health promoting school concept. The results of the sequential phases in the methodology are discussed around four areas, namely: the building blocks of the health promoting school; key personnel involved in implementing the health promoting school framework; the interface between the health and education sectors in shaping health promoting schools; and the support (resources and professional development) needed for teachers to implement the health promoting school concept.

The building blocks of the health promoting school

School health policies

Teachers appear to accept these and are prepared to monitor them. However, many of the policies have been imposed on schools, e.g. no tobacco use, safety requirements, equal opportunity regulations, mandatory reporting of certain illnesses. Others which the schools have introduced, e.g. no hat—no play! for sun protection, have followed substantial community-based health promotion campaigns and wide community acceptance.

There was little evidence in the study of the willingness of teachers to establish school-based policies unless they are grounded in wide community support. This was very evident when teachers discussed what food should be served in the canteen and what approach should be used to address gender variations in participating in physical activity. Strategies for handling areas, such as these where there was no clear community consensus about the direction, were not seen by teachers as being amenable to school-based policies.

It appears primary schools will accept policies imposed on them but do not wish to initiate policies about health without widespread community support.

The various guidelines and frameworks for health promoting schools, e.g. WHO (Euro), WHO (WPRO), CSHE which encourage schools to adopt a range of policies may be unrealistic in their expectations of what teachers and schools can do and are prepared to do. Only those which are mandated externally or which have widespread community support are likely to be incorporated as school policies.

Physical environment

The teachers in the study had inconsistent views about the significance of the physical environment in school health. The physical environment emerged as a key part of school health in phase 1, was not significant in phase 2, was rated lowly in phase 3 and prompted confused comment in phase 4. It may be the methodology of encouraging teachers to take photographs in phase 1 produced more environmentally based examples, particularly as two of the three schools were in environments which were atypical of most schools—one bordering a national park on the side of a hill, and the other in the crowded inner
city with limited playing space, asphalt surfaces and busy traffic. In more usual school settings the physical environment did not seem to be very important for teachers as a building block of the health promoting school.

Perhaps the most useful understanding of the physical environment occurred in phase 3, where it was acknowledged by 10% of the respondents as being part of a health promoting school in their responses to the question ‘what does the term health promoting school mean to you?’, but was ranked 15/16 in the comparative ranking of components. Is the physical environment taken for granted? Do teachers understand how it impacts on health?

Australian schools are usually well sited and have adequate buildings and playing space. Recent improvements in staff amenities, computer facilities and gardens have contributed to physical environments which are pleasing to staff and students. The author has found all the schools he visited in this study, taking great pride in their environments and decorating their walls and common spaces with student work, photos and examples of school celebrations and events. It is contended that the physical environment is not seen as significant in the components of a health promoting school because teachers have had quite reasonable environments in which to work in the last 25 years.

Social environment
The study shows teachers value the social environment very highly in their primary schools. However, they expressed this in language and ways which required some further investigation and reflection. Of all the six components of a health promoting school, it is the social environment which was the most difficult for teachers to describe and define.

Teachers couldn’t photograph it, but in their stories about the photographs, referred to it constantly, e.g.

I think the most important thing we can do as teachers is to make school a place of pleasure and fun and a place where the kids want to come each day. (Karen—school B)

They talked about a school ethos, a place of happiness and calmness in phase 2, and in phase 3 when asked to rank it, they rated it equal second of the 16 health promoting school statements.

Community partnerships
There is considerable rhetoric in the health promotion literature and health promoting school frameworks about community partnerships (WHO, 1986b; Kickbusch, 1993; Labonte, 1993; Kickbusch and O’Byrne, 1995; WHO, 1995b; WHO, 1996). This study shows that teachers do not understand what it means. They appear to acknowledge the rhetoric but see community partnerships more in terms of resource acquisition, e.g. visiting speakers and information kits, rather than in working with the local community in collaborative activities to improve the opportunities for the students’ health.

Phase 4 confirmed the acceptance and willingness of schools to work with their local communities and be part of them; however, the discussion was more about resources, e.g. ‘the community use the school oval and book rooms for meetings’ (Shirley), than about joint working arrangements. There is little research about the benefits of school–community partnerships in school health. Perry et al. (1989) and Kalnins et al. (1994) demonstrate working with the local community on health issues relevant to students can have considerable benefits for students, but it is labour intensive and very demanding on the time and skills of teachers.

