New Zealand Health Promoting Schools National Strategic Framework

Section Three: Literature Review of International and National Health Promoting Schools Best Practice and Strategic Frameworks

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Draft Values Driven Framework

Values driven framework

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Transformational

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Literature Review of International and National HPS Best Practice and Strategic Frameworks

EXECUTIVE SUMMARY

The purpose of this literature review is to inform the development of a strategic framework for Health Promoting Schools (HPS) in New Zealand.

This literature review will firstly identify international trends and understandings of HPS in terms of best practice in relation to:

- Strategic frameworks (vision, mission/purpose, values, principles and valued outcomes)
- Theory for change, intervention and implementation
- Implementation
- Evaluation

The underlying principles of effective health promotion in schools will be compared with the components of effective schools and theories for change, intervention and implementation, as there is considerable international and local evidence about how best to achieve change within a school environment.

The context in New Zealand will then be explored, with a focus on health promoting developments that have achieved positive impacts in school communities.

Finally a synthesis of international and national effective practice will inform recommendations for an HPS national strategic framework in New Zealand.

SYNTHESIS OF NATIONAL AND INTERNATIONAL RESEARCH

Framework

Taking into account both the national and international research, an HPS framework in the New Zealand context will need to provide:

1. A clear HPS vision and purpose/mission that is shared at government, ministerial, regional and local levels and reflects New Zealand’s unique context.

2. Intersectoral agreements and policies that promote partnership and joint planning and that support the implementation of the HPS framework.

3. A values-driven, outcomes-focused framework that is based on the principles of Te Tiriti o Waitangi.

4. HPS policies and practices that reflect Te Tiriti o Waitangi and a bicultural partnership.

5. An HPS theory for change, intervention and improvement that is based on the international HPS best practice, current New Zealand educational context, Best Evidence Synthesis practice research, Healthy Community Schools, Fruit in Schools and Victory Village findings and school improvement evidence.
Implementation

An implementation plan will need to take into account the elements/critical success factors that improve health in New Zealand school communities. These factors relate to both the school and health contexts:

1. School setting
   - transformational learning
   - an inquiry based approach
   - student voice, leadership and empowerment
   - valuing student and community knowledge and capacity
   - participant ownership
   - effective and consistent school leadership and supportive infrastructure
   - strong leadership and trust-based interdependent partnerships between the child, school, whānau, community, health and social services
   - sharing of effective practice within and between communities
   - on-going learning and professional development in action research
   - the use of an integrated approach supported by national, regional and local professional development
   - hands-on support of people involved in HPS
   - providing needs assessment tools so that the most appropriate and effective initiatives can be identified
   - ensuring that the balance between regional and national leadership is effective and that there are opportunities for all stakeholders to contribute to the ongoing development of the HPS framework
   - an evaluation framework that includes:
     - triangulation of data/evidence
     - a theory for change, intervention and improvement
     - the context (physical, social, cultural, political)
     - the process (identifying, planning, acting, monitoring, reporting and evaluating/reflecting on outcomes as a basis for on-going improvement)
     - the factors that contribute to health in a school community
     - the health actions that improve educational outcomes in the school context
     - the outcomes (positive changes in knowledge, attitudes, skills, behaviours)
     - a social and physical environment that reflects in participation, engagement and achievement through quality relationships

2. Health Sector
   - On-going resources and funding to support the development of the national framework within the time frames known to be necessary for sustainability (five to seven years)
   - Practitioners who have the capacity, capability and support to fulfil the partnership role
- National Māori and non-Māori co-ordination of HPS services
- Nationally consistent professional development which includes an intensive workforce development period to introduce the new framework
- National/regional hui for workforce development, sharing learnings/better practice and professional development on kaupapa Māori approaches
- Development of national indicators/measures to assess impacts/outcomes across regions, localities and schools
- Annual professional development for HPS Managers including strategic input from managers into the development of HPS
- Regional and local hui for HPS practitioners
- One on one support and mentoring for HPS facilitators
INTERNATIONAL TRENDS AND UNDERSTANDINGS ABOUT HPS

SUMMARY OF INTERNATIONAL RESEARCH ON HPS BEST PRACTICE

- There is general agreement around the world that HPS is an effective mechanism for improving health and educational outcomes; there is a lack of understanding about how health and education interact and impact on each other.

- The six components of health promotion are seen by the health community as separate to the curriculum, but for educators the six components are seen as part of what they do already in the curriculum and through enquiry-based pedagogy.

- Effective health promotion and illness prevention strategies in schools moved from provision of basic knowledge about health in the 1980s (informational) to students taking an active and authentic role in ensuring their own health and that of others in their community (transformational), but many HPS activities remain informational.

- HPS requires changes in participants’ beliefs or values as “it is the purposeful thinking that counts, not the mere doing” but few initiatives are structured on the basis of values-driven practice.

- Researchers have identified the need for an HPS theory of change, intervention and improvement that takes into account the wealth of evidence of effective practice from the education sector; this has not been utilised.

- Although a “whole school approach” is advocated, there is no description of what this is or how and why it works.

- Evidence-based practice and outcomes in a whole school approach is promoted, but the vast majority of research and evaluations have focused on programmes/topic-based delivery and process.

- HPS as an approach is cited as being valuable; it is the implementation of the approach that often fails as there is no evidence-based theory to describe how HPS will be implemented and why this approach will work in a particular school setting.

- The Ottawa Charter describes the action streams for health promotion (the approach); it does not describe how health promotion can be best actioned in a school context.

- Evaluations of HPS initiatives have focused on the process. They also need to consider the outcomes and identify the factors that contribute to health in a school community, the elements/critical success factors that improve health promotion in a school as well as the experiences of the participants as the long term results of health promotion cannot be observed during school years.

- HPS aims to improve outcomes for all, particularly those groups experiencing the greatest inequities (who are often indigenous peoples). There is little to no research or evidence of HPS best practice where indigenous knowledge and approaches have been integrated into the HPS framework.

- HPS has been utilised to provide guidance on best practice. It does need to be contextualised within the parameters of each country and community. In many cases countries have branded their own versions which have been driven by a variety of government and non-government organisations and imperatives.

- International evidence shows that joint policy commitment or signed agreements between government departments is required for a national HPS framework to be successful; many are administered through single departments or NGOs.
Recognition of partnership between education and health

The World Health Organisation (WHO), the United Nations Children’s Fund (UNICEF), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the US Centres for Disease Control and Prevention (CDC), European Network of Health Promotion Schools (ENHPS) and the International Union for Health Promotion and Education (IUHPE) have all recognised that schools can make a substantial contribution to students’ health and well-being. In turn, this is reflected in improved educational/academic achievement. These organisations have initiated a range of strategies and programmes over the last fifty years to implement and evaluate HPS programmes throughout the world. A timeline of international and national developments in HPS are in Appendix 10.

Historically, changes in thinking and best practice in relation to health promotion have influenced the priorities, design and planning of HPS delivery. While there is ample evidence and research on effective health promotion practices, little consideration has been given to schools as a context in terms of their unique setting and complex inter-relationships. In addition, the wealth of research that exists on how change, interventions and improvements can be successfully achieved in schools has not been utilised by the HPS community when designing and planning health promotion activities.

United Nations - Millennium Summit Goals

At the Millennium Summit in September 2000, the largest gathering of world leaders in history, the UN Millennium Declaration was adopted. The world leaders committed their nations to a global partnership to reduce poverty, achieve universal primary education, improve health, and promote peace, human rights, gender equality, and environmental sustainability. The correlation between health and educational achievement is reflected in the prominence given to both of these issues in the United Nations Millennium Development Goals.

WHO International priorities

In the current decade there has been a continual focus on the unacceptable gap in quality of life and life expectancy of people within nations and between nations. The WHO Global Commission on the Social Determinants of Health was established in 2005 because there was widespread belief and evidence that social determinants contribute to most of the global burden of disease and death, as well as to the bulk of existing health inequities between and within countries. Throughout the world, vulnerable and socially disadvantaged people have less access to health resources, get sicker and die earlier than people in more privileged social positions. These unfair gaps continue to grow in spite of an era of unprecedented global wealth, knowledge and health awareness.

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1 http://www.undp.org/mdg/goal2.shtml
The Millennium Development Goals (MDGs) are eight goals to be achieved by 2015 that respond to the world’s main development challenges. The MDGs are drawn from the actions and targets contained in the Millennium Declaration that was adopted by 189 nations-and signed by 147 heads of state and governments during the UN Millennium Summit in September 2000. The eight MDGs break down into 21 quantifiable targets that are measured by 60 indicators.

- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education
- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce child mortality
- Goal 5: Improve maternal health
- Goal 6: Combat HIV/AIDS, malaria and other diseases
- Goal 7: Ensure environmental sustainability

2 http://www.epha.org/a/1737

3 http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf
Operating for three years, the Commission recommended interventions and policies to narrow health inequalities through an innovative multi-sectoral approach that ensured access to health care, healthy living conditions, safe working environments, and food and education for people who are poor and marginalized.

The final Global Commission on the Social Determinants of Health report stated three overarching recommendations and principles of action which have also been translated into the HPS framework. These recommendations fall into three key interrelated areas:

1. The ethos and environment of a school
2. Curriculum learning and teaching
3. School partnerships and services

**WHO 2005 Bangkok Charter**

The 2005 WHO Bangkok Charter called for a greater commitment to inter-government and agency partnerships. This charter gave new direction to health promotion by calling for policy coherence, investment and partnering across governments, international organisations, civil society and the private sector to work towards four key commitments. These included ensuring that health promotion is central to the global development agenda, that it is a core responsibility of all governments and part of good corporate practice, as well as a focus of community and civil society initiatives.

**WHO Commission on Social Determinants of Health, Health Equity**

The WHO Commission on Social Determinants of Health provided research and evidence on what can be done to promote health equity and to foster a global movement to achieve it. The Commission’s 2008 summary report made three overarching recommendations and principles of action. All entailed education playing a significant role in achieving more equitable outcomes. Education and training in social determinants of health were seen as a vital vehicle for the promotion of health equity.

**2009 Global Conference on Health Promotion, Nairobi, Kenya**

The Nairobi conference produced a “Call to Action” which identified key strategies and commitments urgently required for closing the implementation gap in health and development through health promotion. The urgent responsibilities identified were:

- Strengthening leadership and workforces
- Mainstream health promotion
- Empowering communities and individuals
- Enhancing participatory processes
- Building and applying knowledge

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three overarching recommendations and principles of action to:

1. Improve daily living conditions – the circumstances in which people are born, grow, live, work and age.
2. Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally
3. Measure and understand the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

5 http://www.who.int/healthpromotion/conferences/7gchp/en/index.html
Strategies and actions to close the implementation gap in health promotion were identified and included a strong research and evidence-based component, as well as the inclusion of the concepts of “acceleration” and “equity”. The strategies were detailed as being:

- **Global commitment through:**
  - Using the untapped potential of health promotion
  - Making health promotion principles integral to the policy and development agenda, including accelerating the attainment of national and international development goals
  - Developing effective and sustainable delivery mechanisms including dissemination of compelling evidence on social, economic, health and other benefits of health promotion to key sectors

- **Strategies and actions through:**
  - Building capacity for health promotion
  - Strengthening health systems, including building and applying the evidence base, investing in research evaluation and dissemination to increase the adoption of better practices in health promotion, and by setting up databases on research evidence and mechanisms to meet the need for evidence-informed policy formulation and decision-making
  - Partnerships and intersectoral action to achieve health equity including developing and incorporating indicators of equity and intersectoral action, focusing both on health outcomes and determinants, and evaluating initiatives to determine critical success factors for scaling up health promotion
  - Community involvement including narratives and empirical evidence of success and lessons, learned and the incorporation of indigenous knowledge systems into planned curriculum and mainstream application across key sectors
  - Health literacy and health behaviours including using qualitative and quantitative methods to develop a core set of evidence-based health literacy indicators and tools based on constructs and concepts relevant to health; surveying and monitoring health literacy levels; and setting up a system to monitor, evaluate, document and disseminate health literacy interventions.

It is important to note that this world conference on health promotion outlined the need for evidence-driven decisions and practices that could be shared with others as a means of closing the implementation gap. This conference also acknowledged the importance of incorporating indigenous knowledge systems. However, the document does not articulate an explicit theory for change, intervention or improvement where evidence-driven practice is described as part of a total process. Instead, there is a limited approach to education with the focus being on disseminating “health literacy interventions”; this is informational rather than transformational in approach.

**Whole school approach, partnerships and strategic leadership**

The most influential international organisations that have provided evidence informed guidelines for health promoting school communities are the IUHPE in partnership with WHO.
IUHPE is now over half a century old. It is a unique worldwide, independent and professional association of individuals and organisations committed to improving the health and well-being of people through education, community action and the development of healthy public policy.” The organisation has played a major role in championing a whole school approach and the importance of strategic leadership.

Since the 1950s the WHO has identified ways to improve the health of young people. Initially the focus was on the inclusion of more comprehensive health education in schools. Over time WHO argued strongly for education settings and the health sector to work more closely together. Two significant conferences helped create the building blocks for HPS and the partnership between health and education. These were the:

- WHO International Conference on Primary Health Care held in Alma Ata, Kazakhstan in 1978 which adopted the Declaration of Alma Ata. This declaration urged governments to use education as a means of preventing, controlling and promoting health issues
- The First International Conference on Health Promotion held in Ottawa, Canada in 1986 which adopted the Ottawa Charter for Health Promotion

The Ottawa Charter reshaped health issues across the world in two ways. Firstly, by providing an affirmative framework where the focus was prevention and resiliency rather than mortality. Secondly, by taking an holistic strategic approach that centred on planning and actions.

**Ottawa Charter**

The Ottawa Charter defined health promotion as “the process of enabling people to increase control over, and to improve, their health...”

The vision for health promotion in this document was “where every individual/group has reached a state of complete physical, mental and social well-being.”

The mission or purpose of health promotion was seen to focus on “achieving equity in health.” Health promotion action aimed “to reduce differences in current health status and ensure equal opportunities and resources to enable all people to achieve their fullest health potential.” This included “a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices.”

The values identified in this approach were “caring, holism and ecology.”

The principles explained how the values would be implemented through health promoters “advocating, enabling and mediating.”

**The theory for change, intervention or improvement** outlined in the charter identified that a number of pre-requisites needed to be in place if every individual/group is to reach a state of complete physical, mental and social well-being. These were:

- Peace
- Shelter
- Education

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7 [http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf)
● Food
● Income
● Stable eco-system
● Sustainable resources
● Social justice and equity

The Charter identified six areas of operation that need to be addressed if health promotion programmes were to be effective. These health promotion actions listed below were believed to lead to improvements in health for individuals and groups:

● Build Healthy Public Policy
● Create Supportive Environments
● Strengthen Community Actions
● Develop Personal Skills
● Reorient Health Services
● Move into the Future

The Ottawa Charter’s areas of operation have been refined over the past twenty years to the six components identified in the 2010 IUHPE "Promoting Health in Schools – From Evidence to Action".

In terms of implementing the strategic framework, the participants at the Ottawa conference pledged to:

● Move into the arena of healthy public policy and advocate a clear political commitment to health and equity in all sectors
● Counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition
● Focus attention on public health issues such as pollution, occupational hazards, housing and settlements
● Respond to the health gap within and between societies and tackle the inequities in health produced by the rules and practices of these societies
● Acknowledge people as the main health resource; support and enable them to keep themselves, their families and friends healthy through financial and other means; and accept the community as the essential voice in matters of its health, living conditions and well-being

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• Reorient health services and their resources towards the promotion of health and share power with other sectors, other disciplines and, most importantly, with people themselves

• Recognise health and its maintenance as a major social investment and challenge

• Address the overall ecological issue of our ways of living

The valued outcomes sought as a result were:

• To develop a new understanding about public health and articulate this movement in public health focus around the world

• To build on the progress that had already been made through the Declaration on Primary Health Care at Alma-Ata, the WHO’s Targets for Health for All document, and the debate at the World Health Assembly on intersectoral action for health

• For health to be viewed as a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, the concept of health goes beyond healthy life-styles and includes well-being and health promotion and is not just the responsibility of the health sector.

The document did not give any details, guidelines or recommendations in relation to monitoring, reviewing and evaluating progress. In addition, the Ottawa Charter did not provide any discourse on health promotion within a school setting.

Shift from health promotion in schools to Health Promoting Schools

During the 1980s effective health promotion and illness prevention strategies in schools moved from the provision of basic knowledge about health to students taking an active and authentic role in ensuring their own health and that of others in their community. In this new approach students were seen as agents of change and sustainability\(^{11}\). Learning became a more interactive process for students involving action and reflection,\(^{12}\) where meaning and knowing were negotiated and dynamically created and re-created through social interactions.\(^{13}\) As noted by St Leger\(^ {14}\) this was in response to a number of factors which included recent learning from research findings, better professional development opportunities for teachers, and evaluations of interventions. The WHO’s 1997 description of a health promoting school\(^ {15}\) embraced the above concept of students being action-based change agents who, through democratic processes, can be empowered to make positive changes in their lives and the lives of others.

\(^{11}\) Freire, P (1972) *Pedagogy of the Oppressed*. Penguin Hammondsworth


\(^{13}\) L St Leger, Health Promotion International, 2004, Vol 19 No.4

\(^{14}\) The Health Promoting School improves young people’s abilities to take action and generate change. It provides a setting, within which they can gain a sense of achievement, working together with teachers and others. Young people’s empowerment, linked to their visions and ideas, enables them to influence their lives and living conditions.” (WHO, 1997)

Transformational learning

Perhaps the most compelling factor in the change was a move towards a participatory enquiry-based learning model in education. This was influenced by the educational and behavioural research that showed that learning and behaviour modification programmes that were based on knowledge acquisition were unlikely to succeed. What was required instead of knowledge transfer was a change in the values and ways individuals think and then act, which is termed transformational learning (participatory, authentic and inquiry based learning). It is transformational learning that changes thinking and behaviours, while informational learning adds new skills and information without a change to belief systems or to related behaviours and attitudes. This shift from informational to transformational learning required a major change in direction and locus of control in terms of how health and education approached the issue of healthy schools. It was clear that students needed to be directly involved and connected to the issues and interventions in order for change to occur. This was later reflected in the IUHPE inclusion of ‘action competencies’ as one of the essential elements of promoting health in school. Action competence can be defined as “the ability to act and bring about positive change with regard to health.” (Jensen, 1997; 2000; 2004)16.

