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# *An Evaluation of Factors Which Can Affect the Implementation of a Health Promotion Programme Under the Schools for Health in Europe Framework*

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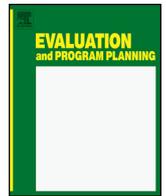
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# An evaluation of factors which can affect the implementation of a health promotion programme under the *Schools for Health in Europe* framework



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## ABSTRACT

The Health Promoting Schools concept helps schools to promote health in a sustainable and long-term fashion. However, developing the capacity to promote health in this way can be challenging when a busy teaching curriculum must be fulfilled. This study aimed to identify factors which affect the acceptability of health promotion programmes to the everyday school environment.

Semi-structured qualitative interviews were audio-taped with primary school teachers in one Irish county and transcribed verbatim. The resulting transcripts were analysed using content analysis.

Thirty-one teachers were interviewed. The factors which may adversely affect the acceptability of health promotion programmes include the: attitude of teachers towards an additional extra-curricular workload; lack of confidence amongst teachers to lead health promotion; and different organisational cultures between schools.

When health promotion programmes under the Health Promoting Schools concept are being implemented, it's important to consider: the readiness for change amongst teachers; the resources available to increase staff capacity to promote health; and the ability of a programme to adapt to the different organisational cultures between schools.

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## 1. Introduction

Children from a wide spectrum of ethnic and socio-economic strata spend a substantial number of their waking hours in school (Maziak, Ward, & Stockton, 2008; Neiger et al., 2008). Schools are uniquely placed to create a single environment in which healthy food and lifestyle habits are consistently and positively promoted (Jourdan, Stirling, Mannix McNamara, & Pommier, 2011; Neiger et al., 2008). For this reason, schools have long been identified as a critical setting for promoting positive health behaviours amongst children (Fox, 2010; Rowling & Jeffreys, 2006; St. Leger, 1998).

A Health Promoting School is one which is constantly strengthening its capacity to improve and protect the health of the school community (World Health Organisation, 1997). In 2009,

the European Network of Health Promoting Schools was rebranded as Schools for Health in Europe (SHE). SHE provides a framework to help schools to build their capacity to sustainably promote health, thus making them Health Promoting Schools (Buijs, 2009). Under the SHE framework, schools enhance health-related elements of school life outside of the traditional classroom curriculum. These elements include: (a) school health policies, (b) health skills taught to pupils, (c) physical and social environments, and (d) relationships with the wider school community. Schools identify their needs under each of these elements and implement activities and health programmes which fulfil the needs identified (World Health Organisation, 1997).

Therefore, effectively implementing health programmes which enhance an element of the SHE concept is important to the process of becoming a Health Promoting School. However, the success of these programmes depends upon their acceptability to the everyday school environment. Developing the capacity needed to implement such programmes can be challenging when the

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requirements of a busy teaching curriculum must be met (Department of Education and Skills, 2005; Inchley, Muldoon, & Currie, 2006; St. Leger, 1998). An “implementation gap” has been observed by several authors (Gugglberger & Dür, 2011; Roberts-Gray, Gingiss, & Boerm, 2007; Rohrbach, Grana, Sussman, & Valente, 2006), where health programmes, although designed for schools, are not successfully implemented when subjected to the everyday workings of school life.

In Ireland, revised guidelines for Health Promoting Schools were jointly issued by the health and education systems in 2013 (Health Service Executive, 2013). With the publication of these guidelines, there was renewed encouragement amongst schools to engage in long-term health promotion programmes. This study aimed to identify factors which affect the acceptability of health promotion programmes designed for primary schools.

## 2. Methods

Ethical approval was obtained from the Health Service Executive Midlands Research Ethics Committee (1010600CJ).

### 2.1. Irish primary school system

In Ireland, children begin to attend primary (also called elementary) school from the age of 5 years. The academic year extends from September to June. It takes 8 years to complete primary school in Ireland, with students progressively moving through classes (also called grades) each year. Students begin in a class called Junior Infants, progress to Senior Infants, and then to First Class, Second Class, etc., until they reach Sixth Class, the final year of primary school. One teacher is responsible for teaching a particular class of students all of the subjects in the national primary school curriculum.

