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## Health-promoting schools in New Zealand: Belonging and empowerment in two primary schools

The concept of Health-Promoting Schools (HPS) was first proposed by the World Health Organisation (WHO) in the early 1980s (Deschenes et al, 2003). "A *health-promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working*" (WHO, 2010).

Much has been written on the outcomes of the HPS approach but very little on the actual structures required for developing and sustaining the concept of a health-promoting school.

This paper describes the evolution of two primary schools, in the South Auckland Region of New Zealand, toward becoming health promoting schools.

### Health-Promoting Schools in New Zealand

The HPS concept was developed and introduced by the New Zealand Ministry of Health in 1995.

Grant (2004) indicated that the philosophy of HPS in New Zealand is embedded in the Treaty of Waitangi. It is based on a holistic approach, to include all four aspects of health, namely the physical, social, emotional and spiritual aspects.

Different countries introduced different approaches to HPS as well as different educational theories to underpin the concept thus providing no definitive model to follow (Grant, 2005; Cushman, 2008).

Cushman (2008) described the New Zealand Government's approach to implementing the concept of HPS using a framework containing 3 distinct but interwoven processes. These were:

1. The curriculum
2. The school organisation and ethos
3. The links with parents and health providers.

Counties Manukau is a district in South Auckland providing school services for 130 primary and intermediate schools and 23 secondary schools. South Auckland is an ethnically diverse, primarily low socio-economic status area (Grant, 2005). Getting schools interested in the concept of HPS presented health promoters with problems. The Kidz First Public Health Nursing of Counties Manukau District Health Board (CMDHB) eventually provided a framework on which to base a HPS model.

In some countries, school health nurses and public health nurses established HPS (Grant, 2005; Manchester, 2004; Swart & Reddy, 1999). This was also the approach in the Counties Manukau Region, as nurses had a strong association with the community in general. Public health nurses helped schools gain an understanding of the concept of HPS, and identify factors which promote and support the health and well-being of all members of the school community. They did this by working with schools to identify students, staff and parents who could serve as resource people for health education programmes<sup>1</sup>.

### Methodology

#### Research design

A qualitative descriptive case study design described the process of two schools which had attained the Kauri level of the CMDHB Tipu Ka Rea model of a health promoting school. The

1. [http://www.cmdhb.org.nz/funded-services/hospital-specialist/Services/KidzFirst/public\\_health\\_nurses.htm](http://www.cmdhb.org.nz/funded-services/hospital-specialist/Services/KidzFirst/public_health_nurses.htm)

two schools were selected from a list of schools in the CMDHB region that had attained the Kauri level. From this list, schools were divided into groups by decile rating<sup>1</sup>. The decile 1-4 rated schools formed one group (School X) and the decile 5-10 schools formed the second group (School Y). Both schools are primary schools. School X (Decile 1-4) draws from a lower socio-economic population whereas School Y draws from a higher socio-economic population (Decile 5-10).

### **Aims of the study**

The study sought to gain insight into the developmental stages of the Tipu Ka Rea model, the required infrastructure, and potential sustainability of two schools which have used the HPS model. For each school, the case study describes the process of implementing the Tipu Ka Rea model; the perceptions of key stakeholders at this school (in terms of their understanding of the HPS approach); and explores the sustainability of the health-promoting schools concept at the Kauri level.

### **The "Tipu Ka Rea" model**

An operational model for HPS was developed for schools within Counties Manukau - the "Tipu Ka Rea" model, which in Maori means "To grow, expand and multiply". Sustainability is inherent in the metaphor that refers to levels of a regenerating forest. The model enabled the schools to progress through three developmental phases. Each level of the development of a HPS are represented by three indigenous New Zealand trees, namely the Manuka (for the initial pioneering or establishment level), the Kowhai (for further growth to a more structured or more developed level), and the Kauri (for a fully developed, independent and self-sustaining level) (Grant, 2005).

### **Data collection**

Semi-structured interviews were undertaken with: the Principal of School X; the Acting Principal from School Y; Three senior teachers at School X; two facilitators, who were involved

in establishing the original concept of the Health Promoting School in the CMDHB region; One community representative from School Y; One Board of Trustee (BOT) from School Y; One adult student liaison, and two former pupils from School Y who were original Health Promoting School representatives when the concept was first established in the school. Student participation was twelve students from School X and four students from School Y who were House leaders and mediators.

The final authored article was developed by Johann Keogh and Louise Rummel and was circulated to all researchers prior to submission for publication.

### **Sampling and consent**

Ethical approval for the study was obtained from the MIT Ethics Committee.