In spite of this shift, there still remains internationally a tension between those who still see health promotion action as prevention and control of illness, as opposed to those who see health promotion action as achieving positive outcomes, for example “wellness”. In addition, there are varying assessments of the causes of health/ill health which brings a division between those who advocate for major social and environmental change (critical health promotion) and those who are focused on individual lifestyle changes. Within these health promotion tensions and divisions, health education in school communities often plays contradictory roles.17

European Network of Health Promoting Schools (ENHPS) Egmond Agenda

By 1992 the ENHPS was established. There were 38 countries involved in HPS initiatives by 1999. Over the course of the 1990’s many groups embraced the concept of HPS. This included organisations like the European Commission (EC) and Council of Europe (CE). During this phase the organisations acknowledged “the many different aspects of a school which impact on the health and well-being of young people.” A significant outcome of the 2002 ENHPS “Education and Health in Partnership” conference was the Egmond Agenda (Appendix 3) which outlined the principal components for success in establishing health promoting schools nationally. The document proved to be ahead of its time in that it identified the importance of having a theory for change, intervention or improvement as well as an evaluation process that includes both process and outcome evaluations.

The definition of HPS expressed at the conference reflected the position of the WHO definition as the Egmond Agenda saw HPS as “an investment in health, education and in democracy.”

The outcome of that Conference was “a set of principles which defined the values and purposes of HPS, and set out methods that could be used to establish those principles in practice.”

The core principles identified as being necessary to establish a national HPS approach were:

- Partnership
- Equity and access


Empowerment and action competence
Health knowledge and understanding
Safe and supportive environments
Health promoting teaching and learning methodologies
Curriculum-based health promotion
Democratic practices and participation
Involvement of stakeholders, communities and parents
Evaluation for building on success

It is interesting to note that in comparison to the 2009 IUHPE guidelines the main difference is that “health knowledge and understanding” is seen as a core principle in the Egmond Agenda but is not seen as a key principle in the 2009 guidelines. This could be in line with the new understanding that sustainable learning must be *transformational* rather than *informational*. The IUHPE 2009 principles have instead included:

- “enhances the learning outcomes of students”
- “addresses the health and well-being issues of all school staff”
- “sets realistic goals built on accurate data and sound scientific evidence” and “seeks continuous improvement through on-going monitoring and evaluation”

This indicates that by 2009 the HPS international community had better alignment with educational research and best practice around pedagogy, evidence-based on-going improvement and the importance of staff modelling values and behaviours.

The **Egmond Agenda** stressed the importance of collaboration between the health and education sectors.

The three components that were identified as being essential in order to develop and sustain HPS on a national basis were **conditions, programming** and **evaluation**. Although the mission, values and valued outcomes are not identified in the Egmond Agenda, the three components do go some way to **exploring a theory for change, intervention and improvement**.

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**PRINCIPLES OF HEALTH PROMOTING SCHOOLS (HPS)**
- Promotes the health and well-being of students
- Upholds social justice and equity concepts
- Involves student participation and empowerment
- Provides a safe and supportive environment
- Links health and education issues and systems
- Addresses the health and well-being issues of staff
- Collaborates with the local community
- Integrates into the school’s ongoing activities
- Sets realistic goals
- Engages parents and families in health promotion.

**PURPOSES OF HEALTH PROMOTING SCHOOLS**
- To build health knowledge, skills and behaviours in the cognitive, emotional, social and behavioural domains
- To enhance educational outcomes
Conditions

The first component, **conditions**, identifies that a **national needs analysis** is required in order to identify the needs and available resources, current practices and methods for data collection. A brief description of the types of evidence that could be collected to inform the above is outlined, but there is no indication of how it should be analysed or used to inform decisions.

Fair and transparent **partnerships** are also identified as a prerequisite for effective national HPS development. This is to ensure progress is based on mutual objectives, fair dispersal of resources and an appreciation of the expertise each brings to the context, as well as an understanding of when expert assistance is required.

Interestingly advocacy (as first identified in the Ottawa Charter) reappears. It is felt that stakeholders from health, education and other sectors who support or deliver HPS programmes need to be involved in the advocacy process. They are often instrumental in advocating for investment in HPS programmes and in providing rigorous evidence that the programmes work.

The *Egmond Agenda* does identify that a **sound theoretical** base is essential for the development of a national HPS approach and that “effective programmes are based upon a **theory** of building comprehensive health promotion approaches”. Change is seen and articulated as an integral part of the process. However, the document does not unpack what a “sound theoretical base” looks like. In essence this document is one of the first to articulate the need for a **national theory of change, intervention and improvement** to guide developments at national, regional and local levels.
Programming

The Egmond Agenda advised that for a national HPS programme to be successful the HPS programme content, design and process should:

- Share and inform best practice amongst networks
- Link with current national policy development in health and education
- Advocate for the rights of every child as outlined in international agreements like the UN Rights of the Child and Millennium Goals
- Be networked to other systems and processes
- Continually improve the quality of HPS programmes to foster health, support quality education and create positive school cultures and environments

The document also cited evidence that the development period of a national HPS programme can be from three to eight years and, as such, required long term planning and sustainable political commitment around a national action programme within a planning cycle of three to five years, when objectives and outcomes are continuously monitored, evaluated and redefined.

A further recommendation of interest in the Egmond Agenda is that a national structure, combined with a regional / local structure for HPS has been found to be the most effective. This needs to be combined with professional development at all levels (national, regional and local) to build the capacity and capability of both the health and education sector.

Evaluation

The document also recommends that evaluation accompany theoretically based programmes (programmes that have a theory for change, intervention or improvement). Good HPS evaluation is defined in the Egmond Agenda as being an evaluation which includes both process and outcome evaluation, as this has been seen to aid the progress of action plans in becoming nationally implemented programmes.

This document has to date provided the most useful guide into the development of a national strategic framework for HPS.

Evidence of effectiveness IUHPE 1999

‘The Evidence of Health Promotion Effectiveness’, commissioned by the IUHPE and published in 1999, supported some of the views expressed by the Egmond Agenda and suggested that school health interventions are most effective if:

the focus is on cognitive and social outcomes as a joint priority with behavioural change (transformational learning), programmes are comprehensive and holistic, linking the school with agencies and sectors dealing with health, the intervention is substantial, over several school years and relevant to changes in young people’s social and cognitive development, and if adequate attention is given to capacity-building through teacher training and the provision of resources. (St Leger and Nutbeam, 1999).
IHUPE First version of protocols and guidelines for promoting health in schools - Links to improving educational outcomes

Through the analysis of research and the evaluation of evidence on effective practice, the IUHPE produced the 2005 ‘Protocols and Guidelines for Promoting Health in School.’ The principles incorporated all the key findings and drivers in international public health issues and advocacy first articulated in the Ottawa Charter. For the first time the guidelines made explicit that a key purpose of HPS is to improve educational outcomes.

WHO - Effective HPS Programmes

In 2006 the WHO disseminated a systematic review that sought to determine the effectiveness of the HPS approach in improving health or preventative disease. There was evidence that health promotion programmes in schools can improve children’s health and well-being. This approach is programme based rather than a holistic process that is integrated into all aspects of the school community. Among the most effective programmes were those that promoted mental health, healthy eating and physical activity. Programmes on preventing substance abuse were shown to be ineffective; it was suggested that substance abuse may be better addressed in a more holistic programme that promotes mental health. Programmes for preventing suicide could reduce suicide potential, but it cautioned that potential harmful effects in young males should be considered. Although programmes based on peer-delivered health promotion were highly valued by young people, their effectiveness varied.

Some evidence supported key components of the HPS programme – namely, that programmes should be sustained, multifactorial, whole school approaches that provide appropriate training. However, there was a lack of evidence on all the elements that contribute to an effective health promotion programme, or to the HPS approach as a whole. The recommendation was for there to be an holistic evaluation of programmes in local settings. It was interesting to note that, in general, the programmes reviewed did not reflect the current thinking about best practice teaching and learning as they were not based on a participatory, enquiry-based learning model. Instead, they were programmes driven by the teacher/facilitator and delivered to students.


WHO, CDC and IUHPE - Enhancing educational outcomes

In 2009, WHO, CDC and IUHPE collaborated to produce ‘Achieving Health Promoting Schools: Guidelines for Promoting Health in Schools’. This was the second version of a document formerly known as ‘Protocols and Guidelines for Health Promoting Schools’ which looked at the broad principles and actions needed to establish and sustain health promotion in schools. These guidelines identified that the primary purpose of HPS is to enhance educational outcomes for students and, secondly, to facilitate action for health by building knowledge and skills in the cognitive, social and behavioural domains. Until this point, improvements in health outcomes had been given higher priority than educational outcomes. There were also three new and important concepts included in the latest principles of HPS. Firstly, they reinforced the importance of integrating the programme with the delivery of curriculum and assessment in the school. Secondly, they stressed that the HPS programmes needed to be both evidence-based and formative. Lastly, the evidence needed to continually inform better practice. In essence, an action research approach to monitoring, review and evaluation was recommended.

In this document HPS is defined as a whole school approach to enhancing both the health and educational outcomes of children and adolescents through learning and teaching experiences initiated in the school. (IUHPE 2009)

The vision was that HPS would “make schools a better place for learning, health and living.”

The document identified that HPS served two purposes:

1. To enhance educational outcomes
   Healthy students learn better. The core business of a school is maximising learning outcomes. Effective Health Promoting Schools (HPS) make a major contribution to schools achieving their educational and social goals.

2. To facilitate action for health by building health knowledge and skills in the cognitive, social and behavioural domains
   The school is a setting where health issues and perspectives are used to complement and enrich education priorities e.g. in literacy and numeracy. HPS actions assist in building specific and generic competencies in knowledge and understanding, in analysing and synthesising information, and in creating solutions for local and global issues. Students can learn and practise personal and social skills and health-promoting behaviours, which can enhance their learning. (IUHPE 2009)

Values are not explored in the IHUPE publications. But as Tones (2005) notes, “most countries pay at least lip service to the canons of the World Health Organisation” and “felt confident in identifying the following key values in HPS:

- Health is holistic and not solely concerned with disease and prevention
- Health is about equity and social justice
The document sets out principles that define a Health Promoting School rather than values that guide practices. These principles are that an HPS school:

- Promotes the health and well-being of students
- Enhances the learning outcomes of students
- Upholds social justice and equity concepts
- Provides a safe and supportive environment
- Involves student participation and empowerment
- Links health and education issues and systems
- Addresses the health and well-being issues of all school staff
- Collaborates with parents and the local community
- Integrates health into the school’s ongoing activities, curriculum and assessment standards
- Sets realistic goals built on accurate data and sound scientific evidence
- Seeks continuous improvement through ongoing monitoring and evaluation

A theory for change, intervention or improvement is implied rather than explicitly explained in the advice below where a number of pre-requisites are discussed and the six essential elements are identified. These prerequisites centred around the need to build relationships, to develop an understanding about the school context and education language, and to provide recent evidence that would show how a reciprocal relationship between health promotion and education has supported schools to achieve better outcomes for their students.

A Health Promoting School was identified as having six essential components that would facilitate change or improvement in health and education outcomes for students. These required effective practices in relation to the six areas listed below. However, the document does not explain how (the theory and processes) are implemented in a school setting:

- Healthy school policies
- The school’s physical environment
- The school’s social environment
- Individual health skills and action competencies
- Community links
- Health services

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INTERNATIONAL TRENDS AND UNDERSTANDINGS ABOUT HPS THEORY OF CHANGE, INTERVENTION AND IMPROVEMENT

Change in culture

Essentially HPS is a process that seeks to change (improve) the health and educational outcomes for students. Ledger explains that the prime purpose of HPS is “achieving educational goals through addressing health issues within an educational framework.”29 The important questions that change theory in education poses are: “Under what conditions will continuous improvement happen?” and “How do we change cultures?”

Culture reflected in valued outcomes and practices in school communities

Research has identified that any school improvement initiative that focuses on improving outcomes and practices requires teachers and leaders, as well as students and families/whānau, to change their beliefs or values in addition to adopting new skills or knowledge. “It is the purposeful thinking that counts, not the mere doing.”30

The values and beliefs of a school community are reflected in their practices and the kinds of outcomes that are valued. The practices and valued outcomes are often referred to as the “culture” of the school community. The culture of an organisation or government department is evident in the practices and valued outcomes that are displayed.

In a school setting students’ learning needs are identified in relation to the valued student outcomes that have been determined by the community. Some valued outcomes are influenced by international and government priorities, while others are determined by a local school community. Sometimes there is a difference between a school community’s ‘espoused theories’ (what they say they value) and ‘theories in use’31 (what their actions show they value).

Student outcomes are the results or evidence of students' learning experience. Outcomes may relate to knowledge or skills gained, attitudes, values, or behaviours changed, or health condition or status improved.

Culture of HPS reflected in valued outcomes and practices

The HPS values/valued outcomes and practices internationally reflect the “culture” of the national service provider and/ or intervention. It follows then that at both a national level (an HPS framework) and a local level (an HPS intervention in a school) there needs to be a values-driven process and practice. Values driven practice can be aligned to the moral, social and professional purpose of professionals’ roles within both the health and education sectors. This is described by Elmore (2004) as “learning to do the right things in the setting where you work.”

Figure 1 below describes how the values and beliefs should be identified, articulated and evident at every level (national and local) of an organisation or intervention like HPS. The process should be dynamic with reflection, evidence and learning informing the on-going modification of values and beliefs.

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**Figure 1**: Relationship between core values and beliefs and practices adapted from Julia Atkin (1996)

![Relationship between core values and beliefs and practices](image)

**Theory for change, intervention and improvement – important tool for evaluation**

In addition to the understanding that changes in the school community’s *beliefs or values* are required in order to improve outcomes and practices in a school context, there is a wealth of international research and practice on the actions that are most likely to achieve change within a school setting. As Leger has noted in several articles:

“The health sector have largely ignored the vast literature on school organisation and improvement, teaching and learning practices, professional development, and innovation and dissemination......Schools are complex places and the way forward in school health requires more sophisticated theoretical models which are based on both health and educational frameworks.”

“The education sector has certain language and concepts, which have different meanings to those in the health and other sectors, and vice versa. Time, partnerships and mutual respect are needed to build a shared understanding

The necessity to provide the education sector with evidence about the advantages a health promoting strategy can offer schools in improving educational outcome”

This sentiment was first articulated by Colquhoun in 2005. He suggests that effective measurement of whether or not HPS “works” (improving health and educational outcomes) and why it will continue to elude researchers because researchers and health promotion programmes:

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32 St Leger, LH (1999) *Health Education Research Theory and Practice* The opportunities and effectiveness of the health promoting primary school in improving child health - a review of the claims and evidence, Vol no.1

33 St Leger, LH (1999) *Health Education Research Theory and Practice* The opportunities and effectiveness of the health promoting primary school in improving child health - a review of the claims and evidence, Vol no.1

34 St Leger, Lawrence (2201_ “Schools, health literacy and public health; possibilities and challenges” *Health Promotion International*, Vol 16 No. 2

1. Treat schools as simply sites for data-gathering or implementing their programme (whether it is needed or not). HPS is done “to” rather than “with” the school.

2. Do not include, consult or inform all members of the school community about the outcomes.

3. Do not appreciate that schools are complex and adaptive organisations and this needs to be taken into account when planning interventions or evaluations.

4. Do not realise that schools find themselves in a context which is dynamic, changing and evolving. They are bounded with other systems and structures in a way that is changing day by day.

5. Do not understand that there are greater demands on all members of a school community from society, the media, the government, and other systems like health, transport, justice, and the Ministry of Social Development.

6. Use the term ‘whole school approach’ but there are very few examples of why or how this model works in practice.

In 2010 this still remains an issue as a recent literature review by Douglas Lee Gleddie suggests that education change literature should be considered when reviewing effective HPS implementation.

Leger also noted the importance of an intervention or improvement being based on a theoretical model when he noted that “findings indicate health gains for primary school students are difficult to assess, and will most likely occur if a well designed program is implemented which links the curriculum with other health promoting school actions, contains substantial professional development for teachers and is underpinned by a theoretical model.”

At the IUHPE World Conference, Geneva, July 14, 2010, the whole school approach itself was again questioned. It was also identified by Wolfgang Dür & Karin Waldherr Ludwig Boltzmann Institute Health Promotion Research, Vienna, Austria that while HPS as an approach is valuable, it is the implementation of the approach that often fails. They suggest what is needed is a clear implementation (or change) theory that explains the relationship between the intervention (HPS) and the intervened system (schools).

The IUHPE 2009 document identified implicitly many of the above issues described by Leger, Colquhoun, Gleddie and Wolfgang Dür & Karin Waldherr in their list of enablers and inhibitors of HPS development in a school (summarised in Table 1 below). The inhibitors can be explained by the lack of a theory for change, intervention or improvement to guide HPS practices (added in italics).