Primary schools in Ireland have the second largest class sizes in the European Union (Organisation for Economic Cooperation and Development, 2014). The average number of students per teacher in primary school is 24 students (Organisation for Economic Cooperation and Development, 2014), and each teacher must teach 12 subjects to each class of students under their care, making time management a particularly challenging aspect of the Irish classroom. The number of classes assigned to a teacher will vary depending upon the total number of students in a school. For example, in urban areas where the student population is larger, teachers in these schools usually have one class of students. However, in rural schools where the number of students in a class is smaller, teachers often have 2, if not 3 or 4, classes of students to teach.

### 2.2. Study background

The Mid-Leinster Community Nutrition and Dietetic Service provide services to counties Laois, Offaly, Westmeath and Longford. This service offers a school health promotion programme, called the *ACE (Activity, Confidence and Eating) Schools Programme*, to primary schools. The *ACE Schools Programme* is a voluntary long-term programme which promotes healthy eating, physical activity, dental health and mental health in schools. Schools are incentivised to participate in the programme through the provision of resources such as water bottles, cookery courses for parents and students, health-related books, and support from a dietitian.

To keep schools motivated throughout the process of becoming a Health Promoting School, schools that participate in the programme are rewarded as they make small but meaningful steps on their journey towards becoming a Health Promoting School. The *ACE Schools Programme* has 4 award levels (bronze, silver, gold and platinum). To obtain an award, schools must

accomplish specific and increasingly difficult health-related criteria under 5 themes, namely:

1. Leadership in School;
2. Partnership with the Community;
3. Promotion of Nutrition and Dental Health;
4. Promotion of Physical Activity; and
5. Promotion of Mental Health.

When schools fulfil the criteria within these themes for each increasingly difficult award level, they progressively build their capacity to promote health across the whole school community and fill the health-related gaps they identified under each element of the SHE framework. As such, the programme helps schools to adopt the habits needed to promote health in a sustainable and long-term fashion.

Upon a review of the *ACE Schools Programme* under the SHE framework, it was recognised that the programme needed to be more easily integrated into everyday school life. To this end, a semi-structured qualitative interview for primary school teachers was devised. The interview sought their suggestions on how to improve the acceptability of long-term health promotion programmes to the everyday school environment.

### 2.3. Data collection

No school in County Longford was availing of the *ACE Schools Programme* at the time of the programme review. These schools were targeted because no relationship had been built with the teachers through the *ACE Schools Programme*. Therefore, it was hoped that these teachers would be more forthcoming with their critique of the programme, and with their views on how to make health promotion programmes more palatable to a time-poor school day.

A teacher in each of the 38 mainstream primary schools in County Longford was contacted by telephone and asked to consent to a face-to-face interview with the lead researcher.

Interviews were arranged with consenting teachers. Informed written consent was obtained prior to interview. An outline of the *ACE Schools Programme* and of how the programme aims to promote health in school was provided. Interviews, ranging in duration from 13 min to 84 min, were conducted on school grounds during school hours until data saturation was achieved. All interviews were recorded and the resulting tapes were transcribed verbatim.

### 2.4. Data analysis

Content analysis was used to analyse the data (Sandelowski, 2010). Content analysis presents a substantial description of, and puts into context, what participants said. Themes were inductively developed and revised from the data collected.

One researcher collected, transcribed, and analysed the data, which helped to ensure a consistent approach to the analysis.

The four-stage Constant Comparative Method (Lincoln and Guba, 1985) was used to manage the data. First, the researcher became familiar with the transcripts and loosely grouped the data into suitable categories. A more thorough analysis was then conducted to ensure that the data were placed in the most appropriate category, with new categories developed as needed. The development of categories was an ongoing and iterative process; revisions were made upon further review of the data, and some categories with similar quotes were merged and given a more appropriate title. Each transcript was reviewed several times to ensure that all relevant quotes had been coded. Consultation

took place between two authors on the final categories and interpretations.

### 3. Results

Thirty-one teachers (81.6% response rate) agreed to participate in the study. These teachers represented underprivileged ( $n=8$ ), privileged ( $n=23$ ), urban ( $n=12$ ) and rural ( $n=19$ ) schools. The teaching experience of teachers ranged from 8 to 42 years, and the teachers interviewed had occupied their current role from 2 to 33 years.