Participating schools were chosen to represent both ends of the decile spectrum and were selected by the Public Health Nurse who was familiar with the region. She initiated contact with the relevant schools. Once the initial contact with the schools was established, the Principal (School X) and Acting Principal (School Y) selected the rest of the participants. In School X, the Principal contacted the staff and students and obtained ethical consent at the time of the arranged interviews. In School Y, the Acting Principal obtained consent from the students who participated in the interviews. Participants were given the questions prior to interview, thus enabling them to pre-consider responses. One Board of Trustee member in School X was invited to be interviewed but declined. Parents were invited to be interviewed, but none participated. The facilitators, BOT, and community workers identified by the Principal and Acting Principal were contacted by a member of the research team gaining their consent to be involved.

### **Analysis of the data**

The recorded interview material was transcribed. All transcripts were returned to participants for verification and correction. The data were analysed using content analysis,

1. The Decile classification is a summarising indicator derived from Census data. Each decile comprises approximately 10% grouping of the number of children within a specific geographical area and the decile assigned to a school is allocated by considering a range of socio-economic variables (New Zealand Ministry of Education 2010). Factors used to calculate this summarising classification include household income, occupation, household crowding, educational qualifications and the extent, if any, to which income is supported.

<http://www.minedu.govt.nz/NZEducation/EducationPolicies/Schools/SchoolOperations/Resourcing/OperationalFunding/Deciles/FrequentlyAskedQuestionsAboutDeciles.aspx>

although no definite categories were built.

## Presentation of the findings

### The facilitators

The Health Promoting facilitators were involved in establishing the Health Promoting School Concept in both schools. Theirs was an overarching role spanning a number of schools in the CMDHB region. The facilitators were thus involved in establishing the partnership between the school, community students and staff so they could collectively determine how to address health issues. As health issues arose, the facilitators would liaise with other health services, such as public health nurses and link together with relevant community services. Each emphasised the integration of the HPS in the total school community (students, school, parents, staff) and were clear that implementing principles of a HPS had to be a deliberate process that involved children.

Both facilitators identified a holistic approach as crucial; it is not only about physical health, but also about social, emotional and environmental aspects each of which impact on the overall health of the child.

The facilitators clearly identified the benefits of the programme and saw programme sustainability as advantageous. The involvement of parents and children, as driving forces in the programme, was also recognised. Hindering factors were that the implementation involved staff who had to be prepared for new roles.

### The Principals

Principals were viewed as pivotal to HPS implementation as health promotion has to be at the centre of the school activities if it is to succeed. In school X the programme was originally implemented because of problems around sexual behaviour. This was not the case in school Y. As noted earlier, School X and School Y are primary schools. Students commence primary schooling at age 5 years and conclude aged between eleven and thirteen years.

The Principal, Acting Principal and teachers described the selection process for recruiting health promoting representatives in their schools in great detail. They noted that the high staff-turnover in the schools presented continuity problems and no formal educational

programme for preparing teachers for HPS was available.

One of the greatest achievements of the HPS programme was participation in Whanau nights (PTA-meetings). Before the HPS concept was implemented in School X, only four parents attended. After implementation, the attendance increased to up to 200 parents per night. Because of this greater involvement, teachers engaged directly with parents and were able to discuss important issues (for example teenage pregnancy) with parents and involve them in problem-solving strategies.

### The Teachers

The interviews were conducted with teachers from School X only. In school Y the Acting Principal was the only staff member interviewed because a new principal was being appointed and all teachers at the school were new. The teachers all indicated that the support of the principal was crucial to the success of the programme.

The teachers believed that the HPS concept was introduced because of the large numbers of girls leaving School X at the age of 13 and having babies when they were 14 years old. A new approach to sex education was necessary in order to change this outcome; one that involved parents in the process of preventing pregnancies at a young age. It seemed that the parents themselves were not well informed, thus being unable to give appropriate information to their children. However, teachers were unable to indicate if the sessions resulted in any changes in children's sexual behaviour.

Teachers identified specific problems in implementing health promoting activities at school. They had little time for new activities but acknowledged an increase in workload only at the beginning of the HPS programme. Once all structures were in place their workload diminished.

### The Children

The children were excited and proud to be part of the structure of the HPS. They were able to define health according to their own standards, although this was often limited to an activity, such as eating fruit, cleaning teeth or doing sport. At the time of the interviews, most children were engaged in some form of "physical activity" even if they only walked with

their parents after school. There were some specific questions as to the activities that kept people healthy, which were by and large answered correctly, for example doing sport, hours of sleep, eating the right food (5+ a day was often mentioned) and the effect of sugar on the body. One child indicated that he went "hyper" if he ate a lot of sugar.