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37 L. H. St Leger (2007) The opportunities and effectiveness of the health promoting primary school in improving child health—a review of the claims and evidence http://her.oxfordjournals.org/content/14/1/51.abstract

Table 1: Adapted from IUHPE Achieving Health Promoting Schools: Guidelines for Promoting Health in Schools version 2 of a document formerly known as ‘Protocols and Guidelines for Health Promoting Schools’

<table>
<thead>
<tr>
<th>Inhibitors</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>School health initiatives funded over a short project base, with unrealistic expectations and without a whole school-approach (These initiatives are implemented without a theory of change, intervention or improvement and do not take into account the substantial evidence of how to best achieve change in a school setting)</td>
<td>Developing and maintaining a democratic and participatory school community.</td>
</tr>
<tr>
<td>Health promotion outcomes occur in the medium to long-term (These initiatives have occurred without a theory of change, intervention or improvement and implementation action plan that is translated into the schools’ strategic framework which would map out short, medium and long term outcomes)</td>
<td>Partnerships between health and education policy makers</td>
</tr>
<tr>
<td>Evaluation is difficult and complex (A theory for change, intervention and improvement is a powerful way of explaining, evaluating and improving practice. Without a theory, evaluation is difficult and complex)</td>
<td>Parents and students having a sense of ownership in school life.</td>
</tr>
<tr>
<td>Health sector funding limiting the targets to morbidity and mortality rather than changes in beliefs and behaviours (Limited understanding that learning needs to be transformational for change to occur)</td>
<td>Using a diversity of teaching and learning strategies</td>
</tr>
<tr>
<td>Misunderstandings between the health and education sector due to professional jargon (Lack of understanding of the context, demands and interconnection of education with other systems)</td>
<td>Adequate time for the organisation and co-ordination of both in-class and outside activities.</td>
</tr>
<tr>
<td>Schools need to be provided with evidence that HPS improves educational outcomes (Lack of theory, evidence and examples of how HPS and the whole school approach works. What works for whom and in what circumstances?)</td>
<td>Exploring health issues that exist within the context of the students’ lives and the community.</td>
</tr>
<tr>
<td>Adopting a whole school approach</td>
<td></td>
</tr>
<tr>
<td>Providing capacity building professional development for teachers and staff</td>
<td></td>
</tr>
<tr>
<td>Creating a social environment characterised by open, honest relationships within the school community.</td>
<td></td>
</tr>
<tr>
<td>Ensuring a consistency of approach across and between the school, home and community.</td>
<td></td>
</tr>
<tr>
<td>Alignment between school goals and effective leadership and support.</td>
<td></td>
</tr>
<tr>
<td>Providing pedagogically sound and accurate resources that are linked to the curriculum.</td>
<td></td>
</tr>
<tr>
<td>Creating a culture of high expectations for student health and educational attainment.</td>
<td></td>
</tr>
</tbody>
</table>
IUHPE From Evidence to Action 39

In February 2010 the IUHPE released a document which was designed for policy makers. The purpose of the document was to explain how and why the promotion of health in schools is important, the key role leadership and effective management play and the international evidence that supports why and how HPS programmes should be implemented. Key messages in the document were:

1. The growing evidence that shows that health and education are inextricably linked to each other as well as to issues like poverty, income and equity

2. Health promotion improves educational and health outcomes. Although the IUHPE makes the case that there is evidence that health promotion in schools can improve both educational and health outcomes for students, it does not provide references for evidence that HPS improves educational outcomes

3. The countries that have joint policy commitments, legislation or signed agreements between government departments are among the leaders in developing and sustaining the growth of health promoting schools

4. Action Competencies in the 2010 IUHPE document the six components of effective HPS programmes remain with the addition of action competencies for individuals. This champions a participative and active approach which encourages students and others to take action to improve the health and well-being of themselves and others in their community. This, in turn, enhances their learning outcomes

5. The definition of HPS is broadened and defined in this document as “any activity undertaken to improve and/or protect the health of all school users” and includes the six components previously identified and broadened

6. The same vision, purpose, values and principles as articulated in the 2009 IUHPE remain but there is no theory for change, intervention or improvement articulated

7. A whole school approach is not defined

8. The evidence is based on a meta-analysis of findings from research and evaluation studies of health education and health promotion programmes/topics in schools, not whole school approaches or HPS approach. The document acknowledges that there is “clearly a need for more research on whole school approaches to help us understand how this works and why it is more likely to be effective” 40

9. In the absence of comprehensive research on the whole school approach, IUHPE recommends that “the associated research in the field of effective schools may help us understand what features of schools will support effective school-based health promotion and how school-based health promotion can contribute to effective schools” 41

39http://www.iuhpe.org/uploaded/Activities/Scientific_Affairs/CDC/PromotingHealthInSchools-fromEvidenceToAction_WEBSITE.pdf
40 http://www.iuhpe.org/uploaded/Activities/Scientific_Affairs/CDC/PromotingHealthInSchools-fromEvidenceToAction_WEBSITE.pdf, pg 5
41 http://www.iuhpe.org/uploaded/Activities/Scientific_Affairs/CDC/PromotingHealthInSchools-fromEvidenceToAction_WEBSITE.pdf, pg 5
INTERNATIONAL TRENDS AND UNDERSTANDINGS ABOUT HPS EVALUATION

One of the shortfalls of HPS internationally and in New Zealand has been the lack of rigorous and robust evaluation at all levels of delivery. Most evidence has emerged from international topic-based research and evaluation studies rather than a whole school process. Nilsson notes “it is no longer legitimate to base evaluation on measurement of outcomes in health knowledge or behaviour” as we know that this is extremely unlikely to lead to changes in thinking and behaviour.

In addition, it is impossible to draw a direct causal link between improving the health of students and subsequent improvements in their educational outcomes. Researchers cannot isolate all the other social, political, economic, environmental and cultural factors that contribute to a student’s well-being and achievement. As Whitty et al. (1998, p. 642) remark, “to do well in education seems to be really good insurance against poor health. However the relationships are complex and compounded by a spectrum of social factors.” The complexity and difficulty in isolating cause and effect is acknowledged in “From Evidence to Action”.

Tassavainen et al note that “the long term results of health promotion cannot be observed during school years, the effectiveness of health promotion cannot be measured merely by changes in health behaviours of children and adolescents. Thus, it is necessary to ensure the quality of the process and to evaluate the experiences of the participants as learning outcomes.” Springett (2001) suggests that health promotion is a decision-making process involving a number of key agents whose combined actions contribute, in variable degrees, to the final outcome. The focus of evaluation may not even be impact of an initiative in health, but rather on the factors considered to contribute to or determine health. The basic questions of evaluation are hence: what has changed? And where is the school going? In this context the aim of HPS evaluation is to identify the factors that contribute to health in a school community and the elements that improve health promotion in the school rather than improvements in health behaviours.

In considering these arguments what can be shown in an HPS evaluation is that an initiative ‘contributed’ to improvements in health and educational outcomes for students. In many parts of the world traditional health promotion intervention programmes that were developed in a school community are gradually changing into “participatory action research projects” where teachers, pupils, and parents play key roles in actively analysing, planning, implementing and evaluating health promotion activities.

As evidence informs inquiry within HPS there needs to be a deep commitment to evaluation and building critical review processes into all HPS actions. In this way evidence continues to inform future practice. A commitment to evaluation requires the development of an evaluation framework which provides:

- Triangulation of data/evidence

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42 NatCen (2009) Evaluation of the National Healthy Schools Programme Department Of Health, UK
46 IUHPE (2010) Protocols and Guidelines for Health Promoting Schools
49 http://www.iuhpe.org/uploaded/Activities/Scientific_Affairs/CDC/PromotingHealthInSchools-fromEvidenceToAction_WEBSITE.pdf, pg 5
● A theory for change, intervention and improvement
● The context (physical, social, cultural, political)
● The process (identifying, planning, acting, monitoring, reporting and evaluating/reflecting on outcomes as a basis for on-going improvement)
● The factors that contribute to health in a school community
● The health actions that improve educational outcomes in the school context
● The outcomes (positive changes in knowledge, attitudes, skills, behaviours, social and physical environment reflected in participation, engagement and achievement through quality relationships. (WHO 2009)

Leadership of Health Promoting Schools

Internationally, HPS concepts and delivery vary according to the social, political, economic and environmental context of a country. Listed below are a few examples of how HPS is delivered around the world.

Canada

Canada has Comprehensive School Health, supported by the Canadian Association for School Health. This association brings schools and preschools, professionals and community members together to promote health in school settings.

United States

In the United States, Coordinated School Health is overseen by national health and health promotion agencies. The process consists of eight interactive components (e.g., compared to Enhancing Education Outcomes 6 components on p.46).

United Kingdom

The United Kingdom has a National Healthy School Standard funded jointly by education and health. It aims to reduce health inequalities, promote social inclusion and raise educational standards. In July 2010, the new Coalition Government confirmed that Healthy Schools will continue but there will be significant changes. The Government wants Healthy Schools to provide guidance to schools on the physical and emotional well-being of children and young people, recognising that Healthy Schools plays an important role in helping children and young people reach their full potential.

The government changed how Healthy Schools was organised – nationally, regionally and locally and how schools use and access it. It has also changed Healthy Schools to reflect new education and health policies and priorities.

Schools can still use all of the resources on the Healthy Schools website, including the online tools, and all information entered by schools into the Healthy Schools online tools could be downloaded by schools until March 2011. All key Healthy Schools guidance and associated resources were moved to the Department for Education website at the end of March 2011. 48

Australia

In Australia a comprehensive approach to school health is commonly described as a HPS approach. The Australian Health Promoting Schools Association, AHPSA was established in 1994 to:

- Promote the concept of health promoting schools
- Encourage collaboration, research and advocacy

The Centre for Health Promotion, Children Youth and Women’s Health Service in South Australia supports a free electronic health promoting schools discussion network where resources are shared and questions posted.

Hong Kong

In Hong Kong, the Centre for Health Education and Health Promotion at the Chinese University of Hong Kong (CUHK) first launched the HPS programme in 1998 and further developed the concept of the Hong Kong Healthy Schools Award Scheme (HKHSA) in 2001. The aim of the HKHSA is to promote educational achievements and to enhance the well-being of school students and staff. The expected outcomes of the HKHSA are:

1. Students will increase their awareness and knowledge of health issues, and become equipped with the skills necessary to practise healthy habits
2. Schools will make health a key consideration in school improvement plans, provide health education to ensure all students have the knowledge and skills to lead healthy lives and promote the concept of collaboration and encourage school community members to work together for the students
3. School sites will be a safe and healthy environment for pleasurable learning and working
4. Schools will develop an ethos, which respects equity, justice, tolerance and care
5. Schools will promote community awareness about how to educate young people in healthy living in order to complement other health initiatives occurring in the community

Scotland

The Schools (Health Promotion and Nutrition) (Scotland) Act 2007 builds on the work of health promoting schools and Hungry for Success.

http://www.ahpsa.org.au
In summary the Act:

- Places health promotion at the heart of a school’s activities
- Ensures that food and drink served in schools meets nutritional requirements specified by the Scottish Ministers by regulations
- Ensures local authorities promote the uptake and benefits of school meals and, in particular, free school meals
- Reduces the stigma associated with free school meals by requiring local authorities to protect the identity of those eligible for free school meals
- Gives local authorities the power to provide pupils with healthy snacks and drinks, either at a cost or free of charge
- Requires local authorities to consider sustainable development guidance when they provide food or drink in schools

Under the Act, all schools in Scotland are required to initiate activity to become health promoting schools. Schools are considered health promoting when they provide activities, an environment, and facilities that promote the physical, social, mental and emotional health and well-being of pupils in attendance. These activities may be carried out by schools themselves or in conjunction with a range of partners that can include the Health Board, other Council and related services, community organisations, and parents and carers.

Schools examine their provision to promote health and well-being under the following broad headings:

- How health promotion is led and managed
- School ethos
- Work with partners
- Health and well-being curriculum, learning and teaching
- Environment, resources and facilities
- Staff training and development for health promotion
- Overall monitoring and evaluation of health promotion in the school

From this, schools identify strengths and areas for action to further improve their health promotion provision. This is then included in school improvement plans, and progress and impact of this work is evaluated and reported on an annual basis.

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50 Health Promotion and Nutrition) (Scotland) Act (2007)
Summary of HPS approach and delivery internationally

In summary, the approach in each country is heavily influenced by social/cultural, political, economic and environmental imperatives, and changes happen according to these variables. Different names and programmes emerge under the HPS banners and are driven by a variety of government and non-government organisations. The main point is that there is not “one way” or a “right way” in terms of HPS design and delivery. However, as the IUHPE document “From Evidence to Action” notes, “the countries that have a joint policy commitment or signed agreement between government departments are among the leaders in developing and sustaining the growth of health promoting schools.”51 (pg 2). With this in mind, the expectation would be that Scotland, the UK and Australia have well developed and sustainable HPS processes and structures in place as they have the sustained political commitment to support this.

51 http://www.iuhpe.org/uploaded/Activities/Scientific_Affairs/CDC/PromotingHealthInSchools-fromEvidenceToAction_WEBSITE.pdf
New Zealand HPS Context

Summary of HPS in New Zealand

- There is general agreement in New Zealand that HPS is an effective mechanism for improving health and educational outcomes, but there is a lack of understanding about how health and education interact and impact on each other.

- Schools are seen as an effective context to implement changes in health outcomes, but the health sector has a limited understanding about how New Zealand schools work.

- HPS requires changes in participants’ beliefs or values but few initiatives in New Zealand are structured on the basis of values driven practice.

- The six components of health promotion are seen by the health community as separate to the curriculum, but for educators the six components are perceived as part of what they do already in the New Zealand curriculum - which advocates enquiry based pedagogy and teaching as inquiry.

- Effective health promotion and prevention strategies in schools e.g. In the UK FiS has moved from provision of basic knowledge about health in the 1980s (informational) to students taking an active and authentic role in ensuring their own health and that of others in their community(transformational), but many other HPS activities and agencies still remain informational.

- Researchers have identified the need for a theory of change, intervention and improvement that takes into account the wealth of evidence of effective practice in this area from the New Zealand education sector, but this has not happened in most of the HPS initiatives that have been implemented in New Zealand schools.

- A “whole school approach” is advocated but there is a great deal of misunderstanding amongst the HPS workforce and stakeholders about what this is or how and why it works.

- Evidence-based practice and outcomes in a whole school approach is advocated, but the vast majority of research and evaluations in New Zealand have focused on programmes/topic-based delivery and process. The FiS evaluation was the first comprehensive evaluation to evaluate both HPS practices and outcomes for all participants.

- The HPS workforce needs to have the capacity and capability to work in partnership with schools as they investigate actions that are most likely to improve health and educational outcomes for students and whānau. These outcomes facilitate school’s access to health and social service resources that will provide solutions/change; but there has been little workforce development in this area.

- Student input and leadership is an important component of effective HPS strategies but this is often not included as part of the process.

- HPS as an approach is valuable; it is the implementation of the approach that often fails as there is no evidence-based theory to describe how HPS will be implemented in New Zealand school communities and why this approach will work and hence has been taken.

- The Ottawa Charter describes the action streams for health promotion (the approach) but it does not describe how health promotion can be best implemented in a New Zealand school context within Te Tiriti o Waitangi.
● Evaluations of HPS initiatives have focused on the process. Evaluations also need to consider the outcomes and identify the factors that contribute to health in a school community, the elements/critical success factors that improve health promotion in a school as well the experiences of the participants. The FiS research evaluation and Victory Village are some the first to do this.

● Inter-agency partnerships guided by national and regional policies and interagency agreements are acknowledged as best practice but the Tripartite Agreement was dissolved before this partnership was able to establish a shared vision and consistency in service delivery, planning and evaluation (in relation to HPS or other health initiatives in schools).

● HPS, particularly those groups experiencing the greatest inequities, are often Māori and Pasifika but there is little to no research or evidence of where indigenous knowledge and approaches have been integrated into the HPS actions.

● The HPS framework and interventions should be based on the principles and values reflected in Te Tiriti o Waitangi, but in many cases this has not been so.

● An HPS framework needs to promote a trust based partnership between the child, school, whānau, health and social services. The partnership is a network of collaborative interdependence that acts as a bridge between the social capital of the child, whānau, and community and the resources and support services.

● HPS has been utilised as a framework to guide best practice but in New Zealand implementation has often been confused with a variety of providers, stakeholders and topic/deficit based programmes claiming to be HPS. A new strategy that clearly provides an HPS strategic framework for the New Zealand context would benefit from a brand name that more accurately describes an approach that incorporates a kaupapa Māori.

● HPS workforce needs to have the capacity and capability to work in partnership with schools as they look inwards at their own culture, identify the issues, investigate actions that are most likely to improve health and educational outcomes for students and whānau and to facilitate a school’s access to health and social service resources that will provide solutions/change. There has been little workforce development in this area.

● Professional development will be needed for the whole HPS workforce including portfolio and contract managers, facilitators and stakeholders to re-focus and align all with the new Theory for Change, Intervention or Improvement (TCII) and HPS national strategic framework.

HEALTH SNAPSHOT-INTERNATIONAL COMPARISON

New Zealand’s poor health statistics and growing inequity in outcomes for children and their families have been a cause for concern for some time.

New Zealand has ‘developing country’ diseases, with rates of some diseases having more than doubled since 1991. These rates are still increasing. New Zealand tops the developed world in rates of hospitalisation for preventable conditions like meningococcal disease, rheumatic fever, skin infections (cellulitis), pneumonia, dental disease, gastroenteritis, ear disease, diabetes and chronic lung infection (bronchiectasis). In all health outcomes and measures Māori and Pasifika children are significantly disadvantaged and over represented in preventable conditions. In addition:

● More of our infants die than in many other similar countries, and our OECD ranking for infant mortality has risen over the last 3 decades.

● In South Auckland among Pacific children under one, about 1 in 300 have been struck with the meningococcal disease.
● We have high rates of death among Māori children, 90% of which are potentially avoidable.

● Our dental health used to be the best in the world. Children and young people now have disturbingly high rates of missing and filled teeth.\(^{52}\)

● Compared with other OECD countries New Zealand’s youth have considerable health issues which include relatively high rates of suicide, unintended pregnancies, abortions and sexually transmitted infections. Compared with other age groups, young people have higher degrees of injury (intentional and unintentional) and higher rates of mental illness and alcohol and other drug use and abuse.\(^{53}\)

**Children and their families - growing inequity in New Zealand**

The 2007 Paediatric Society’s report\(^{54}\) clearly showed how poverty impacts on children’s health, with children in low income households far more likely to get illnesses that require admission to hospital. “There is a strong body of research showing that people’s health – including children’s health – is negatively affected by the sort of income gap that puts New Zealand second only to the U.S. in the OECD.” This is shown in Figure 2.