All teachers had some experience of engaging with school health promotion programmes and all acknowledged that the school has a potentially important role in promoting child health. However, this acknowledgment was tempered by concerns with certain aspects of health promotion programmes which teachers felt were incompatible with the everyday work of the school. These concerns have been categorised into three themes:

- (a) Unrealistic expectations of school commitment to health promotion
- (b) Perceived lack of capacity amongst teachers to promote health
- (c) Lack of consideration for different organisational cultures between schools

#### 3.1. Unrealistic expectations of school commitment to health promotion

All teachers acknowledged that the school setting is a logical vehicle through which positive health behaviours can be modelled for children.

*"We have a structure where positive living is built into the environment, so children are more compliant because they see their peers conforming to this positive environment."* [10]

However, although teachers appreciated the notion of schools being used as a component of child health promotion, some resentment was expressed at the seemingly cavalier manner in which schools are targeted to address complex societal issues.

*"You know, there was talk about obesity in children, and next thing it's like, 'Oh, we must get onto the schools about children being more active and healthy eating and everything.' But it's a losing battle if it's not coming from home as well, you know?"* [12]

The fundamental role of a primary school is to meet the requirements of the national primary school curriculum. Teachers expressed frustration at the dichotomy between their obligation to fulfil this essential role, and the pressure on them to address these multi-faceted and time-intensive issues which fall outside their designated remit.

*"The curriculum is so broad that you are really pinning yourself to your collar to just get the basics covered. I think sometimes teachers just feel, 'Oh, here's another thing being flung at us,' you know?"* [7]

In light of this, teachers repeatedly iterated that the design of a school health promotion programme should respect their fundamental role of teaching the primary school curriculum. They stressed that this role fully encompassed each school day, thus severely limiting the time available for activities outside the curriculum.

*"The curriculum is just crammed as it is – it's not as if there's a half hour in the week where we are twiddling our thumbs and wondering what to do."* [5]

#### 3.2. Perceived lack of capacity amongst teachers to promote health

Readily-available professional support was frequently reported to be one of the most important elements of a school health promotion programme. Teachers had reservations about the capacity of teaching staff to effectively promote health without the assistance of a health professional.

*"We need guidelines as much as anybody, you know . . . sometimes your confidence mightn't be top-notch, and you would be quite happy to have someone else direct and guide you."* [22]

In particular, teachers were concerned about their ability to garner support from the wider school community. Assistance with creating a link between the school and home environments was repeatedly raised as an important consideration. Teachers felt it was only logical that a health promotion programme would help with transferring healthy habits learned in school to the home environment.

*"You know, there's no point in doing it here and then they go home and don't pay heed of it—you know, it's just a waste of time if it's not followed on at home."* [19]

To bridge the gap between the school and home environments, hands-on assistance from health professionals was deemed necessary. Teachers observed that the diet and lifestyle practices of children can be sensitive issues for parents. Trained health professionals were viewed as an appropriate means to tactfully bridge the gap between school and home on these issues.

*"I wouldn't like to think that I would be doing that [providing health information to parents], because I think that they would have more respect for somebody from that field."* [24]

*"Getting reinforcement on making changes at home would help – you know, that it's not just us fuddy-duddies saying it to parents – but that there are professionals saying these positive messages as well."* [5]

In addition to helping with the implementation of a programme, some teachers felt that health professionals could drive the momentum of a programme. This emphasis on involvement from health professionals and on the perceived lack of capacity amongst staff to effect change highlights the common difficulty schools have in internalising health promotion, and making it the "norm".

*"The curriculum is so full that it's easy to get enthusiastic about something and then it falls off after a while. Teachers can get a bit weary, and on-going support would be a reminder to, you know, keep the momentum going."* [3]

#### 3.3. Lack of consideration for different organisational cultures between schools

Organisational culture is defined as the set of values and behaviours which contribute to the unique social and psychological environment of an organisation. Organisational culture includes an organisation's expectations, experiences, philosophy and values.

The organisational culture between schools can vary enormously, but the national primary school curriculum is consistent across all schools. It underpins the work of every school day, regardless of the size, location, or student demographic of a school. As such, it was unsurprising when teachers emphasised that a programme which was to be implemented across the whole student body in multiple schools should be structured according to the curriculum.

