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THE HEALTH PROMOTING SCHOOL (HPS) - CONCEPT AND ASPECTS

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Introduction

Health Promotion emerged in the 1980's as a way of addressing health issues in an integrated way. It is multi-disciplinary, drawing on fields such as psychology, biology, sociology, economics, political science, medicine, and law. It developed as a response to a significant body of research which suggested that it was more effective to look at the contexts in which people lived, rather than only addressing their behaviours.

The Origins of the Health Promoting School

The Health Promoting School concept emerged simultaneously in Europe and North America in the mid-1980's. It is based on the Declaration of Alma Ata (WHO, 1978) and the Ottawa Charter for Health Promotion (WHO, 1986). The Declaration of Alma Ata called on all governments to:

"... formulate national policies, strategies and plans of action; to develop a multisectoral approach; to involve citizens in planning, organisation, operation and control of primary health care; and to focus on education as a means of preventing and controlling health problems". (p5).

The World Health Organisation encouraged its regional offices to work with member states in their region to develop more holistic and effective approaches to school health using the principles of the Declaration of Alma Ata and the Ottawa Charter. The Western Pacific Region of WHO (WPRO) embraced the challenge enthusiastically. This region, of which Australia is a member, has the largest human population of the five WHO Regions. It includes countries as large as China (1.2 billion) and as small as Nuiai (2000). A major WPRO policy document 'New Horizons in Health' was adopted by the 32 member states in the region. The document identified three themes: (i) preparation for life; (ii) protection of life; and (iii) quality of life.

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The Health Promoting School (HPS) was identified as a vital strategic direction for the theme – preparation for life.

The Structure of the Health Promoting School

A set of regional Guidelines for Health Promoting Schools was developed in 1995 for WPRO (WHO, 1996). All member states endorsed the guidelines, including Australia.

The Guidelines defined the HPS as:

A Health Promoting School is a place where all members of the school community work together to provide students with integrated and positive experiences and structure which promote and protect their health. This includes both the formal and informal curricula in health, the creation of a safe and healthy school environment, the provision of appropriate health services and the involvement of the family and wider community in efforts to promote health.

The concept of the Health Promoting School is international in its development, with many countries around the world working on programmes which support schools and their communities in better health actions. It complements the WHO School Health Initiative, which provides an impetus for mobilizing and strengthening school health promotion and education activities at local, national, regional and global levels.

Health Promoting Schools need to be set up in a way which ensures that positive changes are sustained. A school's future should not be dependent on the enthusiasm and commitment of a few staff members or an individual school administrator. For this reason the proposed approach is to develop policies, practices and structures which embed the fundamentals of a Health Promoting School into a school's operation.

There are six components of the Health Promoting School. These included:

School Health Policies

School health policies are the clearly defined and broadly promulgated directions which influence the school's actions and resource allocation in areas which promote health. Many schools may already have overall school policies on a range of issues. If these existing policies do not already refer to health issues, they could be extended to incorporate them.

The physical environment of the school

The physical environment refers to the buildings, grounds, and equipment for both indoor and outdoor activities and the areas surrounding the school. The term also refers to basic amenities such as sanitation and the availability of water.

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The school's social environment

The social environment is a combination of the quality of the relationships among staff, among students, and between staff and students. It is often strongly influenced by the relationship between parents and the school, which in turn is set within the context of the wider community. It is also influenced by senior staff from within the school, and by health and education personnel who visit the school, all of whom provide role models for students and staff by the attitudes and values they display in their social behaviour.

Community relationships

Community relationships are the connections between the school and the students' families, plus the connection between the school and key local groups who support and promote health. By definition a health promoting school is one where parents are closely consulted about and involved in the school's health promotion activities.

Personal health skills

This refers to the formal and the informal curriculum whereby students and others gain age appropriate knowledge, attitudes and understanding and skills in health which will enable them to become more autonomous and responsible in individual and community health matters.

Health services

These are the local and regional health services which have a responsibility for child and adolescent health care and education, through the provision of direct services to students and in partnership with schools.