Emma Davis and Dr Nikki Turner commenting in the *New Zealand Herald*\(^{55}\) on the 2007 report from UNICEF on child well-being in rich countries noted that international comparisons were useful contributions to a debate about the status of our children. In this regard the report made two crucial points\(^{56}\).

“First, there is no obvious relationship between gross domestic product - relative to population - and child well-being.

Second, countries poorer than our own do better by their children...We are still bottom of the table for too many indicators of child well-being.”

The Ministry of Social Development’s *Living Standards Report* and other indicators of inequality received media attention. In the *New Zealand Herald* 2 February 2010,\(^{57}\) Simon Collins wrote on the report:

"New Zealand’s reputation as a good place to bring up children has taken yet another hit - this time from an official survey finding that families with children are far more likely to be in hardship than any other New Zealanders....

*The ratio of child hardship to the overall national level of hardship was higher in New Zealand than in any of the other countries except Britain. " *(See Figure 3)*

The Salvation Army ‘s 2010 report “The Road to Recovery”\(^{58}\) highlighted that between 2008 and 2010 the number of children living in workless households has risen by 12%.

The recent living standards report from the Ministry of Social Development showed that in 2008 one in five New Zealand children was experiencing serious hardship or unacceptably severe restrictions on their living standards. The Salvation Army’s report suggested that the number is now even higher.

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\(^{52}\) http://www.cpag.org.nz/child-poverty/Health.html


\(^{55}\) Emma Davies and Dr Nikki Turner: Children fall by the wayside, New Zealand Herald 5:00AM Wednesday February 28, 2007


\(^{57}\) Families with kids feel pinch hardest, NZ Herald, By Simon Collins 4:00 AM Tuesday Feb 2, 2010


**Figure 2:** NZ Social Equity by comparison to other OECD countries, 2008

![GINI VALUE IN THE MID-2000s](image)

**Figure 3:** New Zealand hardship rates by age group, 2008

![HARDSHIP RATES BY AGE GROUP, 2008, %](image)

**Māori and Pasifikā Approaches**

The Ministry of Health has a number of strategies and approaches that aim to provide equity in outcomes for Māori and Pasifikā.

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[^59]: http://www.nzinstitute.org/index.php/nzahead/measures/inequality1/
The approaches for Māori and Pasifikā⁶⁰ which are described more fully in the backward map in Appendix 2 include:

- **Te Wheke** (Pere, 1988)
- **Te Whare Tapa Wha** (Durie, 1994)
- **Te Pae Mahutonga** (Durie, 2000) Community health promotion development in Māori settings.
- **TUHA-NZ**, framework for Treaty–based Health Promotion Practices
- **Whānau Ora Framework** (2010) The heart of Whānau Ora lies in building on whānau strengths and capability, growing whānau connections, supporting the development of whānau leadership and enhancing best outcomes for whānau
- **Fonofale**–Karl Pulotu Endemann (Samoan) house as a symbol of holistic model
- **Fa'afaletui**–Carmel Peteru and Kiwi Tamasese (Samoan) 3 views from mountain, coconut tree, and canoe ascertaining facts/knowledge in the houses of elders
- **Tivaevae** –Teremoana Maua-Hodges (Cook Islands) quilting of diverse facts and perspectives
- **Kakala**–Konai Helu-Thaman (Tongan) Cultural process of kumi/search, tui/plaiting, luva/giving ofa Tongan garland or kakala
- **Fonua**- Sione Tu’itahi (Tongan) land and its people and their on-going relationship, a concept that is present in many other Pacific culture

The Ministry of Health strategies that target improvements for Māori and Pasifikā include:

- Māori Health Strategy (He Korowai Oranga), the Māori Health Action Plan (Whakatātaka Tuarua), and the New Zealand Health Strategy.
- ‘Ala Mo’ui: Pathways to Pacific Health and Well-being 2010-2014 which sets out the priority outcomes and actions for the next five years that will contribute to achieving better health outcomes for Pacific people, families and communities. ‘Ala Mo’ui is for the entire health and disability sector.
- The New Zealand Disability Strategy which provides an overarching umbrella for all government agencies.

**EDUCATION SNAPSHOT-INTERNATIONAL COMPARISON**

Like the international comparison of our children’s health status, comparisons in terms of educational outcomes also show that New Zealand has high levels of inequity fuelled by large inequalities in socio-economic backgrounds. In education too Māori and Pasifikā students achieve the poorest outcomes. Thirty years of international research by Kate Pickett and Richard Wilkinson demonstrates that more unequal societies are bad for almost everyone within them.⁶¹ Inequities in both health and educational outcomes for our children and young people are therefore of great concern, as Pickett and Wilkinson’s research would suggest that the impact is experienced across the whole of New Zealand society.

**The OECD programme for international student assessment (PISA) 2009**

PISA 2009 results and comparisons with other 15 year olds from OECD countries show the following:

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● The countries with the very highest overall reading performance in PISA 2009, Finland and Korea, as well as the partner economies Hong Kong-China and Shanghai-China, also have among the lowest variation in student scores.

● New Zealand has strong overall education achievement

● New Zealand has some of the widest disparities (highest variation) in student achievement between top performers and bottom performers.

● New Zealand has large income inequalities and the impact of socioeconomic background on learning outcomes is large.

● Low education achievement is more common in the growing Māori and Pacific Island communities.

● Pasifikā students are at the bottom of New Zealand’s achievement statistics.

● Too many young New Zealanders do not complete secondary school. Those least likely to complete upper secondary are Māori and Pasifikā.

New Zealand’s Unique Educational Context

International HPS research and practice is not always immediately transferable to the New Zealand context as international HPS evidence often relates to:

1. Geographically connected countries
2. Euro-centric school contexts and homogenous school communities
3. Countries that do not have a formal agreement and partnership with the indigenous people
4. State governed schools and school regions
5. Curriculum that is set by the government

Geographically isolated, national clusters and networks

New Zealand does not share the proximity to other nations that European countries do. Our isolation provides us with a unique set of social, political, economic and educational circumstances or imperatives that impact on every facet of our lives.

However, within New Zealand there have been many attempts to cluster schools and encourage networks and professional learning communities through policy initiatives.

Diverse school communities

By comparison New Zealand has an increasingly diverse student population. Over the next two decades:

● New Zealand's Māori, Asian and Pacific populations are projected to grow.

● The 'European or Other (including New Zealander)', Māori, Asian and Pacific populations are projected to age, which is reflected in rising median ages and increasing proportions of people in the older ages.62

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**Treaty of Waitangi**

No other nation has a formal agreement with the indigenous people of the land. In New Zealand the Treaty of Waitangi\(^{63}\) outlines the formal agreement between Māori and the Crown. The Treaty of Waitangi is central to, and symbolic of, New Zealand’s national heritage, identity and future. The Treaty settlement process provides new and different opportunities for the crown (Ministries of Health and Education) to be involved with our Treaty partners.\(^{64}\) The Treaty is a broad statement of principles on which the British and Māori made a political compact to found a nation state and build a government in New Zealand. Included in this agreement is for Māori to enjoy a health and educational status at least as good as that enjoyed by non-Māori. Both Health\(^{65}\) and Education\(^{66}\) sectors are expected to demonstrate commitment to this agreement in both policies and practices that promote the principles of participation, protection and partnership.

- Participation at all levels
- Partnership in service delivery
- Protection and improvement of Māori health and educational achievement

Not only is it important to improve Māori health status and educational achievement, but other goals based on concepts of equity, partnership, economic and cultural security must also be achieved.

**Self Governing, Evidence-based Inquiry, Develop Own Curriculum**

New Zealand is the only country in the world to have “self-governing schools”, which is the most devolved model in the world. Former Minister of Education Wyatt Creech described the devolution of control of schools from the Ministry to the community as enabling people to take “control of their own lives and taking control of their children’s schooling.”\(^{67}\) This means that schools are autonomous and responsible to their local community for the development of a curriculum that best meets the needs of their students. The development of self-governing schools was driven by the desire for flexibility and responsiveness and a belief that the local school community knows best. The role of the Board of Trustees is to work on behalf of stakeholders. The Board focuses on strategic leadership and ensures compliance with legal and policy requirements. Student achievement is the Board’s focus.

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65 http://www.moh.govt.nz/moh.nsf/c43c7844c94e08cd4c2566d3008388b43/4464f7efc3241299c256567007b85c7fOpenDocument
67 Wyatt Creech http://www.cognitioninstitute.org/fullpage.php?type=research&slug=twenty-years-on
Figure 4: Board of Trustees and schools-inquiry and evidence-based practice

Trustees and schools ask key questions about how...

- do we know what we want for our students?
- well are our students doing?
- do we check that all of our students are learning?
- do we know if our curriculum meets the needs of students?
- do we know if our staff are doing a good job?
- do we know if our school is a safe and healthy place?
- are we managing our assets wisely?
- are we keeping in touch with our community?

Trustees & schools evaluate evidence/data in the following areas of responsibility:

- Plans & policies
- Student achievement
- Student engagement
- Learning programmes
- Employment
- School climate & environment
- Asset management
- Community consultation & reporting

The data is from:

- Planning & policy documents
- Achievement reports
- Student databases
- Curriculum reports
- Appraisal reports
- Health & Safety reports
- Financial & property reports
- Community feedback reports
Evidence-based inquiry cycles already operate at every level of school communities

Schools and boards have several processes for gathering and analysing data/evidence. These inform the development and progress towards goals that have been identified and detailed in their Charter’s strategic and annual plans (Appendix 4). Figure 5 shows the evidence-based inquiry cycle that operates at all levels of a school community. Figure 6 describes how evidence-based inquiry drives review processes for boards, principals and staff.

Schools in New Zealand are currently focused on accelerating achievement particularly in literacy and numeracy through evidence-driven inquiry processes at every level.\(^{68}\)

In schools evidence refers to more than data on student learning or engagement. It also includes professional knowledge and practices and what is known about making the most difference, particularly for those experiencing the greatest inequity.

Evidence-based health promotion refers to the use of information from formal research and systematic investigation to identify causes and contributing factors to health needs and the most effective health promotion actions to address these in given contexts and populations. (WHO)

Inquiry is fundamental to effective professional practice in schools and school communities. It involves students, teachers, principals, boards and communities investigating what is working well for students and why, so it can be continued, and what is not working well and why, so it can be changed. There is ample evidence in NZ research that engagement in this cycle has been shown to result in improved student outcomes. (2010 Timperley, Parr) It is a recursive process and describes the task of evidence–based decision-making and the process by which decisions are made and plans or actions are implemented and reviewed in a school setting.

**Figure 5:** Evidence-based inquiry processes at all levels in a school\(^6\)

**Figure 6:** Evidence-based inquiry drives review processes for Boards, Principals and Staff\(^7\)

**Self review**

- School boards of trustees have a responsibility under the National Administration Guidelines to review their school’s performance
- Reviews should be cycles of connected and focused processes to gather evidence and act on the results:

  - Strategic self review
  - School - regular self reviews
  - Emergent reviews

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\(^7\) Adapted from [http://www.minedu.govt.nz/~/media/MinEdu/Files/Boards/BoardRoleNationalStandardsMay2010.pdf](http://www.minedu.govt.nz/~/media/MinEdu/Files/Boards/BoardRoleNationalStandardsMay2010.pdf)
New curriculum

The new curriculum articulates a vision, values and principles and focuses on key competencies, personalised learning and 21st century skills as shown in Figure 7. There is little prescription and the expectation is that learning should make use of natural connections that exist between learning areas, values and key competencies.

**Figure 7**: Schematic overview of the New Zealand Curriculum

For the first time the new curriculum also outlined effective pedagogy, which is well-documented evidence about the kinds of teaching approaches that consistently have a positive impact on student learning. This evidence tells us that students learn best when teachers:

- Create a supportive learning environment
- Encourage reflective thought and action *(inquiry based learning see Figure 9)*
- Enhance the relevance of new learning *(inquiry and transformational based learning)*
- Facilitate shared learning *(inquiry and transformational based learning)*
- Make connections to prior learning and experience *(inquiry and transformational learning)*

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● Provide sufficient opportunities to learn (*inquiry and transformational based learning*)

● Enquire into the teaching–learning relationship (*inquiry and transformational based learning*) as seen in Figure 8 as any teaching strategy works differently in different contexts for different students.

**Figure 8:** New curriculum inquiry into the teaching–learning relationship

National Assessment

National assessment in the form of National Standards takes place in Year 1-8 (intended to provide a nationally consistent guide to student achievement against the New Zealand Curriculum). Secondary schools offer year 11-13 secondary school students the quality assured national assessments and qualifications on the New Zealand Qualifications Framework (NZQF).

Greater accountability—student achievement

Recently New Zealand’s unique educational context has experienced greater community and government scrutiny with expectations that schools should be able to show that they are achieving positive outcomes for students.

In 2010 Anne Tolley, the Minister of Education, announced the Government’s plans for a much stronger frontline focus on lifting student achievement.

“While there is much we can be proud of in our education system, too many students aren’t achieving even the minimum qualifications they need to be engaged and informed citizens, and to play an active role in our society. Change will happen only if there is a relentless, system wide focus on improvement.”

Literacy and numeracy focus

In a speech at the New Zealand Schools Trustees Association conference in July 2010 Anne Tolley, the Minister of Education, outlined the New Zealand government’s priority that every child achieve literacy and numeracy levels that enable their success, particularly the “up to 20 percent of our children who are being failed.” The purpose of the government’s initiatives “are to lift achievement, particularly in reading, writing and maths; to keep young people engaged in learning at school; and to enable every single young New Zealander to get the qualifications they need to succeed in life. The initiatives outlined were:

- National Standards (intended to provide a nationally consistent guide to student achievement against the New Zealand Curriculum in primary schools years 1-8)
- Youth Guarantee in secondary schools (providing alternative pathways for secondary students)
- Positive Behaviour for Learning Action Plan (aims to reduce truancy and disruptive behaviour, increase engagement, and ultimately lift achievement) 74

Equity of Educational Outcomes

In addition to the strategies listed above, there are a number education plans in place to improve outcomes for students and young people, particularly Māori and Pasifikā. These include the Pasifikā Education Plan 75 (Appendix 5), Ka Hikitia 76 (Appendix 6), Education Strategy, 77 Whānau Ora outcome goals and the The Whānau Ora Tool 78, new contracts in 2011 with national teacher and leadership professional development providers for schools and the Disability Strategy. 79

The Disability Strategy objectives relate to encouraging and educating for a non-disabling society and providing the best education for disabled children. The Ministry of Education’s priority outcomes for children with special education needs are presence, participation, learning and achievement. Full participation of all disabled children in high quality, culturally appropriate education is targeted to ensure that strong foundations for whole-of-life learning are in place.

Valued outcomes

The valued outcomes sought by all these strategies that have been developed to address the needs of Māori and Pasifikā can be synthesized as:

- Presence
- Engagement
- Achievement through the development of quality relationships between students and adults and adults in the community

In terms of how health influences achievement of these valued outcomes:

75 http://pasifika.tki.org.nz/Pasifika-Education-Plan
● **Presence**- Students have to be present at school in order to be able to learn. There may be health related needs that are not being met that are preventing students from being present at school.

● **Engagement**- It is a well-known fact that “healthy students learn better.”

● **Achievement**- through the development of quality relationships between students and adults and adults and adults in the community. This acknowledges the health concept of Hauora and wellness and a school’s responsibility to ensure that all students and members of the community have a healthy and safe environment.

**New Zealand –Leadership in Educational Research**

New Zealand has been internationally recognised for its educational research methodology and comprehensive approach to evidence in the **Iterative Best Evidence Synthesis (BES) programme**. BES is a collaborative knowledge building strategy designed to strengthen the evidence base that informs education policy and practice in New Zealand.

The touchstone of the programme is its focus on explaining and optimising influences on a range of desired outcomes for diverse learners. The series of BESs is designed to be a catalyst for systemic improvement and sustainable development in education.

The 2006 edition of the World Education Yearbook describes New Zealand’s Iterative BES Programme "as the most comprehensive approach to evidence” and goes on to say: "What is distinctive about the New Zealand approach is its willingness to consider all forms of research evidence regardless of methodological paradigms and ideological rectitude, and its concern in finding...effective, appropriate and locally powerful examples of ‘what works’”.

**New Zealand research - improvement in school context**

International research over the past thirty years shows that there is no silver bullet for improvement in a school community context. But recent New Zealand research, informed by the BES programme, shows that those school communities in New Zealand who are most successful in improving outcomes

- Use a range of evidence to inquire into the effectiveness of everyone’s current practices
- Decide what should stay because it is working
- Decide what needs to change and how it needs to change.
- Provide opportunities for the school community to plan actions that will address the changes
- Check the effectiveness of everyone’s efforts
- Identify new challenges that form a new cycle

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81 http://www.educationcounts.govt.nz/themes/BES

The main outputs of the Iterative BES Programme are Best Evidence Synthesis Iterations (BESs) To date eight BESs have been completed.

7. Social Sciences Tikanga a Iwi by Aitken, G. and Sinnema, C.
6. Teacher Professional Learning and Development by H. Timperley et al
5. Effective Pedagogy in Mathematics/Pangarau by G. Anthony & M. Walshaw
4. Professional Development in Early Childhood Settings by L. Mitchell & P. Cubey
3. Community and Family Influences on Children’s Achievement by F. J & C. Biddulph
2. Quality Teaching: Early Foundations by S. Farquhar
1. Quality Teaching for Diverse Students in Schooling by A. Alton-Lee

Timperley and Parr (2010) describe a theory for change, intervention and improvement as being a set of linked ideas about how to improve valued outcomes. They suggest that the values and beliefs of a school or intervention should be evident in the ideas, processes and practices.