*"Look, in this set-up here, teachers have multi-grade classes. You have only 2 classes in this room, but you have 3 class groups in the*

other rooms. We all have 15 subjects to teach each class, so you can't actually make time for anything else—you can't. It has to slot into the work we are already doing." [28]

Even in larger schools, where teachers are responsible for one class of students, the larger staff size and more diverse student population within the school may make it difficult to implement a programme consistently across all classes.

*"You need a core group of committed people who will keep reining the staff in and driving it forward. This school has 26 teachers, so you'd need 3 or 4 people to be actively promoting it. And you have to be mindful that teachers have their own ideas for their class, and have their own programmes they want to run."* [9]

To promote cooperation amongst staff and to reduce the risk of negatively impacting the organisational culture of a school, teachers stressed the importance of clear planning and goal-setting from the outset of a programme.

*"It's so important to know from the outset what you have to do and where you can integrate it into your curriculum plans for the year. You can get staff on board more easily when they know exactly what is required of them... you don't want staff feeling unappreciated, you know? You need everyone's buy-in."* [11]

#### 4. Discussion

This study identified some factors which primary school teachers in Ireland felt should be considered to improve the acceptability of health promotion programmes to the everyday school environment.

From the factors highlighted by teachers in this study, they appear well-informed about the necessary prerequisites for health promotion under the Schools for Health in Europe (SHE) concept (World Health Organisation, 1997). The mentions of maintaining a consistent and sustainable workload, having a team of people to drive a programme forward, of involving parents, and of bridging the gap between school and home, seem to indicate that teachers understand the essential elements of long-term health promotion.

However, there is a disparity between understanding the elements of health promotion and successfully implementing them to become a Health Promoting School. To help address this disparity, it is important to consider the concerns highlighted, which include the increased workload for teaching staff, the difficulty in encouraging staff to lead health promotion, and the necessity of making health promotion programmes malleable enough to adjust to different organisational cultures between schools.

Teachers in this study did recognise that schools can play an important role in promoting health amongst children. However, teachers qualified this recognition by stating that the design of health promotion programmes should respect the fundamental role and existing workload of the school. As rightly observed by a teacher in this study, schools are not only expected to enhance traditional areas of learning, such as numeracy and literacy, they are also expected to address various societal issues (Jourdan et al., 2011; Thomas, McLellan & Perera, 2013), and child health is just one such issue. Staff acceptance of a programme is crucial to its integration into the everyday core business of a school, which in turn makes positive health-related change more likely (Gugglberger, 2011; Gugglberger & Dür, 2011; Ingemarson, Rubenson, Bodin, & Guldbbrandsson, 2014).

Since health promotion programmes have little chance of success if support from teaching staff is lacking (Deschesnes, Martin, & Jomphe Hill, 2003; Jourdan et al., 2011; St. Leger, 2001), these programmes should be discussed with staff using the language of the education sector (St. Leger, 1998). As

emphasised by teachers in this study, and as has been reported elsewhere (Jourdan et al., 2011), teachers are more receptive towards health promotion programmes when it is obvious that a programme has been designed with consideration towards the school curriculum.

For example, if some of the tasks to be accomplished as part of a programme mirror certain requirements of the curriculum (Jourdan et al., 2011; Rowling & Jeffreys, 2006) teachers can simultaneously meet the requirements of the health promotion programme and school curriculum, thus reducing time pressure in the classroom. Teachers also appreciate user-friendly resources which enrich the existing curriculum and promote class interaction (St. Leger, 1998; St. Leger, 2005). If such resources are made available as part of a health promotion programme, teachers may feel more empowered to promote health in the domain in which they feel most comfortable, i.e. the classroom. These two advantages to modelling a health promotion programme on the curriculum can engender positive regard towards the programme from teaching staff.

Once a programme is being successfully implemented by staff in the classroom, efforts must be made to extend the programme to aspects of school life outside the classroom (Clelland, Cushman, & Hawkins, 2013; St. Leger, 2005). In light of concerns regarding staff capacity to extend a health promotion programme towards all staff, parents and the wider school community, teachers in this study referred to the need for adequate professional support. Assistance from health professionals is important for programme success (Inchley et al., 2006; St. Leger, 2005), and such emphasis on the need for trained health professionals has been documented in the literature (Gugglberger & Dür, 2011; Ingemarson, Rubenson, Bodin & Guldbbrandsson, 2014). However, if a programme is to be part of the daily school routine, involvement from health professionals must be balanced with the positive involvement of all school staff in order to build the capacity needed to sustain long-term change.