Benefits of the Health Promoting School

The literature identifies a number of potential and real benefits of health promoting schools. Those which are identified relate to benefits which should occur if schools had a comprehensive framework for school health which encompasses skill development, physical and social environments, integrated health services, attention to equity issues, community partnerships and closer involvement with parents.

The real and potential benefits of health promoting schools identified in the literature are summarised under nine headings. Selected examples from the literature are described to portray the range of benefits claimed.

The health promoting school model has been portrayed as a most promising framework which should produce better health outcomes for students, now and into the future. By linking the curriculum with the school environment and community, a greater range of the factors which

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effect student's health have a better chance of being addressed than if only explored through classroom curriculum (Young & Williams, 1989; Green, et al., 1980; Hamburg, 1990; Kolbe, 1993; WHO, 1994; Allensworth, 1994; Dommers & Ingolby, 1996; NHMRC, 1996; WHO, 1996; Rowling & Ritchie, 1996; Lister-Sharp, et al., 1999).

The proponents of health outcomes in school health frequently base their case on the diversity of factors which are part of school health and impact on a student's health, knowledge, attitudes and practices. Common themes suggest, that in nutrition, a school which has a comprehensive health curriculum that addresses food purchase, composition, preparation; involves students in linking with community agencies, e.g. retailers and producers; and has a school canteen which promotes healthy food and is largely managed by the students, will provide better nutritional outcomes than merely teaching children about the five food groups in the classroom (Burns, 1992; Harberts, 1992; Dunt & Day, 1995; NNESP, 1995).

Education Outcomes

Children learn better if they are healthy (WHO 1995; Lavin et al 1992; NHMRC, 1996; Arya & Devi, 1991; World Bank, 1993; Igoe, 1993). Schools which take an integrated and holistic approach to education and which place emphasis on teacher effectiveness and parental participation appear to offer opportunities for children to learn effectively and to gain a number of life skills which are foundation stones for education achievement. (Levinger, 1994; Hill et al., 1993; Cantwell, 1996). The health promoting school approach is consistent and compatible with a more integrated and holistic view of education and should facilitate the learning capacities of students.

School based health policies

All the major international health promoting school frameworks identify healthy school policies as a vital part of their building blocks. There have been very few well evaluated studies, however, which compare the health outcomes of schools which have focused on establishing and upholding health enhancing policies with those which do not have or do not implement such policies. The policy component seems self-evident, but is not totally supported by, at this stage, the literature because very few substantial studies have been undertaken to demonstrate the usefulness of school health policies. The apparent obvious benefits of school health policy may have mitigated against comprehensive and relevant research studies which have focused more on the curriculum domain and gaining knowledge about students' health knowledge, attitudes and practices and the influence of the curriculum on these.

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Health services

For many years schools have enabled health and other associated professionals to enter their premises and to screen and/or treat children. There are some indications in the literature which suggest that school health services interventions would be more effective if they worked more closely with the schools themselves (NHMRC, 1996; Kolbe, 1993; Shilton, 1993; Brellochs, 1995).

Local community

The local community figures prominently in all models of the health promoting school (WHO, 1995; WHO, 1996; Dommers & Ingolby, 1996; WHO, 1993). There are very few studies, however, which provide a rich understanding of how school-community links are established, how they operate and whether they are effective. The findings from this limited pool suggest that such school community partnerships require major effort and time to bring the key stakeholders together. In addition all stakeholders appear to have a poor understanding about how the other sectors work and what needs to be done collaboratively to meet the goals of all participating groups (Goltz, 1992; Minkler, 1991; O'Neill, 1992).

The school's physical environment

The physical environment is considered significant in all the different models of the health promoting school. Components identified include school buildings which are adequately furnished, ventilated and lit; drinking, washing and toilet facilities with appropriate use of freshwater; play space and playground protection including trees and covered areas; recycling of renewable resources and appropriate disposal of waste matter (Tones & Tilford, 1994; NHMRC, 1996; WHO, 1995; American Cancer Society, 1993). There is an abundance of literature which clearly articulates the problems school children face if their environment does not have adequate fresh water and sanitation facilities, and the benefits of design to reduce the risk of physical injury (Rowe, 1987). Appropriate numbers, position and design of buildings also appear to enhance the mental health of students (Wulf, 1993).