This evidence forms the basis of theories for change, intervention and improvement in New Zealand schools. These actions also align with the Health Promoting Schools conceptual framework (Appendix 7) and Health Promoting Schools process steps (Appendix 8).

Therefore the development of an HPS theory of improvement and implementation should be underpinned by an understandings of transformational learning (Kegan 1994; Mezirow 2000), theory of change (Fullan 2006), evidence-based teaching decision making (Earl & Katz 2006, Lai 2009), inquiry based learning and large scale schooling improvement (Levin 2009).

**Theory of sustainability**

New Zealand research also shows that a theory for change, intervention and improvement should include a theory of sustainability for valued outcomes.

Sustainability is the process of organisational learning to improve outcomes already achieved (Lai et al., 2009). Sustainability is NOT planned after an intervention it needs to be planned from the beginning of the process.

**Evaluation**

One of the shortfalls of HPS internationally and in New Zealand has been the lack of rigorous and robust evaluation at all levels of delivery. Most evidence has emerged from international topic-based research and evaluation studies rather than a whole school process. As evidence informs inquiry within New Zealand education there needs to be a deep commitment to evaluation and building critical review processes into all change/intervention/improvement actions in a school. In this way evidence continues to inform future practice. The ultimate measure of the effectiveness of change needs to be improved valued outcomes for students and whānau.

Evaluating theories is also fundamental to effectiveness, because not all theories will contribute equally to desired/valued outcomes. An HPS theory for change, intervention and improvement needs to be relevant and rigorous for the education and health promotion community as well as New Zealand’s unique context.

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83 NatCen (2009) Evaluation of the National Healthy Schools Programme Department Of Health, UK
THEORY FOR CHANGE, INTERVENTION AND IMPROVEMENT (TCII) IN SCHOOL SETTINGS

Figure 10 shows a theory for change, intervention and improvement that explains the practices and processes that will deliver the desired or valued outcomes in New Zealand schools. This model aligns with evidence-based best practice in achieving change/improvements in schools internationally and in New Zealand. It also aligns with the approach taken with the Whānau Ora initiative from the perspective of educators and health promoters. The 2010 IUHPE conference and a recent doctoral thesis highlighted the need for HPS to have a theory for change, intervention and improvement. The model below could be used as a basis for the development of an HPS model. It is further explained in the following paragraphs.

**Figure 10: Theory for Change, Intervention and Improvement adapted from PowerPoint presentation “Theories for Improvement and Sustainability” delivered by Dr Mei Kuin Lai**

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68 http://repository.library.ualberta.ca/dspace/bitstream/10048/1501/1/Gleddie_Douglas_Fall-2010.pdf

PRE-REQUISITES TO ENGAGEMENT WITH SCHOOL COMMUNITIES

Timperley and Parr (2010) identified four pre-requisites to engagement with school communities. The first is that participants need to have a clear theory of improvement (Figure 23) and understanding of the implementation process (Figure 24) before they begin. Secondly, an understanding of the current school context/setting in New Zealand is needed if all participants are to gain credibility, trust, meaningful engagement and improvement. Thirdly, relationships that are interdependent and based on trust and challenge need to be developed. New Zealand has clear evidence about the importance of partnerships, effective leadership and community involvement in order to achieve improvements in outcomes in a school context. Finally, participants must be able to articulate and provide on-going evidence that shows how the intervention has achieved better outcomes for their students and Whānau.

Theory for change, intervention and improvement has been discussed above as has the complexity and drivers of the current New Zealand educational context. The pre-requisites to engagement in terms of relationships and on-going evidence are discussed in the following section.

Relationships

Russell Bishop in the Kotahitanga project in NZ has identified that “Culturally Responsive Pedagogy of Relations” 88 provides the key to improvement in outcomes for Māori. These relational practices have also been shown to provide significant gains for Pasifikā as well. An understanding of these practices is important when considering improvement in outcomes for both Māori and Pasifikā students.

Evidence shows that successful partnerships between health promoters and school communities are more likely to be productive if they are based on:

- Managed interdependence
- Trust and challenge 89

Managed interdependence

Managed interdependence involves complementary and mutually informed relationships between the school community, health promoters, and other outside agencies with specialist expertise. In this relationship the school community is in the driving seat of inquiry and change. Health promoters provide a partnership characterised by on-going support and health promotion expertise. As the school community develops greater capability in providing their own solutions, they will need less support to make decisions and inquiry into whether their current practices are working or not.

Trust and challenge

Trust involves personal respect, integrity and carrying out mutual agreements. Tony Byrk and colleagues (1998)90 identified having a base level of trust developed through day to day exchanges, as being fundamental to success. Trust also comes with a great deal of mutual accountability.

88 http://www.educationcounts.govt.nz/publications/series/9977/9454
As evidence and inquiry are at the heart of the theory for change, intervention and improvement and inform the process, it is important that ideas, beliefs, evidence and understandings are challenged as part of this relationship. Challenge requires that rigorous debate of the ideas put forward and the evidence that underpins them takes place at all levels of the community in the dialogue. When trust is established these discussions will be respectful and productive leading to new understandings or clarity.

**Effective Partnerships in School Communities**

The necessity for collaboration in a school context is based on ample international and national evidence that health and education outcomes are best achieved when stakeholders are involved in the decision making around priorities, planning and provision.

Research evidence\(^91\) in New Zealand shows that effective partnerships between schools and parents, whānau and communities can result in better outcomes for students. The better the relationship and engagement, the more positive the impact on students’ learning.

The Education Review Office’s National 2008 Report ‘Partners In Learning: Schools’ Engagement with Parents, Whānau and Communities’ \(^92\) identified six key factors as critical to enhancing and strengthening engagement as listed in Appendix 9.

**Leadership**

What the ERO research highlights is how important school leadership is in brokering and maintaining partnerships and relationships. It is for this reason that an effective HPS strategic framework will need to develop leadership across all stakeholders as well as the other five key factors necessary to maximize the effectiveness of partnerships.

Kiwi Leadership for Principals is based on best evidence synthesis \(^93\) and provides guidelines for effective school leadership. The synthesis identified that principals who develop relationships that lead to improved learning experiences and outcomes for all students:

- Encourage and participate in professional conversations that help teachers to share evidence-based expertise and successful strategies that improve student learning;
- Manage the delicate balance between supporting and challenging others;
- Encourage regular and documented classroom observations, and actively lead and participate in professional learning opportunities with staff;
- Manage dilemmas when the needs of the students and those of other members of the school community are in conflict;
- Build trusting relationships through active listening, caring for others, and demonstrating personal integrity.

An effective HPS framework should enable students and their families to interact and participate in decisions because leadership amongst all the stakeholders builds trust-based relationships where what they have to say matters.

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\(^92\) [http://ero.govt.nz/ero/publishing.nsf/Content/pil-schls-engmnt-may08#Footnotes](http://ero.govt.nz/ero/publishing.nsf/Content/pil-schls-engmnt-may08#Footnotes)

\(^93\) [www.leadspace.govt.nz/klp](http://www.leadspace.govt.nz/klp)
Three-way strengths-based model

Effective leaders also maximise and empower students and their families’ abilities to interact and participate in education. What Bishop et al.⁹⁴ and Smith and Blanc⁹⁵ propose is a relational approach to power and decision-making in schools that is ‘trialectic’⁹⁶, interactive, shifting and contestable. In this model stakeholders are viewed as equal sides of a triangle: education and health professionals, family/community and students. Trialectic logic is one of viewing the world in terms of wholeness and relationships, focusing on sustainable relationships of the whole. Rather than a third factor being an ‘answer’ or ‘solution’ to the problem of relating two opposed factors, as in some of the other logics, it is merely one more factor.

The challenge of trialectic logic is to hold all three separate factors in tension and, simultaneously, to view them as whole - without letting go of one or making synthesis of just two.

**Figure 11:** Three way strength based model

In this model all stakeholders have an equal contribution and the power to influence decision-making. When applied to the HPS, effective partnerships are achieved when all three stakeholders are engaged and feel their part in the relationship is valued because they have an equal ability to participate in the decision-making process.

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The idea of whānau-centred approaches to improving well-being is gaining a much wider base of political support.”97 Whānau Ora, as detailed in the backwards mapping in Appendix 2, is a reflection of this philosophy as it is based on the concept of whānau taking responsibility for whānau. It places whānau at the centre and empowers them to lead the development of solutions for their own transformation.

NEW ZEALAND HPS DEVELOPMENT

A recent overview of the state of HPS in New Zealand by Cushman (2008) concluded that “in the last 20 years the health promoting schools movement has gained momentum internationally but that without strong national leadership and direction its development in New Zealand has been ad hoc and sporadic.” In addition HPS programmes will not attain positive improvements in health and educational outcomes for our young people until there is “significant, positive multilevel contributions (from Government, Ministry, parents, the community, students and staff).” 98

The history of development and HPS pilot projects in New Zealand supports this view and is shown in Appendix 10 which maps international progress against that of New Zealand. In addition, most of the topic-based HPS programmes have been initiated within primary schools as secondary schools have historically shown some reluctance to engage in the concept.

There is also a lack of clarity about what constitutes an HPS activity or a “whole school approach”. Communications around “Health Promoting Schools” can lack clarity. An example of this confusion is a website which states;

“Following on from the successful Fruit in Schools programme is Health Promoting Schools, providing fruit and vegetables to:

• 470 Decile 1 and 2 schools in
• 20 regions from the far North to Southland, supplying
• 96,322 pieces of fruit and vegetables every day”

The implication here is that the provision of fruit and vegetables is the fulfilment of an HPS approach.

HPS development has largely been ad hoc, without the use of a strategic, interagency approach from central government agencies. Initiatives have often lacked national consistency in service or workforce delivery and any unifying theoretical basis or framework. For example, the Heart Foundation and Cancer Society have had formal links with the HPS workforce whereas other projects like Enviroschools, Cool Schools and Healthy Schools have often had informal links.

The history and reviews of HPS development in New Zealand show that there has been some very good practice but under-investment in HPS from its establishment to the implementation of FiS has hindered progress. HPS was a significant national Public Health programme but little funding was allocated for evaluation or for workforce development nationally and regionally. The lack of national infrastructure and co-ordination has long hampered the timely development of both capacity and capability of the workforce. While the establishment of regional co-ordinators facilitated some regional linkages and workforce development, this was ultimately variable across regions. The regional co-ordinators structure did not facilitate or enable a national strategic framework to evolve.99

This has resulted in a fragmented and disjointed sector as shown in Figures 12 and 13, where strategic and innovative approaches to HPS need to be further developed and strengthened.100 Figure 12 shows the myriad of HPS providers operating in school communities. This was echoed in the 2009 Fruit in Schools (FiS) evaluation.101 Figure 13 demonstrates the complexity of the service structure.

Collaboration between Health and Education

There are many national laws and international agreements that govern and guide all stakeholders in best practice educational and health care provision for students and that require collaboration at a variety of levels.

HPS was an initiative to formalise the partnership between the health and education sectors with a common aim of ensuring that young people’s rights to adequate health, engagement in learning and educational outcomes are honoured. An important component is strengthening the local community, parent and student input into decisions about the support services required to improve health and educational outcomes for students and their families. Schools are a convenient forum to facilitate improvements in health and educational outcomes for our young people as they are a meeting point between parents, students and communities and provide opportunities to identify needs, provide support, learn and develop programmes.


101 “Challenges related to the number of health-related initiatives in the sector were also reported. Just over a quarter of survey respondents indicated they did not believe clear messages were communicated to schools about how FiS,”
Tripartite Agreement

In 2005 to 2007 a Tripartite HPS agreement was developed between the Ministry of Health, Sport and Recreation New Zealand (SPARC) and the Ministry of Education in New Zealand; this signalled a cross-agency/government department collaborative approach. Significant progress was made including the development of an agreement and joint planning in terms of HPS policies, services and delivery in the school sector. However, divergent government imperatives soon resulted in the dissolution of the agreement.

Figure 12: HPS providers

**HPS Tripartite Agreement expired in 2007**
In order to understand the current complexity and confusion within the New Zealand HPS sector it is useful to consider the timeline of development of HPS within New Zealand.

**Timeline of New Zealand HPS Development**

The journey in New Zealand HPS began in 1991 when the School Trustees Association held workshops around the concept of Health Promoting Schools. As the timeline in Appendix 10 shows, this is approximately ten years after the HPS developments in Europe.

**1995 – Healthy Schools-Kura Waiora**

Health Promotion Guidelines for Schools was launched by the Ministry of Health in 1995. This outline included many of the principles and guidelines that had been provided by WHO conferences, working parties, research models and IUHPE guidelines. Health promoters delivered this programme.

**1997 three year HPS pilot**

In 1997 the Northern Regional Health Authority funded a three-year HPS pilot in Auckland and Northland. This was the beginning of the HPS workforce. The pilot used three models of delivery: cluster, intensive, and sub-regional delivery. Regional HPS co-ordinators were engaged to support the HPS advisors who worked directly in the schools.

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In addition, a separate topic-driven pilot initiative ‘Mentally Healthy Schools’ was established in Auckland and Northland to focus specifically on mental health promotion. This was delivered by the Mental Health Foundation and not the HPS workforce.

An evaluation of the HPS pilot project in 2000\(^\text{103}\) was carried out by Phoenix at the completion of the pilot programme. Data was gathered at two main points: project establishment and project conclusion. The pilot identified the following challenges:

- Inadequate selection processes resulted in insufficient commitment from some schools and their communities
- A range of providers in a region created difficulty in establishing the role of the regional co-ordinator
- HPS co-ordinators needed to be supported in the development of a range of skills before they engaged with schools
- Principals did not actively support the pilot


In 2004 the Ministry of Health wrote the Healthy Eating Healthy Action Strategy and Implementation Plan. This was largely influenced by the government and other sector concerns regarding New Zealand’s obesogenic society and the rising percentage of the total population with preventable diseases like diabetes. HPS was seen as an important mechanism for the implementation of HEHA in schools and communities. In 2005 HEHA was complemented by the introduction of Fruit in Schools (FiS) which included a stronger focus on nutrition and physical activity in the school setting.

This plan provided an integrated policy framework to bring about changes in the environment in which New Zealanders live, work and play as this relates to nutrition, physical activity and obesity. It was the Ministry’s response to three of the 13 priority population health objectives in the New Zealand Health Strategy (Minister of Health 2000). The focus was reducing inequalities in the priority groups which included:

- Māori
- Pacific
- Low SES
- Children/ Youth
- Families and whānau

The **valued outcomes** were:

- Improving nutrition, increasing physical activity, and reducing obesity as these were three of the thirteen health priorities identified in the New Zealand Health Strategy.\(^\text{104}\)
- Funding provision
- Project management by project managers in each of the DHBs


\(^{104}\) http://www.moh.govt.nz/healthyeatinghealthyaction
Inter-sectoral initiatives co-ordinated in districts

In 2008 an Evaluation of the HEHA Strategy was conducted by a Research Consortium.

The approach taken was ‘translational research’, a “comprehensive applied research that strives to translate the available knowledge and make it useful in everyday clinical and public health practice.”

The reasons why an evaluation was undertaken were because:

- There is lack of evidence about effectiveness of population level strategies to reduce obesity and overweight
- The HEHA Strategy Evaluation was an important opportunity to evaluate a national population health strategy
- Objective 6 of the HEHA implementation plan was: “Monitor, research and evaluate”

The focus areas were:

- Implementation - Was the Strategy implementation effective?
- Outcomes - What resulted from the Strategy implementation?
- Economic - Did the strategy represent value for money?
- Improvement - What opportunities for refinement and further development exist?

The HEHA implementation plan did detail what would be done but not how this was going to happen within the context of an ECE or school. An interim HEHA evaluation report was produced which recommended continuation of the implementation process. With a change of government in 2008 the HEHA initiative was disestablished as nutrition promotion was not seen as a priority.

**Fruit in Schools (FiS) Pilot**

Based on the UK fruit in schools programme, the 2004 project was successfully piloted in New Zealand as a “free fruit in schools” project within lower decile Auckland primary schools. The pilot was run in 20 schools (ten intervention and ten control) during term two of 2004 and demonstrated how children can be guided towards healthier eating habits. The project was delivered by FiS co-ordinators in collaboration with the HPS workforce. Both workforces were employed by the same providers. Teachers wanted the pilot to continue and be rolled out nationally.

Fruit intake decreased to almost original levels within six weeks of the pilot ending; this reinforced the need for more extended research. On the basis of this evaluation the Ministry of Health decided to run FiS as a nationwide programme over three years.

**Fruit in Schools (FiS) Programme**

In Term 4 2005, on the basis of evaluations of FiS pilot programmes in the UK and New Zealand schools, collaboration was achieved between the Ministry of Health, Ministry of Education, SPARC, New Zealand Principals Federation, NZSTA, Cancer Society, National Heart Foundation and DHBs to provide a FiS programme in low decile primary schools throughout the whole of New Zealand. In most places FiS co-ordinators were employed by DHBs and worked alongside the HPS workforce. The

programme took a broad HPS approach, was inequalities focused and prioritised 4 topics: food and nutrition, physical activity, sun protection and smokefree policies. It was also strongly linked to the Healthy Eating Healthy Action (HEHA) strategy. The Cancer Control Action identified FiS as an action along with sun protection and smokefree as cancer prevention initiatives.

**How the FiS project worked**

The FiS project was spearheaded by HPS advisors in most regions who approached the high needs schools and invited the schools and their communities to commit to:

- The HPS whole school focus
- Four priority areas (food and nutrition, physical activity, sun protection and smokefree policies)
- Working together as part of a cluster with the expectation that they would be self-sustaining after three years
- Participating in the evaluation of the project.

Low decile primary schools (deciles 1 and 2) were the recipients and later intermediates were included. In return:

- Clusters/schools were provided with fruit and teacher release funding for cluster meetings, planning and professional development.
- School communities were expected to adopt an HPS/whole school community approach to well-being with a specific focus on nutrition, physical activity, sun protection and smokefree.
- One piece of fruit was supplied daily for each child, over a period of three years. After this, clusters and their communities were expected to be self-sustaining (for example, by gaining local sponsorship for fruit, establishing orchards or parents paying for the fruit.)