Capacity building amongst staff has been identified as important for the success of the SHE concept (Hoyle, Samek, & Valois, 2008; Inchley et al., 2006; Jourdan, Samdal, Diagne, & Carvalho, 2008). The SHE concept is more sustainable if it is supported by programmes which actively enhance staff capacity to: coordinate health-related activities; judiciously allocate resources for health promotion; and implement health policies for the school community (Inchley et al., 2006; Roberts-Gray et al., 2007; St. Leger, 2005). Although a health professional can provide guidance and reassuring assistance on such issues, school staff should be clearly recognised as the experts on their school environment. From the outset, roles should be clearly delineated to school staff and health professionals (Glasgow, Lichtenstein, & Marcus, 2003; Hoyle et al., 2008). School staff should be supported to embrace their role as the driver of health promotion, and health professionals should provide reasonable assistance with, and oversee adaptations to, a health promotion programme in line with the health goals identified by school staff.

Implementing a health promotion programme as faithfully as possible is important for its evaluation, but some adaptations may be needed depending on the organisational culture of a school (Deschesnes et al., 2003; Poland, Krupa & McCall, 2009). Schools differ in the number of staff available, classes per teacher, the number of other programmes to which they have committed, and the sociodemographic profile of the school community (Sormunen, Tossavainen, & Turunen, 2013). These factors, amongst others, affect how a school drives health promotion, and as such, health promotion programmes need to be flexible enough absorb such differences between schools without the integrity of the programme being compromised (Jourdan et al., 2008; Poland et al., 2009; St. Leger, 2001).

Before drawing final conclusions on the findings of this study, the methodological strengths and limitations must be considered. The findings of a qualitative study design cannot be generalised, particularly with the sample size being limited to one county. There are no concrete guidelines regarding sample size in a qualitative study, but data saturation was achieved within the sample size obtained. The use of an established framework to guide analysis also added rigour to the methods and results presented.

All teachers had some experience of engaging with school health promotion programmes and no minimum experience with health promotion programmes was sought by the authors. More detail may have been obtained if a minimum period of engagement had been stipulated. However, in light of the documented difficulties schools have in implementing long-term health promotion programmes, and in light of the varying levels of involvement required by different programmes, it was deemed inappropriate to stipulate a minimum period of engagement.

It should also be noted that the views presented are those of teachers who were not currently participating in a long-term health promotion programme. As such, these teachers may have been more inclined to emphasise the barriers to programme participation. However, since all teachers should ideally be in a position to implement sustainable health promoting measures, the perspective of those teachers who struggle with the concept of long-term health promotion is an important one.

Ultimately, qualitative research enables researchers to empathise with respondents and discover how they see the reality of a particular situation (Kreuger, 2009), which was the aim of this study.

## 5. Conclusion and lessons learned

Schools can make a substantial contribution to the well-being of children. However, the internalisation of the Schools for Health in Europe (SHE) concept and programmes associated with it takes time and collaboration with all parts of the school community (Inchley et al., 2006).

Despite being recognised as agents of change in schools (Darling-Hammond, 2003), teachers are not experts in health promotion. However, they are experts in their own school community, and as such, their concerns regarding the changes to be wrought within a school community during the cycle of health promotion should be carefully heeded.

To address the concerns expressed in this study about the *ACE Schools Programme*, and about health promotion programmes in general, there are a number of strategies which programme organisers could consider. These strategies could include: meeting with all school staff to clearly explain how a programme will impact the workload in a classroom; speaking with school staff using the language of the education sector; providing practical training to empower teachers to coordinate their own health-related activities; offering appropriate assistance with communicating health goals to the wider school community; and sanctioning minor amendments to a programme so that it is tailored to meet the individual needs of a school community.

Perhaps with more considerate and collaborative school health programmes, a more successful relationship can be developed with schools to effect positive change on the health of the entire school community.

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