More convincing evidence of a practical and achievable nature will need to exist before teachers are prepared to undertake action to match the rhetoric in the community partnerships area. Also, they will need considerable professional development and opportunities to experience success in this area before they embrace it.

Personal health skills
The study shows teachers rate this very highly and spend the majority of their efforts in school health in this area as they work in the formal curriculum. However, the proponents of the health promoting school in the education sector tend to embrace educational learning theories and models in facilitating the development of specific health-related skills in students (Allensworth and Kolbe, 1987; Lavin, 1993; Bruun Jensen, 1994; NHMRC, 1997). The health sector tends to see schools as useful settings where a captive audience can be reached to bring about behavioural change which lowers morbidity and mortality rates (American Cancer Society, 1993; National Health Strategy, 1993; WHO 1995a,b, 1996).
Certainly, recent reports in Australia which have emerged out of specific health concerns in young people, e.g. illicit drug taking, inactivity, suicide, obesity, always suggest the need for ‘education programmes’ in schools to reduce the health problems (Committee for the Review of Physical and Sports Education in Victorian Schools, 1993; Nutbeam, et al., 1993; Premiers Drug Advisory Council, 1996). The challenge in the personal health skills area is for the education and health sectors to identify an agreed set of competencies in school health in the context of the different outcomes they wish to achieve. Colquhoun and Patrick (1992), Brunn Jensen (1994), Kolbe (1993), Cohen (1995) and Allensworth (1995), all address this issue in their writings. Its resolution is one which still appears to be avoided by both the education and health sectors as they both seek to improve school health.

Teachers need more clarity and consistency if they are to make their maximum contribution in this area, namely personal health skills. It is what they probably do best in school health and it is where they need consistent messages and support.

**Integrated health services**

The study showed teachers place great reliance on external health-related organisations and are dependent on their materials and services to underpin their programmes. But this is not integration. Nor does it address what the school does about its own health services, e.g. first aid, canteen, play equipment and space. Much needs to be done here to encourage teachers to look at school-based health services and to work in more collaborative ways with the health agencies rather than the schools acting as their client. The health promoting schools framework takes a more eclectic view of integrated health services. The WHO (WPRO) document in particular, attempts to encourage teachers and health care workers to collaborate on joint actions rather than in the current customer/client focus (WHO, 1996). For example:

(i) there is consultation between health services personnel and teachers about the design and implementation of the health related curriculum, and

(ii) local health services support schools in explaining and implementing local health campaigns (p. 16).

Similarly a number of the proponents of the CSHE in the United States make the same arguments (Seffrin, 1990; Kolbe, 1993; Allensworth, 1995).

To make this component effective, considerable work has to be done with both teachers and health care professionals to reshape their current working relationships and move them away from information provision to joint and collaborative actions towards specific goals which are focused on enhancing the health of students.

**The key personnel in health promoting schools**

There appear to be three core groups which are essential to the growth of health promoting schools: teachers; education system administrators, including principals; and public health and health promotion policy-makers.

This study has shown teachers are very interested in the concept. However, teachers and schools do need financial and consultancy support, substantial professional development, and opportunities to create their own health promoting school models in collegial settings with appropriate affirmation from within and outside the school. The study has shown that teachers will most likely shape their health promoting school initiatives using the curriculum as the anchoring point. This has implications for the development of resources with a health promoting school focus. The findings of this research suggest that such resources should extend the official health curriculum by mapping it on to the health promoting school components. Teachers’ core business is to teach the curriculum. An innovation such as the health promoting schools will have a greater chance of success if it is explicitly linked to the formal curriculum.

The health promoting school is a whole school approach. As such it needs the support and commitment of the school principal and school council. Innovations across schools have little chance of success if there is no support from the administration. The challenge for the health promoting school movement is to convince school principals and their school councils that they should be doing more in school health, that there are better ways of doing it and that the health promoting school is the appropriate way. This is a difficult challenge. Schools are constantly under pressure to take on societal issues in a number of areas, e.g. the environment, technology, alienation, violence and family breakdown. Health is just one of these areas. There are also pressures to enrich traditional school areas such as literacy, numeracy and
science. The concept of health promoting schools must be ‘sold’ in a competitive market-place. It cannot be packaged as an additional issue to be added to a school’s already overloaded portfolio. It needs to be presented astutely and truly. It is argued that its components are eclectic and will enable schools to address other issues, e.g. alienation, environment, violence, family breakdown, etc. by using the organising framework of the health promoting school which links the categorical issues. But it needs to be careful in not ‘selling’ itself as the health sector’s solution to improving child health behaviours and reducing morbidity and mortality data. While the public health sector has often set the agenda for school health in the past, the success of the health promoting school concept will be enhanced if it grounds its arguments in better educational discourse and speaks the language of the sector with which it wishes to engage as the translator of the health promoting school concept. A number of promising examples of this approach have occurred in some countries in the European network of health promoting schools (Brunn-Jensen, 1994; McDonald and Ziglio, 1994).