While the school communities strongly supported the FiS project, there was limited support for the cluster concept.

In terms of analysing the strategic framework for this initiative, it can be concluded that:

The **vision** for FiS was that it would promote the health and well-being of students in schools.

The **mission or purpose** of FiS was to enhance student learning through promoting the well-being of the school community with a particular focus on:

- Healthy eating
- Physical activity
- Being sun smart
- Being smokefree

The **Values** underpinning the initiative were not articulated.

The **principles of the initiative** were those articulated by HPS internationally, like those detailed in the 2009 IUHPE document, as the programme was based on the HPS ‘whole school’ approach. Yet these principles and a description of a ‘whole school approach’ were not explicitly shared with facilitators or HPS providers.
The theory for change, intervention or improvement was that giving children fruit, as well as developing practices and policies that encouraged healthy eating, greater physical activity, sunsmart behaviour and a smokefree environment, will contribute to lifelong health and well being.

In terms of implementing the programme, this was done through:

- The provision of 4 teacher release days per year for professional development
- Developing clusters of schools that worked together to ensure support and development of sustainable FiS initiatives once government funded fruit provision ceased. Provision of free fruit and vegetables for all children in the school (years 1-8)
- Support and advice on a whole school approach from a FiS Co-ordinator (FiSC)
- Access to programmes delivered by other providers e.g. Cancer Society, School Support Services, Regional Sports Trusts and Heart Foundation (although no additional resource was provided for these agencies)

The valued outcomes were based on behaviours in relation to health issues and included:

- Children in participating school communities eating more fruit
- More school communities promoting health through a whole school approach
- Increasing awareness and implementation of policies and practices that encourage healthy eating, physical activity, and smokefree and sunsmart protection in school community environments.
- Improved learning through increased health and ability to focus in class

In terms of monitoring, reviewing and evaluating progress a number of strategies were put in place. The New Zealand Council for Education Research (NZCER) and Health Outcomes International evaluated FiS. The evaluation was a mixed-method longitudinal study incorporating the collection of information from a range of FiS stakeholders. The focus was on:

- change and how it occurs as the four priority areas were delivered in school communities
- changes in student knowledge and behaviours, school practices and community participation
- highlighting aspects of good practice in health promotion

The tools involved were:

- Yearly surveys of school staff and students
- Interviews with non-school stakeholders
- Two sets of good practice case studies of schools in 2006 and 2008

The evaluation looked for change at four levels of the school system:

1. Curriculum, teaching and learning
2. School organisation and ethos
3. Community links and partnerships (parents)
4. Community links and partnerships (health promoting and community groups)
FiS Evaluation Findings

The evaluation report of FiS “Healthy Futures” was delivered in three parts. A final overview (Boyd, Dingle, Hodgen, King and Moss, 2009) summarised the main findings from “Healthy Futures”. In addition to this overview report, there was a separate document (Boyd and Moss, 2009)) summarising the findings from the 2008 case studies and the stories of six FiS schools. A final technical report (Dingle et al. 2009) provided more details about the survey analysis and data.

The evaluations of this HPS initiative focused on the process and health behaviour outcomes and **identified the elements (enablers) that improved health promotion at schools** (p 52). The evaluation\(^{107}\) identified the key changes in process and behaviour in three areas:

- Schools
- Students
- Inter-agencies/ support partners

**Schools**

**The key health process and behaviour changes for schools were that FiS was supporting schools to:**

- Develop a “Healthy School” vision for the school community
- Change their culture to better promote health and well-being
- Make more use of HPS processes e.g. student and community participation
- Strengthen their healthy eating and sunsmart policies and practices and increased participation in physical activity
- Increase participation with agency partners
- Engage with other initiatives e.g. HEHA and National Administrative Guidelines Number 5 (NAG5)
- Develop sustainable practices

**Main enablers of change at FiS Schools that have implications for HPS**

- The FiS created a positive climate and acted as a catalyst for change
- Supportive leaders and staff
- Use of HPS approach (planning and community consultation)
- Student leadership e.g. health teams and PALs
- FiSC and agency partner support, resources and programmes
- FiS school cluster sessions and student led workshops

**Main disablers of change at FiS Schools that have implications for HPS**

- Removal of resourcing for FiS and lead teacher release time

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Variable access to agency partners
Lack of professional development for teachers

**Areas for further development**
- Inclusion of social and emotional health and well-being as an additional health priority
- Further support for schools to make connections with some parents and whānau
- Further support for schools to address the smokefree component of FiS

**Students**

**The key health process and behaviour changes for students and families were:**
- The many small changes in student healthy attitudes and behaviours contributed to a collective picture of positive change
- There was also some evidence that practices at FiS schools were starting to spread to the home environment
- Maintenance of positive attitudes towards, and awareness of, healthy behaviours (Phases 2 and 3 FiS note: these were the two phases where in-depth student information was collected)
- Increases in the consumption of healthy foods such as fruit and vegetables (all groups, with the changes being statistically significant for Phases 2 and 3 FiS)
- Increases in the mean amount of mild to moderate physical activity (Phases 2 and 3 FiS)
- Maintenance over time of sunsmart practices (Phases 2 and 3 FiS)
- A decrease in the number of students who reported they smoked more than one cigarette a week (Phase 2 FiS and comparison)

**The key health process and behaviour changes for students and families that have implications for HPS**
- Students had more positive views about school
- FiS schools offered students more opportunities to take an active role in promoting their school as a “healthy school”
- Data suggest that this “healthy schools” focus helped create a positive climate of “protective factors” that are linked to longer term improvements in both health and education outcomes
- Combined effect of the changes at FiS schools was that students were becoming more like their peers in the higher decile comparison schools

**Main enablers of change in student behaviours at FiS Schools**
- The FiS fruit created a positive climate and contributed to students’ positive attitudes towards healthy eating and school

**Main enablers of change in student behaviours at FiS Schools that have implications for FiS**
- The “healthy schools” focus at FiS schools and the prioritisation of health and well-being
- Use of approaches that enable students to actively promote health (e.g., health teams and PALs)
Partner agencies

In terms of partner agencies working with schools, FiS supported:

- Partner agencies to gain access to, and work with, low-decile schools
- Greater awareness in low-decile schools of the services partner agencies can offer and the types of support they can access to build approaches to health and well-being
- The embedding of health promotion practices within schools

In terms of interagency collaboration, FiS supported:

- Partner agencies to collaborate to better manage their work in schools
- Partner agencies to gain a better understanding of each other’s priorities and ways of working
- Opportunities for joint interagency planning and decision making
- Increased opportunities for professional development for agency staff

Key enablers include:

- Alignment of FiS with the HPS approach
- Opportunities for regional interagency collaboration
- The hands-on and capacity building nature of the ways in which FiSC work
- The current regional leadership structure in which DHBs oversee FiS practice
- The free fruit which catalysed low-decile schools to use the whole school HPS approach and engage in health promotion. The fruit also addresses inequalities by providing increased access to healthy options
- The array of health promotion initiatives currently in the sector which are supporting and enhancing each other

Key disablers include:

- A perceived lack of health and education sector collaboration
- The national leadership structure which did not fully support the on-going development of the FiS initiative and sharing of “ground-up” practice

FiS Summary:

The FiS evaluation identified the elements/critical success factors that improve health promotion as being:

- The use of an integrated approach supported by national, regional and local professional development
- Policy and inter-agency co-ordination and commitment
- Student leadership and empowerment
- Hands-on support of people such as FiSC and agency representatives
- The provision of a package of initiatives that impacted on the school setting, with the fruit being a highly valued component by the school community/students
The **recommendations** point to the omission of a theory for improvement as there was not a clear articulation of how the interventions and processes were going to **improve valued outcomes**\(^\text{108}\). The recommendations of the evaluation were to:

- Review the HPS model to ensure that it provides scope for health promotion work in the classroom and provide additional professional development for classroom teachers that focuses on the use of health promotion processes within the curriculum and how these align with the changes in direction noted in the recent revision of the curriculum
- Review partnership processes to ensure that the balance between regional and national leadership is effective and that there are opportunities for all stakeholders to contribute to the on-going development of FiS
- Include a focus on social and emotional health and well-being within FiS
- Review agency capacity (by agency and region) to ensure schools have access to FiSC and agency partners who work in a hands-on way with schools
- Fund FiS for at least the time frames known to be necessary for sustainability (five to seven years)
- Explore models for continuing some form of free fruit provision

**Review of FiS**

In 2009 the Government undertook a review of all Public Health programmes to assess their efficiency and effectiveness and to ascertain how well they aligned with the Government’s new priorities. This review included the FiS programme.

The original intention of the FiS programme was to run for three years for each phase. It was envisaged that at the end of the three years schools would become self sustaining in fruit supply. Phases one and two ran for over three years and about one-third of the $12 million budget went on maintaining a number of advisors from DHBs to provide advice to schools on how to implement the programme. As a result of the review the MoH ceased the funding of FiS co-ordination and administration. The funding for fruit provision has, however, been continued until June 2011, without the co-ordinators and teacher release.

**Mission-On Education sector led focus on nutrition and physical activity**

On 21 September 2006 Mission-On was launched by the government. This was a broad-based $67 million package of initiatives to give young New Zealanders and their families the tools to improve their nutrition and increase physical activity. Mission-On was led by the Ministry of Education. The programme was developed by the Ministries of Health and Education, Youth Development and Sport & Recreation New Zealand (SPARC). It was aimed at children and young people from birth to 24 years with the primary purpose of preventing obesity by improving nutrition and reversing the declining rates of physical activity in young people. The goal was to produce a new generation of fit and healthy New Zealanders.

The first Mission-On initiative aimed to improve nutrition within the school and early childhood education environments. New guidelines were developed to help schools and early childhood education services provide healthy food options for students, including a food and drink classification system.

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108 Lai, Dr Mei Kuin, 2010 Building Evaluative Capability in Schooling Improvement: Theories for Improvement and Sustainability
School boards were directed to support this through a change in the National Administration Guidelines (NAG 5) by developing policies that promote and achieve healthy nutrition and reduce the consumption of unhealthy food and drink. Teachers received professional development support, and there was a social marketing campaign to back up the changes which included: a toolkit for use by schools and high profile ambassadors promoting the key messages on television, radio and print promotions. HPS facilitators worked alongside school support services and the Heart Foundation to support schools to implement the changes in the NAG utilising the whole school approach.

The **vision** for Mission-On was to produce a new generation of fit and healthy New Zealanders.

The **mission or purpose** was to give young New Zealanders and their families the tools to improve their nutrition and increase physical activity.

The **Values** underpinning the initiative were not articulated.

The **principles of the initiative** were based on the HPS ‘whole school’ approach. However, these principles were not explicitly provided to facilitators or HPS providers.

**The theory for change, intervention or improvement** was that through school policies that promote and achieve healthy nutrition and physical activity, teacher professional development and social marketing young New Zealanders and their families will have the tools to improve their nutrition and increase physical activity.

In terms of **implementing** the programme, this was done through:

- National Administration Guidelines (NAG 5)
- Teacher professional development
- A social marketing campaign

The **valued outcomes** sought as a result were outcome driven and included:

- Young New Zealanders and their families having the tools to improve their nutrition and increase physical activity
- Prevention of obesity by improving nutrition
- Reversing the declining rates of physical activity in young New Zealanders

In terms of **monitoring, reviewing and evaluating** there did not appear to be a framework or process in place to provide on-going evidence and evaluation of progress towards the valued outcomes.

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**NAG 5**

Each Board of Trustees is also required to:

(i) provide a safe physical and emotional environment for students;
(ii) promote healthy food and nutrition for all students;
(iv) comply in full with any legislation currently in force or that may be developed to ensure the safety of students and employees.
**Nutrition Fund**

The Nutrition Fund of $3 million was provided by the Ministry of Health in 2008. The four-year fund for schools and early childhood centre initiatives to encourage healthy eating was part of the Greens' post-election agreement with the government.

Healthy Eating – Healthy Action (HEHA) District Co-ordinators, usually dieticians, were employed to manage the nutrition fund through an external reference group, which had HPS workforce representation. The role of the nutrition fund reference group was to provide guidelines for fund distribution and approve applications for ECE services and schools. Priority was given to low decile schools and clusters.

'Food and Nutrition for Healthy Confident Kids’ guidelines

These guidelines were designed to help early childhood education services, schools, and their communities develop environments that supported healthy eating and developed as part of the HEHA Strategy. These guidelines were produced by the Ministry of Education and were supported by the Ministry of Health’s Food and Beverage Classification System. The information was tailored to suit educational settings which included ECE, primary and secondary schools. They outlined ways of developing policies and procedures about food and beverages provided on site in educational settings and for promoting strong consistent messages about healthy eating. Feedback from the sector indicated that one of the issues with implementation of the guidelines was that they were posted out as a package to schools with no explanation about what they were. As a consequence they were quickly filed onto shelves. It was not until the health promotion workforce, in collaboration with School Support Services, delivered workshops that unpacked the guidelines for those schools who wished to participate that uptake was initiated.

**Healthy Community Schools Initiative (HCS)**

In 2001 the Ministry of Education commenced a pilot programme, the Healthy Community Schools (HCS), based on research conducted by nine Decile 1 multi-cultural secondary schools into how achievement of students could be enhanced. These schools were known as the Achievement in Multi-cultural High Schools (AIMHI) schools. The goal of the HCS was to improve educational outcomes by:

- increasing effective learning time
- reducing barriers to learning
- improving health and social support services with the schools
- gaining greater connectivity and congruency of the school with its community.

The focus of AIMHI schools was to respond to the needs of schools rather than to a government-driven health priority.

Funding was specifically given to the AIMHI schools to support the provision of health and social support services. In 2007 the Ministries of Health and Social Development took over the commitment of funding these services within the AIMHI schools.

In 2008 the Ministry of Health commissioned an evaluation of HCS. In 2009 a report 110 was produced detailing the findings of their evaluation. The primary objective of the evaluation was to ‘inform the

development and implementation of school-based health and social support services in the future.’ The evaluation focused particularly on the school nurse component of HCS to identify:

- how well the initiative is working in improving student access to health and social services
- whether improved educational outcomes have been achieved through the health and welfare needs of students being addressed
- the types of resources required for the future development of school-based student health services

Gains in educational outcomes were measured by:

- increasing effective learning time for students
- reducing health related barriers to learning
- improving health and social support services with the schools
- gaining greater connectivity and congruency of the school with its community

Major findings in the evaluation were:

- The HCS initiative in the AIMHI schools breaks the cycle through providing students with a means to access health and social services. There had been measurable improvements in the immediate health benefits for students and it had opened pathways for students to access services in the wider community. In addition, the initiative allowed major health issues to be addressed e.g. obesity and diabetes, at a time when students were making lifestyle choices.

- Provision of a student health support service in schools significantly improved student access to health and social services. This was evident in the steady improvement of perceptions of the service between 2003-2008.

- Isolating the health service in terms of cause and effect on educational results is difficult. However, the educational results of the students in the AIMHI schools reinforce this research. Compared with their peers in Decile 1 schools:

  - Academic achievement in literacy and numeracy was higher
  - Retention levels were higher
  - Truancy was lower

- Overall Māori and Pasifika students in AIMHI schools tended to perform at higher levels than their peers in other decile 1 schools and in some cases performance levels were higher than the national average.

- From the best practice the research identified requirements for an effective school-based health service.
Victory Primary School and Victory Community Health Centre

In November 2010 the Families Commission published “Paths to Victory: Victory Village (Victory School and Victory Community Health Centre) - A case study.” The research explored the innovative practices and outcomes associated with the convergence of health, education, social and community development goals at Victory Village. This partnership led to the development of a physical ‘community hub’ at the school. The aim of the research was to look at the difference Victory Village is making for families and its community and how it is making that difference.

The history of the Victory Village approach is both a recent history of collective partnership and a longer history of school change and community development.

In the early 2000s Victory School developed its vision and practices in a family-centred direction.

The mission or purpose was to provide a strong learning environment and a school and community that were well connected.

The values were family centred, professional collaboration and integrated services where relationships matter.

The principles of the initiative were based on social capital theory and social intervention. Social intervention provides new solutions to complex and seemingly intractable problems through a network of interdependent relationships at a variety of levels: child, family, community, school, health and social service agencies. An HPS whole school approach was adopted as a means of reflecting on the current culture of the school.

The development principles were:

- organic growth (support that is responsive to families’ changing needs and circumstances)
- reciprocity (as people were helped, so too they became helpers)
- community centeredness (how child, family and community outcomes are interconnected)
- relationships (everyone matters)
- professionalism (collective responsibility for child and family wellbeing, permeable professional boundaries and shared understandings)
- leadership (bold risk taking, creativity and seeing connections between systems, agencies and organisations)

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112 Students’ and their families ability to participate and interact with education is determined by their ability to access what Bourdieu termed social, economic and cultural “capital”. Social capital is defined by Bourdieu as social privilege, which in education takes the form of a good word put in, the right contacts, help with studies, extra tuition, educational experiences like visiting art galleries or libraries, information on the education system, family’s level of education, language use and job outlets/aspirations (Eggleston,J. (1974) Contemporary Research in the Sociology of Education London Methuen:32-43).
The theory for change, intervention or improvement was based on social capital theory which suggests that that “there is a major opportunity to improve educational outcomes through interventions that work at different levels of an interdependent child, family and community social system, because relationships matter.” This is achieved by “social intervention” in Victory Village which seeks to change the underlying system within which the problems operate, rather than improving things within an existing order. This requires new products, services, relationships and models of practice, underpinned by different thinking about human and organisational capacities.

The case study method did not allow a causal link to be drawn between Victory Village activities and outcomes but interview participants strongly asserted the positive correlation. The outcomes reported were:

- improvement in student participation, wellbeing and achievement
- significant improvement in student attendance as well as literacy and numeracy achievement.
- better access of families to services and enhanced health and well being.
- improved confidence of families in engagement with the school and their children’s learning.
- stronger connections between families
- an energised and engaged community
- school has better links to parents and other professionals
- school has developed an infrastructure that matches their commitment to family centred practice.
- other providers have more effective access to clients and are providing a better quality service due to the collaborative and holistic approach.