To be a HPS representative, children from year 6 (the most senior level at the school) were eligible to be elected as a House Leader or a Mediator and candidates had to promote themselves to be elected. There was also an interview process by teachers to gauge the House Leader's values and how candidates saw themselves fitting into the Health Promoting School concept. The children were very proud of their new school roles (House Leaders or Mediators), and could provide a list of their "tasks" within these roles. They also knew how they were selected for these roles, and could describe the voting procedure thus affirming transparency at all levels within the hierarchy.

For the House Leaders in School Y this involved setting up the hall and being on duty during assemblies. The Mediators, on the other hand, felt themselves responsible for solving other peoples' problems. Mediators would identify problems amongst their peers and empower those peers to solve their own problems. They emphasised to the students that they must treat people respectfully. For instance, if a child was lonely, the student could go and sit on a special chair in the playground and their peers knew that they needed to befriend that student. From the lonely child syndrome grew a PALS (Physical Education Activity Leaders) movement.

Year six students developed and led lunch time physical activities for students in year four and below. The children proudly reported some of the changes that happened at school such as introducing the breakfast club which improved their concentration in class, healthier food for lunch, changing the school bells in favour of music, and lowering instances of bullying.

The children at Primary school Y were also involved in projects at school, which they too found satisfying. Examples given were compilation of a recipe book, involvement in the 'worm farm' and compost production, as well as a flower project at school.

The Acting Principal of School Y stated:

*"I think that is what separates us from schools who are not HPS. Our students feel empowered to act and come up with ideas. For example, a group of year five girls went to our Principal and said "we have done a lot of fund raising for ourselves and our school. This year we would like to fund raise for Star Ship Children's Hospital (a large children's hospital in Auckland NZ) by doing a fun run". Those girls went ahead and organised the fun run, the sponsorship forms, and the date and liaised with the appropriate people. They then ran the day (the teachers helped to ensure that all students could be involved), they organised the parents to come and help and take the monies raised and... present it to Starship from the school."*

### **The Community Worker**

The community worker was active in School Y, and specified that the whole school had to be involved before the HPS concept could be implemented. There were other projects running before it became a HPS, but she felt that HPS could bring the whole community together.

Successes could be shown in the bullying project, but the biggest influence was probably the WHO conference in Wellington. The community worker accompanied representative children to the WHO conference, where they had the opportunity to talk to the health ministers of different countries, asking how the HPS concept was implemented in their own countries.

In School X, a big problem was bullying. To create a strategy to deal with bullying, teachers surveyed parents and students from Years One to Eight using smiley faces to ask how they felt about their school.

From the data, the teachers were able to work out when the bullying was occurring and put strategies in place to address it. For example,

Teacher S: stated:

*"We asked for, if there is a bully, who would those people be, and your opinion, and it was all no names, and then we as a staff would monitor those children then we could use mediators and staff that we have to work alongside them ... rather than just having them wander around in the playground, we would take them and re-channel them and put them out into a sporting programme where they could get rid of that*

*energy and work as a team."*

Teacher C stated:

*"Junior bullies ... for some it was pure boredom ... so we got out the sports trolleys so the junior children could access equipment and also opened up the library at lunchtimes so that we're dispersing the children as well. We had organised sport on the field and teachers were expected to say, "there is soft-ball happening on the field". We put music on so that the children could dance and bob around if they wished."*

Teacher K stated:

*"We also provided a teacher to be on between 0800 and 0830 a.m. for the children who came early to school for this too was identified as a problem time."*

### **The Board of Trustees (BOT)**

The BOT member at school Y was convinced that the principal and her husband were the main drivers behind the whole project. He felt that the children should be happy to come to school, and the school environment was, therefore, important. Bullying should not be tolerated, and parents should have a good feeling about leaving their children at school. It was important that children knew about local cultural needs of fellow students, and the BOT member was happy that a teacher of Maori origin taught Maori culture to all children at the school. He felt that HPS was in the interest of the children, and supported the process whole heartedly.

### **Discussion**

In an interview, with the two facilitators, they clearly stated that HPS could only be introduced as a deliberate process covering all areas of health - not only the physical aspects. The HPS must be seen as a partnership between the school, staff, students and the community. These prerequisites were mentioned in a paper *About health promoting schools*, published in 2003 by the New Zealand Ministry of Health<sup>1</sup>. It would seem that both schools managed to involve parents, staff and children in the process of developing their own HPS model.