The school's social environment

The literature is only beginning to unravel the complexities of the social environment which is described in a variety of ways including as the 'psycho-social environment' (WHO, 1995) and the 'school ethos' (NHMRC, 1996). Discrete components of the social environment are difficult to isolate. One document (WHO, 1996) lists the following as being part of the social environment: discipline procedures; physical and verbal violence reduction strategies; cultural,

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religious and tribal celebrations; and support mechanisms for students with a physical and/or learning disability. Others (Hawkins & Catalano, 1990;
Forman & O'Malley, 1985) take the view that students' experience of school is a crucial element in shaping their health behaviours during adolescence and beyond. There is a body of evidence to suggest that schools which provide a place of enjoyment and peace are more likely to produce students with greater health and learning gains (Zins & Ponti, 1985; WHO, 1995; Hurrelmann et al., 1995).

Recent work 'Mind Matters' program showed that schools can make a difference to the mental health of students which translates into better learning outcomes (ACER, 2004).

Effective school health promotion

The primary business of all schools is to maximise learning opportunities and learning outcomes for all students. Schools are also charged with the responsibility to build the competencies of young people in making decisions, relating effectively, understanding justice, equity and honesty and practicing these attributes. The role of the teacher is complex, difficult and challenging. The school is an important influencing agency in a person's life.

There is a body of evidence that shows poor health inhibits learning (World Bank, 1993; WHO, 1996; Devaney et al., 1993). A meta-analysis of many studies by Symons et al., 1997, also shows strong links between poor health behaviours, low health status and educational outcomes (e.g. grades and classroom performance), educational behaviours (e.g. attendance at school and participation in school activities) and student attitudes (e.g. self-esteem, lack of control).

The main reason why schools address health and related issues is to enhance the attainment of educational goals. Schools are largely ineffective if they are asked to address health issues as a way of solving society's problems.

Schools have limited influence on a student's health status and health behaviours. External influences such as the family, media, and peer pressures, biological and social determinants play a major role in shaping their health. The school, however, is central in building a student's literacy, numeracy, problem solving, and conflict management and technology competencies. Interventions on a health issue which focus on schools, need to be developed in the context of what is possible and what is reasonable to expect of teachers and students.

What Works in School Health Promotion

Schools are effective in their health promotion interventions when their programs are:

- Focused on cognitive outcomes as a priority over behaviour change

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- Comprehensive and involve appropriate components of the Health Promoting School (HPS) framework
- Substantial, preferably over several years, and relevant to changes in young people's social and cognitive development
- Enabling teachers to gain new knowledge and skills through professional development
- Using resources which are engaging and interactive and which are complementary to the work of the teachers. (Lavin et al., 1992; Connell et al., 1985; WHO, 1996)

The IUHPE (2000) stated that published findings show a number of commonalities of quality school health programs. Such quality programs address all or most of the six components of the Health Promoting School which are:

- The curriculum
- The physical environment of the school
- The social environment (or ethos) of the school
- Links with relevant health services, e.g. medical, dental, counselling
- Partnerships with parents and the local community
- School policies (the rules, regulations, accepted practices).

(IUHPE, 2000)

These six areas are the components of the Health Promoting School. Further interrogation of the literature shows evidence which demonstrates the essential effective factors of each of these areas.

What Does Not Work in School Health Promotion

Studies over the past decade have also identified approaches to health promotion in schools which are ineffective and should be discouraged. Failed programmes are characterised by the following:

- Programmes which are developed in response to a perceived crisis (especially if accompanied by scare tactics and preaching)
- Broader school involvement which was spasmodic and uncoordinated
- Programmes based largely on external speakers and resources with little involvement of school staff
- Little or no investment in teacher training, and provision of support resources. (Lavin et al., 1992; WHO, 1996; NHMRC, 1996; Allensworth, 1995; St Leger, 1998; St Leger & Nutbeam, 1999)

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