Relevant learning from HCS and Victory Village for HPS

The elements that are relevant for consideration in HPS provision in New Zealand low decile Māori and Pasifikā and vulnerable communities are that an effective strategy needs:

- the school community to look inward at their own culture and practices first and reflect on how they might be contributing to the patterns and outcomes
- a whole school approach and support
- relationships between adults and students that are based on trust
- student input into the initiative
- a committed partnership that bridges health, education and social services to ensure that the appropriate resources and support are delivered in a timely and responsive manner through a network of collaborative interdependence
- practitioners who have the capacity and capability to fulfil the role of bridging social capital at all levels of the organisation
- investments in time and professional development resources for all participants
- seek out what families and communities want from themselves, the school and others
- explore the capacity of the community to undertake positive social change. Think about how existing successes can be built upon and discover the connectors.
practitioners who embrace opportunities to actively promote and support the health of young people, as opposed to taking passive ‘band aid” approach.

- a supportive infra-structure both within the school and externally from the provision of workforce, governing body to professional development and collegial support.

- promotion of school based health and social services where possible.

- be open and responsive to feedback, unexpected results and opportunities from these changes.

**Allen and Clarke Review of HPS 2007**

In recognition that the HPS community needed direction and vision, the Ministry of Health commissioned Allen and Clarke\(^{114}\) to produce a report on the development of recommended approaches to drafting a National HPS Action Plan. The report focused on the development of a national HPS framework through an intersectoral approach in collaboration with the health sector and other stakeholders including education. The following key issues were identified in the report:

- The need for a shared vision for HPS in New Zealand.
- National leadership for HPS, within and between agencies
- Promoting a clear understanding of what HPS is, and is not, at all levels of agencies and groups involved with or working alongside HPS
- Establishment of consistent service delivery and planning
- Clarification of roles and responsibilities within the HPS framework
- The need to develop and maintain a strong workforce
- Accountability, monitoring and evaluation

The report proposed a process to address the key issues while working to ensure that valuable current HPS processes are maintained and further developed. However, the evaluators also acknowledged that this process will be challenging as it will “require confronting entrenched ideas and practices that have not previously been questioned while at the same time preserving the “valuable work” that has been undertaken around HPS. The report advised that the starting point for this process is the development of a shared vision for HPS and meaningful commitment to that vision.

**The Māori Component**

The Phoenix Research 1999 evaluation of Health Promoting Schools pilot in the northern region, *Stakeholders Perceptions of the Māori Component of Health Promoting Schools*, identified that HPS facilitators wanted and needed the support of a Māori colleague. The report noted that there was an “urgent need” for a “Kaiwhakahaere - a person who would organise and manage those Māori dimensions that co-ordinators needed assistance with.”\(^{115}\) The report noted that the Ottawa Charter Guidelines was evident everywhere, but that implementation of the Treaty of Waitangi was minimal. One of the HPS facilitators commented on this irony;”


\(^{115}\) Jenkins, K (1999). *Stakeholder Perceptions of the Māori Component of Health Promoting Schools*. Evaluation of Health Promoting schools Pilot in Northern Region, Phoenix research
"The attention to the Ottawa Charter signalled an adoption of an international model with no understanding/recognition of where they live, or the reality of this country... the Treaty of Waitangi was relegated as a secondary consideration to the Ottawa Charter within the HPS pilot."

The report made a number of recommendations which have been summarised below:

- Professional development for all HPS project managers and facilitators on the Treaty of Waitangi and what this means in terms of service delivery
- Prioritisation of Māori facilitators, Māori providers and Pasifikā providers
- Increase in the number of Māori staff in HPS and schools to assist in meeting the needs of Māori students
- Collating a Māori directorate for communities so that they can access support from a Kaiwhakahaere

**2008 Review of the role of the Māori Strategic Co-ordinator in HPS**

In 2008 Hāpai te Hauora Tāpui, the contract holder for the role of HPS Māori Strategic Co-ordinator (MSC) with the Ministry of Health, commissioned a review of:

- The current function and role of the MSC
- The current working relationships and linkages between MSC, HPS regional co-ordinators and practitioners (Auckland)
- An analysis of research regarding the implementation of HPS in indigenous settings
- An analysis of HPS resources developed for indigenous settings

On the basis of findings in a literature review and interviews conducted with HPS personnel, a proposed strategy and recommendations were made.

In relation to the role of the MSC, the proposed strategy and recommendations focused on ways to:

- Improve delivery of HPS in ‘mainstream’ settings
- Improve delivery of HPS in Māori settings
- Improve working relationships with regional co-ordinators and practitioners

**Table 2:** Bol, J and Lee, J (2008) Proposed Strategy for Māori Strategic Co-ordinator in HPS

<table>
<thead>
<tr>
<th>Proposed Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1</strong></td>
</tr>
<tr>
<td>Establish regional and national MSC positions</td>
</tr>
<tr>
<td>- There are two parts to this initial phase: to consolidate the MSC regional position in Auckland and appoint MSC in other regions, and appoint a National Māori Strategic Co-ordinator.</td>
</tr>
<tr>
<td><strong>Phase 2</strong></td>
</tr>
<tr>
<td>Develop a kaupapa Māori framework for HPS</td>
</tr>
<tr>
<td>- The development of Kaupapa Māori approaches for HPS will clarify the links between theory and practice and support planning, delivery and evaluation of HPS for Māori.</td>
</tr>
<tr>
<td><strong>Phase 3</strong></td>
</tr>
<tr>
<td>Develop Māori focus HPS resources</td>
</tr>
</tbody>
</table>

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• There are two main types of HPS Māori focus resources required: Māori language resources for use in KKM and other Māori language settings, and Māori focus resources to improve the delivery of HPS to Māori in the mainstream.

The **Recommendations** made were:

1. That the Treaty of Waitangi and the bicultural intent of the programme be embedded in the policies and practices of HPS
2. That the in-service training be provided to all HPS personnel about the implications of the Treaty of Waitangi, biculturalism and the Māori focus of HPS
3. That Māori in HPS be brought together to discuss a kaupapa Māori approach to HPS in order to develop a conceptual model of the Māori focus for HPS
4. That the MSC play a key part in the development and implementation of the Māori focus model in HPS
5. That the MSC national position be established to operate at a strategic level within the HPS network
6. That MSC regional positions be established to operate at an operational level within HPS in their regions
7. That the MSC national and regional roles be accompanied by adequate budgets.
8. National and regional roles be accompanied by adequate budgets and that MSC positions be clearly defined and communicated to the HPS network
9. That further evaluation be undertaken and a research literature developed around theory and practice of the Māori focus in HPS in New Zealand
10. That Māori focus resources, especially Māori language resources for Māori language settings, be urgently developed to support the work of generic Māori-specific practitioners.
SYNTHESIS OF NATIONAL AND INTERNATIONAL RESEARCH

Framework

Taking into account both the national and international research, an HPS framework in the New Zealand context will need to provide:

1. A clear HPS vision and purpose/mission that is shared at government, ministerial, regional and local levels and reflects New Zealand’s unique context.

2. Intersectoral agreements and policies that promote partnership and joint planning and that support the implementation of the HPS framework.

3. A values-driven, outcomes-focused framework that is based on the principles of Te Tiriti o Waitangi.

4. HPS policies and practices that reflect Te Tiriti o Waitangi and a bicultural partnership.

5. An HPS theory for change, intervention and improvement that is based on the international HPS best practice, current New Zealand educational context, Best Evidence Synthesis practice research, Healthy Community Schools, Fruit in Schools and Victory Village findings and school improvement evidence.

Implementation

An implementation plan will need to take into account the elements/critical success factors that improve health in New Zealand school communities. These factors relate to both the school and health contexts:

1. School setting
   - transformational learning
   - an inquiry based approach
   - student voice, leadership and empowerment
   - valuing student and community knowledge and capacity
   - participant ownership
   - effective and consistent school leadership and supportive infrastructure
   - strong leadership and trust-based interdependent partnerships between the child, school, whānau, community, health and social services.
   - sharing of effective practice within and between communities
   - on-going learning and professional development in action research
   - the use of an integrated approach supported by national, regional and local professional development
   - hands-on support of people involved in HPS
   - providing needs assessment tools so that the most appropriate and initiatives can be identified
   - ensuring that the balance between regional and national leadership is effective and that there are opportunities for all stakeholders to contribute to the ongoing development of the HPS framework
   - an evaluation framework that includes:
     - triangulation of data/evidence
2. Health Sector

- On-going resources and funding to support the development of the national framework within the time frames known to be necessary for sustainability (five to seven years)
- Practitioners who have the capacity, capability and support to fulfil the partnership role
- National Māori and non-Māori co-ordination of HPS services
- Nationally consistent professional development which includes an intensive workforce development period to introduce the new framework
- National/regional hui for workforce development, sharing learnings/better practice and professional development on kaupapa Māori approaches
- Development of national indicators/measures to assess impacts/outcomes across regions, localities and schools
- Annual professional development for HPS Managers including strategic input from managers into the development of HPS
- Regional and local hui for HPS practitioners
- One on one support and mentoring for HPS facilitators
Appendix 1: Definitions and Acronyms

Strategic Framework Vocabulary
For the purposes of this literature review the following definitions will be used:

<table>
<thead>
<tr>
<th>Word/s</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>The vision paints a word picture of the desired future and sets the direction for the strategic framework.</td>
</tr>
<tr>
<td>Mission</td>
<td>This identifies the purpose of HPS and should describe exactly what HPS does and why it exists.</td>
</tr>
<tr>
<td>Values</td>
<td>These are “the ideals that give significance to our lives, that are reflected through the priorities we choose, and that we act on consistently and repeatedly” (Hall, 1994).</td>
</tr>
<tr>
<td>Principles</td>
<td>They are the beliefs and philosophies that guide all HPS practices and actions. The principles relate to how HPS is implemented in a school.</td>
</tr>
<tr>
<td>Valued outcomes</td>
<td>The values and beliefs of a school community are reflected in their practices and the kinds of outcomes that are valued. Outcomes are valued because of their capacity to meet students'/communities’ learning, development and wellbeing needs: and/or other associated needs as defined by the community.</td>
</tr>
<tr>
<td>A theory for change, intervention and improvement</td>
<td>Any planned intervention for change around a common purpose must include a theory for change, intervention and improvement that explains how change will be achieved. Such theories describe a set of linked ideas about how a process will achieve valued outcomes.</td>
</tr>
<tr>
<td>Implementation</td>
<td>Implementation is the action of putting HPS into practice in school communities.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>As defined by the American Evaluation Association, evaluation involves assessing the strengths and weaknesses of programmes, policies, personnel, and organizations to improve their effectiveness. In terms of HPS in New Zealand, evaluation needs to take place at all levels, including Ministry of Health and Ministry and Education, DHBs, HPS facilitators and school community levels.</td>
</tr>
</tbody>
</table>

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120 Lai, Dr Mei Kuin, 2010 Building Evaluative Capability in Schooling Improvement: Theories for Improvement and Sustainability
121 [http://www.evaluationwiki.org/index.php/American_Evaluation_Association](http://www.evaluationwiki.org/index.php/American_Evaluation_Association) %28AEA%29
122 HPS facilitators are also termed HPS co-ordinators in some of the literature in New Zealand
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>BES</td>
<td>Iterative Best Evidence Synthesis research programme</td>
</tr>
<tr>
<td>CE</td>
<td>Council of Europe</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Boards</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>ENHPS</td>
<td>European Network of Health Promotion Schools</td>
</tr>
<tr>
<td>FiS</td>
<td>Fruit in Schools</td>
</tr>
<tr>
<td>FiSC</td>
<td>Fruit in Schools Co-ordinator</td>
</tr>
<tr>
<td>HEHA</td>
<td>Health Eating-Healthy Action</td>
</tr>
<tr>
<td>HPS</td>
<td>Health Promoting Schools</td>
</tr>
<tr>
<td>IUHPE</td>
<td>International Union for Health Promotion and Education</td>
</tr>
<tr>
<td>MSC</td>
<td>Māori Strategic Co-ordinator</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisations</td>
</tr>
<tr>
<td>NZ STA</td>
<td>New Zealand School Trustees Association</td>
</tr>
<tr>
<td>NZCER</td>
<td>New Zealand Council for Education Research</td>
</tr>
<tr>
<td>SMART tools</td>
<td>Tools which support thinking and transfer of knowledge. Some will already be in use, others may require modifications or design of a new tool.</td>
</tr>
<tr>
<td>SPARC</td>
<td>Ministry of Health, Sport and Recreation New Zealand</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Education Scientific and Cultural Organisation</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>WFD</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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</tbody>
</table>
## Appendix 2: HPS National Strategic Framework Backwards Mapping Chart

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</tr>
</thead>
<tbody>
<tr>
<td>HP Definition</td>
<td>HPS Definition</td>
<td>HPS Definition</td>
<td>Māori family health definition</td>
<td>Māori Health definition</td>
<td>HP definition</td>
<td>HPS Definition</td>
<td>Whanau Ora Definition</td>
<td>HPS Definition</td>
<td></td>
</tr>
</tbody>
</table>
| Health promotion is the process of enabling people to increase control over, and to improve, their health... [http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf](http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf) | Nil | HPS is a whole school approach to enhancing both the health and educational outcomes of children and adolescents through learning and teaching experiences initiated in the school. (IUHPE 2009)

The concept of Te Whake, the octopus defines family health. The head of the octopus represents the whānau, the eyes of the octopus as waiora (total wellbeing for the individual and family) and each of the eight tentacles representing a specific dimension of health. The dimensions are interwoven and this represents the close relationship of the tentacles. |

Conceptualises health as the four walls of a whare: Taha wairua, taha tinana, taha hinengaro and taha Whanau

Describes four supports as the foundation for social policies and well-being: Family; cultural heritage; physical environment; and turangawaewae (Royal Commission on Social Policy, 1989, cited in Durie, 1994).

The four central stars represent goals for a Māori HP model: Mauriora, access to te ao Māori; Waiora, environmental protection; Toiora, healthy lifestyles; Te Oranga, participation in society. The two pointers needed to undertake the tasks are Nga Manukura, leadership and; Te Mana Whakahaere, autonomy. |

TUHA-NZ is a framework for Treaty-based health promotion practice. The framework outlines a process to assist health promoters in their efforts towards Treaty-based health promotion practice. The framework provides a new way to consider health promotion practice rather than a new way to look at te Tiriti21. |

Whānau Ora is about whānau taking responsibility for whānau. It places whānau at the centre and empowers them to lead the development of solutions for their own transformation. |

HPS enhances students’ health and educational outcomes, through an evidence based model with a focus on reducing inequalities. |

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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Vision</td>
<td>HPS Vision</td>
<td>HPS Vision</td>
<td>Vision</td>
<td>HPS Vision</td>
</tr>
<tr>
<td>Where every individual/group has reached a state of complete physical, mental and social well-being.</td>
<td>“making schools a better place for learning, health and living.”[124]</td>
<td>The heart of Whānau Ora lies in building on whānau strengths and capability, growing whānau connections, supporting the development of whānau leadership and enhancing best outcomes for whānau.</td>
<td>A healthy, educated fair society where… Everybody matters: Our tamariki, mokopuna, whānau, hapū, iwi, hapori are informed, are connected, are confident and are contributing O tatou tamariki, mokopuna, whānau, hapu, iwi hapori e matatau ana, e hono ana, e maia ana, e whakaataa ana.</td>
<td></td>
</tr>
</tbody>
</table>

### Ottawa Charter 1986 and NZ Health Promotion Frameworks

<table>
<thead>
<tr>
<th>Mission/Purpose</th>
<th>Previous HPS in NZ</th>
<th>2009-2010 International HPS Framework/Guidelines</th>
<th>Whanau Ora Framework</th>
<th>Current HPS Draft</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promotion focuses on <strong>achieving equity</strong> in health. Health promotion action aims at <strong>reducing differences</strong> in current health status and <strong>ensuring equal opportunities and resources</strong> to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Foster the <strong>healthy development</strong> of young people so that they can <strong>learn, grow and contribute</strong> now and in the future</td>
<td>To enhance educational outcomes Healthy students learn better. The core business of a school is maximising learning outcomes. Effective Health Promoting Schools (HPS) make a major contribution to schools achieving their educational and social goals.</td>
<td>The heart of Whānau Ora lies in building on whānau strengths and capability, growing whānau connections, supporting the development of whānau leadership and enhancing best outcomes for whānau</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Offer schools a framework for development of health promotion initiatives in a way that supports and enhances their existing structures, programmes and practices.</td>
<td>• <strong>Foster the healthy development</strong> of young people so that they can <strong>learn, grow and contribute</strong> now and in the future</td>
<td>To create opportunities to <strong>accelerate health and education outcomes and reduce inequalities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Help schools to evaluate the range of health related activities they are currently involved in, identifying areas of need and setting goals for future action.</td>
<td>• <strong>Enhancing the links</strong> between schools and their communities in promoting positive health and learning outcomes for young people</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Enhancing the links between schools and their communities in promoting positive health and learning outcomes for young people</td>
<td>• <strong>Raise awareness</strong> of the importance of promoting health for all.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Values</td>
<td>HPS Values</td>
<td>HPS Values</td>
<td>Whanau Ora Values</td>
<td>HPS Values</td>
</tr>
<tr>
<td>Caring, holism and ecology</td>
<td>Nil</td>
<td>Nil</td>
<td>kōtahitanga, manaakitanga and rangatiratanga</td>
<td>kōtahitanga; manaakitanga; rangatiratanga</td>
</tr>
</tbody>
</table>