Interestingly, all those involved in implementing the model saw the Principal as being the "kingpin" of the whole process. The Principal and Acting Principal were very enthusiastic about implementing the HPS

model and actually voiced the need to implement HPS as a national 'standard' in education. Each school had some health promotion activities operating by the time the HPS model was introduced which probably aided the overall process. Teachers were already used to some activities, but more importantly, they were used to working with public health nurses thereby introducing multi-disciplinary approaches to health promotion.

The *Support Manual for Health Promoting Schools* mentioned a lack of social support and relationship difficulties, including sexual relations, as one of the factors causing distress in New Zealand children aged 13 - 18. Introducing the HPS model in the decile 1-4 school (School X) was, therefore, of the utmost importance given the background described by the Principal and teachers. The fact that early teenage girls left school X and had babies at the age of 14 was a clear cause for concern; clearly if the HPS approach could prevent or minimise early pregnancies and births, the aims of the model would have been achieved.

Further justifications mentioned by the Principal, teachers, and facilitators for introducing the model included alcohol and drug abuse. These factors were also mentioned in the support manual for HPS as factors leading to distress in as young as 13 years. Introducing the HPS model and mentioning their success in limiting these problems could, therefore, be seen as one of the many and varied programme successes. It was clear that the children were very proud to be part of the programme. Their involvement and the fact that they had the opportunity to voice their needs and demands gave them the opportunity for personal development, which in itself, met the goals of HPS. The advantages of using the 'bottom-up' approach could be clearly seen in the children's responses.

The WHO identified mental health as one of the important health indices and the *Support Manual for HPS* reinforced this by specifying that individuals have a need to develop a feeling of belonging, being valued, and being respected by family members.

Another source of distress to teachers in School X was the expectation that they could be asked to inform parents about unwanted pregnancies. This seemed to be an important

1. <https://www.healthed.govt.nz/health-topic/health-promoting-schools>



privacy issue for young people, but at the same time, it is a social problem that clearly impacts upon the child's development. Not finishing schooling impacts upon future employment due to the lack of skills. These risk factors are highlighted in the *Support Manual for HPS*. In School X, teacher C identified that young boys would come to her and state "Oh my girlfriend is pregnant. Can you tell my mum?"

The USA has one of the highest rates of teenage pregnancy in the industrialised world. At the same time, teachers are viewed as having significant influence in the lives of students from the age of 6-18 yrs. Teachers, though willing to provide advice on general matters of health feel ill equipped to offer advice in mental health, behavioural and reproductive areas (Cohall et al., 2007). Bennett and Nassim (2005) reported that the consequences of introducing educational programmes was inconclusive insofar as reducing the teenage pregnancy rate. As in New Zealand, concerns were raised about the preparation of teachers, professional support and the importance of broadcasting a consistent message. Moreover, funding for adequate services impacted on programme effectiveness.

The Health and Physical Education National School curriculum prepares students at primary school level to develop competencies for mental wellness, reproductive health, positive sexuality and safety management. A review of the School Based Health Services in secondary schools in the Counties Manukau region (Counties Manukau, 2011), reveals many difficulties related to reproductive health education. Difficulties range from the way the subject is taught, to the provision of services for young people. Funding for sustaining programmes is also problematic. A co-ordinated school-based health service with special attention to sexual health needs and professional health support is clearly needed by schools so they can provide information and services to students and families. There was no corresponding review of primary school services and yet it would appear from this case study that young people are sexually active prior to entering secondary school. Given this, it is clear that senior primary school students need health education about specific sexual and reproductive health behaviours prior to leaving primary school.

## Conclusion

The introduction of the HPS model in New Zealand was a step in the right direction. Preventing the anguish of young girls faced with unwanted pregnancies serves as a justification for introducing HPS. This paper has described some obvious successes and some failures. The overall impressions from this case study were positive. It was clear that principals and teachers were convinced of their successes, although minor irritations were also mentioned.

The two primary schools demonstrated many and varied successes after implementing the programme and children developed a stronger feeling of 'belonging'. Students in representative roles developed leadership skills which they had not developed beforehand. Students gained a sense of achievement because they participated in simple decisions such as what lunch food would be presented and exchanging the school bells for music. Because of the voting process used to recruit leaders, children learned to make responsible decisions from the beginning. Parental involvement in school activities could also be deemed a success.

Programme sustainability was a major concern. The Government's financial support was finite and teachers queried what the future would hold for HPS once the money ran out. It is, therefore, of paramount importance that both the New Zealand Ministry of Health and the Ministry of Education critically review research conducted in this field so they can rethink their strategy about supporting the HPS concept.

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