The relative influence of the health and education sectors

The content, focus and support materials of school health have been led and resourced (largely) by the health sector for over 90 years in Australia. The sector has been committed to achieving optimal health for young people and has identified specific goals and targets in attaining this vision. The health promoting school is a well argued and carefully constructed framework to achieve these goals.

It has the support of international, regional and national health authorities. Even across countries and programmes there is a remarkable consistency in its components. But it has been developed in most instances in isolation from the education sector. Exceptions are the US CSHE programme, which is closely grounded in educational theory and practice and some of the country-based initiatives in the European Network of Health Promoting Schools, e.g. Denmark, Norway.

It is now time for the health sector to reflect on its health promoting school frameworks and to establish closer working relationships with the education sector, and schools in particular, in implementing the frameworks. The cause of health promoting schools will be inhibited if the health sector continues to see it as merely a strategy for achieving health gains and imposing it on schools as a solution. A greater appreciation is needed by health personnel, particularly about how schools work, what gains can be realistically achieved in primary schools, and most importantly, what are the views, capacities and commitment of teachers to take, shape and implement health promoting schools.

The place of resources and professional development

This study showed, particularly in phase 3, that teachers need resources and feel secure where they can adapt them. The guidelines and frameworks offered in international health promoting school initiatives vary considerably in the resources they offer teachers. Some, e.g. WHO (WPRO), are directional guidelines for the 32 member countries in the region, where it is expected that these member countries will use the guidelines to develop its own health promoting school approaches. The European Network for Health Promoting Schools (ENHPS) is well advanced in facilitating the implementation of health promoting schools in its member countries and has provided them with specific resources and assisted the countries in developing their own frameworks. In Europe, manuals and newsletters have been produced, and in many countries there is an intensive professional development programme for teachers and consultancy support. Products for the advancement of health promoting schools need to identify and clearly explain the broad directions of health promoting schools, but above all they must be seen by teachers as resources which are user friendly and which encourage school ownership and creativity.

The study has shown professional development for teachers to be one of the major factors in supporting the uptake of health promoting schools. The teachers in the study had little understanding and training in many health concepts and issues, let alone the complexities of the health promoting school. Nevertheless, the study showed a willingness by teachers to take on the health promoting school as an organising framework for school health.

This study also showed that many teachers are very willing to take up the health promoting school concept, but don’t fully appreciate its dimensions. Teachers think about health promoting schools in terms of their core business—what they do in their classrooms. Primary school teachers have limited preservice education and
training in health and have little inservice experiences in health. Inservice education and training in health has largely focused on one-off activities about a specific health issue, e.g. physical activity, first aid and protective behaviour.

Any professional development programme must balance the need to enrich teachers’ basic health knowledge with helping them acquire skills to establish, implement and sustain health promoting schools. Research tells us that teachers learn new ways of working and can sustain these ways if: theory is presented clearly and pragmatically; they have opportunities to see other teachers and schools model and demonstrate approaches to the issue; they are given opportunities to receive feedback on their own initiatives as well as to give feedback on the initiatives of others; and the skills and knowledge gained are supported over time through coaching and collegial support by peers (Sparks, 1986; Joyce and Showers, 1988; Joyce and Weil, 1991; Baird and Northfield, 1992).

The health promoting school concept is a promising framework which may help schools and teachers to integrate health initiatives and to link in a coherent way many of society’s health issues which schools are asked to address. However, it is asserted that the concept will only be successful if teachers can understand it, interpret it and shape it to meet the needs of their school community. This study has demonstrated that while teachers have some understanding of the health promoting school much needs to be done to support them in undertaking their role which the health promoting school concept expects.

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