Values driven practice

Relationship between core values and beliefs and practices

- Core values and beliefs captured in policy
- Core values and beliefs evident in practice
- Dynamic
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td><strong>Advocate</strong></td>
<td></td>
<td>Principle: Active commitment to the Treaty of Waitangi</td>
<td>Principle: Ngā Kaupapa Tuku Iho: the ways in which Māori values, beliefs, obligations and responsibilities are available to guide whānau in their day-to-day lives.</td>
<td>Principle: Te Tiriti o Waitangi principle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Principle: Enhances the learning outcomes of students</td>
<td>Principle: Best Whānau Outcomes: the success of Whānau Ora interventions is measured by increases in whānau capacities to undertake those functions that are necessary for healthy living, and share contributions to the wellbeing of the whānau as a whole, as well as the wellbeing of whānau members</td>
<td>Principle: He Mana Tō Te Tamaiti</td>
</tr>
<tr>
<td><strong>Enable</strong></td>
<td></td>
<td>Principle: Upholds social justice and equity concepts</td>
<td>Principle: Whānau opportunity: all whānau have chances in life that enable them to reach new heights, do the best for their people, engage with their communities and foster a strong sense of whānaungatanga-connectedness.</td>
<td>Principle: Tika, He Mana Tō Te Tamaiti, Whānaungatanga and Manaakitanga principles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Principle: Involves student participation and empowerment</td>
<td>Principle: Coherent Service Delivery: recognises a unified type of intervention so that distinctions between services provided by health, welfare, education and housing, for example, are not allowed to overshadow wider whānau needs.</td>
<td>Principle: Whānaungatanga and Mana principles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Principle: Addresses the health and wellbeing issues of all school staff</td>
<td>Principle: Kaitiakitanga and Kotahitanga principles</td>
<td>Principle: Kaitiakitanga principle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Principle: Collaborates with parents and the local community</td>
<td>Principle: Rangatiratanga, Kotahitanga, Mohiotanga Whānaungatanga, Tika and Whakawhitihiti Kōrero principles</td>
<td>Principle: Rangatiratanga, Kotahitanga, Mohiotanga Whānaungatanga, Tika and Whakawhitihiti Kōrero principles</td>
</tr>
<tr>
<td><strong>Mediate</strong></td>
<td></td>
<td>Principle: Integrates health into the school’s ongoing activities, curriculum and assessment standards</td>
<td>Principle: Connects, coordinates and integrates the whole school community to enhance the environment</td>
<td>Principle: Kaitiakitanga and Wairuatanga principles</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>Act responsibly and with integrity</td>
<td>Provides a safe and supportive environment</td>
<td>Developing safe and supportive infrastructure.</td>
<td>Whānau Integrity: acknowledges whānau accountability, innovation and dignity. This principle assumes that a code of responsibility is present in all whānau, though it may sometimes be masked by events or circumstances that propel whānau into survival mode or trigger a defensive reaction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sets realistic goals built on accurate data and sound scientific evidence</td>
<td>Set realistic measurable goals, based on accurate robust evidence.</td>
<td>Effective Resourcing: underlines two important aspects of services to whānau. First, the level of resourcing should match the size of the task – whānau-centred approaches may initially be time intensive. Second resourcing should be tied to results. Effective resourcing means allocating resources in order to attain the best results and an intervention plan should include a set of indicators that can measure successful outcomes. Involves “action research inquiry”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seeks continuous improvement through ongoing monitoring and evaluation</td>
<td>Continual improvement through sound monitoring, evaluation and reflection processes.</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>---------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Theory for change, intervention and improvement</td>
<td>Theory for change, intervention and improvement</td>
<td>Theory for change, intervention and improvement</td>
<td>Theory for change, intervention and improvement</td>
<td>Theory for change, intervention and improvement</td>
</tr>
<tr>
<td>Pre-requisites:</td>
<td>Pre-requisites:</td>
<td>Pre-requisites:</td>
<td>Pre-requisites</td>
<td>Pre-requisites</td>
</tr>
<tr>
<td>peace, _ shelter, _ education, _ food, _ income, _ a stable eco-system, _ sustainable resources, _ social justice, and equity.</td>
<td>Nil</td>
<td>See for South HPS Australia’s advice on <a href="http://www.healthpromotion.cywhs.sa.gov.au/Content.aspx?p=155">pre-requisites</a> re: working with educators126</td>
<td>The focus on outcomes is one of the most challenging aspects of Whānau Ora. The emphasis is on results that whānau set for themselves. Progress towards these outcomes will impact positively on other whānau and communities as a whole. Establishing <a href="http://www.iuhpe.org/uploaded/Publications/Books__Reports/HPS_GuidelinesII_2009_English.pdf">trust and rapport</a> with whānau and increasing whānau confidence to access a range of social supports can provide a base for whānau willingness to engage in planning.</td>
<td>The necessity to provide the education sector with evidence about the advantages a health promoting strategy can offer schools in improving educational outcomes127</td>
</tr>
</tbody>
</table>

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## Ottawa Charter 1986 and NZ Health Promotion Frameworks

<table>
<thead>
<tr>
<th>Previous HPS in NZ</th>
<th>2009-2010 International HPS Framework/Guidelines</th>
<th>Whanau Ora Framework</th>
<th>Current HPS Draft</th>
</tr>
</thead>
</table>

### Theory for Change /Intervention/Improvement

**Health Promotion Action**

1. **Build Healthy Public Policy**
2. **Create Supportive Environments**
3. **Strengthen Community Actions**
4. **Develop Personal Skills**
5. **Reorient Health Services**
6. **Moving into the Future**

### Theory for Change /Intervention/Improvement

- **Theory for Change /Intervention/Improvement**
  - “The health sector have largely ignored the vast literature on school organisation and improvement, teaching and learning practices, professional development, and innovation and dissemination......Schools are complex places and the way forward in school health requires more sophisticated theoretical models which are based on both health and educational frameworks.”

- **Findings indicate health gains for primary school students are difficult to assess, and will most likely occur if a well-designed program is implemented which links the curriculum with other health promoting school actions, contains substantial professional development for teachers and is underpinned by a theoretical model.**

- **Six Essential Elements of HPS**

### Theory for Change /Intervention/Improvement

- **Theory for Change /Intervention/Improvement**
  - The development of plans which progress whānau to high level outcomes such as self management should be accompanied by identification of indicators that will track towards these goals and meaningful measures of success.

  Action research is part of a wider work stream focused on measuring the success of Whānau Ora. To help guide the action research inquiry, a Whānau Ora Outcomes Framework is being developed in line with the outcomes identified in the Whānau Ora: Report of the Taskforce on Pre-requisites to engagement:

1. TFI, relationships,
2. Understand school context (valued outcomes),
3. NZ up to date evidence of how educational goals have been achieved through addressing health issues within an educational framework

### Theory of sustainability:

- Process of organisational learning to improve outcomes already achieved

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128 St Leger, L.H 1999 Health Education Research Theory and Practice *The opportunities and effectiveness of the health promoting primary school in improving child health-a review of the claims and evidence*, Vol 1

129 L. H. St Leger (2007) *The opportunities and effectiveness of the health promoting primary school in improving child health— a review of the claims and evidence* http://her.oxfordjournals.org/content/14/1/51.abstract

Ottawa Charter 1986 and NZ Health Promotion Frameworks

<table>
<thead>
<tr>
<th>Implementation</th>
<th>Implementation</th>
<th>Implementation</th>
<th>Implementation</th>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commitment to Health Promotion</td>
<td>Commitment to Health Promotion</td>
<td>Commitment to Health Promotion</td>
<td>Commitment to Health Promotion</td>
<td>Commitment to Health Promotion</td>
</tr>
<tr>
<td>The participants in this Conference pledge:</td>
<td>The participants in this Conference pledge:</td>
<td>The participants in this Conference pledge:</td>
<td>The participants in this Conference pledge:</td>
<td>The participants in this Conference pledge:</td>
</tr>
<tr>
<td>_ to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;_</td>
<td>_ to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;_</td>
<td>_ to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;_</td>
<td>_ to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;_</td>
<td>_ to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;_</td>
</tr>
<tr>
<td>_ to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living_</td>
<td>_ to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living_</td>
<td>_ The following elements have been shown to be necessary in starting a Health Promoting School (HPS):_</td>
<td>_ These factors have been demonstrated to be necessary for sustaining the efforts and achievements of the first few years over the following 5-7 years:_</td>
<td></td>
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The following elements have been shown to be necessary in starting a Health Promoting School (HPS):

These factors have been demonstrated to be necessary for sustaining the efforts and achievements of the first few years over the following 5-7 years:

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<td>Outcomes</td>
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<td>• To develop a new understanding about public health and articulate this movement in public health focus around the world</td>
<td>• To enhance educational outcomes</td>
<td>• whānau self management;</td>
<td>• Improved health outcomes</td>
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<td>• Build on the progress that had already been made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization’s Targets for Health for All document, and the debate at the World Health Assembly on intersectoral action for health.</td>
<td>• To facilitate action for health by building health knowledge and skills in the cognitive, social and behavioural domains</td>
<td>healthy whānau lifestyles;</td>
<td>Improved educational achievement (presence, participation and achievement through quality relationships)</td>
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<td>• Health to be viewed as a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.</td>
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<td>full whānau participation in society;</td>
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<td>economic security and successful involvement in wealth creation; and</td>
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OTTAWA CHARTER

Ottawa Charter for Health Promotion
First International Conference on Health Promotion
Ottawa, 21 November 1986 - WHO/HPR/HEP/95.1

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization’s Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

Health Promotion
Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for Health
The fundamental conditions and resources for health are:

- peace,
- shelter,
- education,
- food,
- income,
- a stable eco-system,
- sustainable resources,
- social justice, and equity.

Improvement in health requires a secure foundation in these basic prerequisites.

Advocate
Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable
Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve
their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate
The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health. Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health Promotion Action Means:
Build Healthy Public Policy
Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health. Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create Supportive Environments
Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.
**Strengthen Community Actions**
Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

**Develop Personal Skills**
Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

**Reorient Health Services**
The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

**Moving into the Future**
Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members. Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.
Commitment to Health Promotion
The participants in this Conference pledge

• to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
• to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
• to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
• to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
• to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
• to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

•

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for International Action
The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

CHARTER ADOPTED AT AN INTERNATIONAL CONFERENCE ON HEALTH PROMOTION*
The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada
* Co-sponsored by the Canadian Public Health Association, Health and Welfare Canada, and the World Health Organization
ACHIEVING HEALTH PROMOTING SCHOOLS:
GUIDELINES FOR PROMOTING HEALTH IN SCHOOLS

Schools can make substantial contributions to a student's health and well-being. This has been increasingly recognized by many international initiatives, including those from the World Health Organization (WHO), UNESCO, UNESCO, the U.S. Centers for Disease Control and Prevention (CDC), the International Union for Health Promotion and Education (IUSP), and others. A range of strategies and programmes have evolved in the last twenty years with diverse names such as Health Promoting Schools, Comprehensively School Health, Child Friendly Schools and the FRESH Initiative. However, these strategies share the connecting thread of whole school approach and recognition that all aspects of the life of the school community are potentially important in the promotion of health. It has become clear that these approaches that it is necessary to do more than just offer health education classes in the curriculum if we wish schools to build their potential in promoting the health of all our young people.

The timing is right for a re-appraisal of the health promotion agenda in schools. There is an epidemiological understanding of the interlinked relationships between school education and health and this is reflected by the prominence given to health education in the United Nations Millennium Development Goals. Much attention is currently being focused on the health of young people, particularly in low-income countries. The Bangkok Charter recognized that health should be a core responsibility of all governments and that their success or failure is reflected in the health of its citizens. Inadequate education, in which young people feel connected, can impact on health and quality of life.

PURPOSES OF HEALTH PROMOTING SCHOOLS
• To enhance educational outcomes
  Healthy students learn better. The core business of a school is producing learning outcomes. Effective Health Promoting Schools (HPS) make a major contribution to schools achieving their educational and social goals.
• To facilitate access for health by building health knowledge and skills in the cognitive, social and behavioural domains
  The school is a setting where health issues and perspectives are used to complement and enrich education priorities, e.g., in literacy and numeracy. Health actions are not only a specific and generic competencies in knowledge and understanding, analysing and synthesising information, but also in creating solutions for local and global issues. Students can learn and practice personal and social skills and health promoting behaviours, which can enhance their learning.

PRINCIPLES OF HEALTH PROMOTING SCHOOLS

A HEALTH PROMOTING SCHOOL:
• Promotes the health and well-being of students.
• Enhances the learning outcomes of students.
• Supports social justice and equality concepts.
• Provides a safe and supportive environment.
• Involves student participation and empowerment.
• Involves health and education leadership.
• Adresses the health and well-being issues of all school staff.
• Collaborates with parents and the local community.
• Integrates health into the school curriculum and values, curricula and attainment standards.
• Sets realistic goals built on accurate data and sound scientific evidence.
• Seeks continuous improvement through ongoing monitoring and evaluation.

A considerable body of evidence has emerged in the last twenty years to inform governments, schools, non-government organizations (NGO), teachers, parents and students about effective school health programmes. School programmes that are integrated, holistic and strategic are more likely to produce better health and educational outcomes than those which are mainly information-based and implemented only in the classroom. These guidelines on Health Promotion in Schools identify the basic principles and components of this approach.

The Guidelines have been produced through a process of discussion and consultation with health and educational professionals around the world. They draw on the best available research, evidence and good practice. They are presented in a summary format to assist government education and health ministries, schools, NGOs, and other interested groups and individuals to be more effective and strategic in their efforts to promote health in schools. This second version of the guidelines also incorporates revisions suggested by personnel engaged in school health policy and practice, who were present at various global conferences where the document was presented since the first version was released in 2009, to ensure that these guidelines offer concise assistance to busy policy makers. It was decided not to provide a comprehensive list of scientific references, however, a selection of key documents and papers are referenced at the end and additional school health-related links and more detailed bibliographies are available at the International School Health Network (http://www.internationalschoolhealth.org) and the IUHPE www.iuhpe.org/websites.
Developing a Health Promoting School Charter

This document symbolises the commitment of the school and embeds the locally developed principles into the school's policies. A Charter is helpful in setting out principles and targets, and enables the school community to celebrate their achievements in health promotion. Many schools display their Charter in a prominent place to reinforce all of these features.

Essential elements of promoting health in schools

A Health Promoting School (HPS) is based on the World Health Organization's Ottawa Charter for Health Promotion. It has six essential components, viz:

- Healthy School policies
  These are clearly defined in documents or in accepted practices that promote health and well-being. Many policies promote health and well-being, e.g., policies that enable healthy food practices to occur at school, policies which discourage bullying.

- The school's physical environment
  The physical environment refers to the buildings, grounds, and equipment used and surrounding the school, such as the building design and location, the provision of natural light and adequate shade, the creation of space for physical activity and facilities for learning and healthy eating.

- The school’s social environment
  The social environment of the school is a combination of the quality of the relationships among and between staff and students. It is influenced by the relationships with parents and the wider community.

- Individual health skills and action competencies
  This refers to the formal and informal curriculum and associated activities, where students gain age-related knowledge, understandings, skills, and experiences, which enable them to build competencies in taking action to improve the health and well-being of themselves and others in their community, and which enhances their learning outcomes.

- Community links
  Community links are the connections between the school and the students’ families plus the connection between the school and key local groups and individuals. Appropriate consultation and participation with these stakeholders enhances the HPS and provides students and staff with a context and support for their actions.

- Health Services
  These are the local and regional school-based or school-linked services, which have a responsibility for child and adolescent health care and promotion, through the provision of direct services to students (including those with special needs). They include:
  - screening and assessment by licensed and qualified practitioners;
  - mental health services (including counselling) to promote students’ social and emotional development; to prevent or reduce barriers to intellectual development and learning; to reduce or prevent mental, emotional, and psychological stress and disturbances, and to improve social interactions for all students.

Sustaining health promotion in schools

These factors have been demonstrated to be necessary for sustaining the efforts and achievements of the first few years over the following 5-7 years:

- Ensure there is continuous active commitment and demonstrable support by governments and relevant jurisdictions to the ongoing implementation, renewal, monitoring and evaluation of the health promoting strategy (a signed partnership between health and education ministers of a national government has been an effective way of formalising this commitment).
- Establish and integrate all the elements and actions of the health promoting strategy as core components to the working of the school.
- Seek and maintain recognition for health promotion actions both within and outside the school.
- Ensure there is time and resources for appropriate capacity building of staff and key partners.
- Provide opportunities to promote staff health and well-being.
- Review and refresh after each 3-4 years.
- Continue to ensure adequate resources.
- Maintain a coordinating group with a designated leader to oversee and drive the strategy with continuity of some personnel and the addition of new personnel.
- Ensure that most of the new and ongoing initiatives involve most of the staff and students in consultation and implementation.
- Ensure monitoring services in the education sector view health promotion as an integral part of the life of the school and it is reflected in the monitoring indicators.
- Ensure monitoring services in the health sector view student learning and success as an integral part of health promotion and it is reflected in the monitoring indicators.
- Enable the integration of the health promotion in schools strategy with other relevant strategies relating to the health, welfare and education of young people.
ISSUES WHICH HAVE THE POTENTIAL TO HINDER HEALTH PROMOTION DEVELOPMENT AND SUSTAINABILITY IN SCHOOLS IF NOT ADDRESSED SYSTEMATICALLY

- Some school health initiatives in the past have been funded over a short project base, contain unrealistic expectations and/or do not take a whole school approach.

- Health promotion outcomes occur in the medium to long-term.

- Evaluation is difficult and complex.

- Health sector funding often distorts a health promotion approach to a traditional public health agenda of morbidity and mortality.

- The education sector has certain language and concepts, which have different meanings to those in the health and other sectors, and vice versa. Time, partnerships and mutual respect are needed to build a shared understanding.

- The necessity to link the education sector with evidence about the advantages a health promoting strategy can offer schools in improving educational outcomes.

WHAT WORKS

- Developing and maintaining a democratic and participatory school community

- Developing partnerships between education and health sector policy makers.

- Ensuring students and parents feel they have some sense of ownership in the life of the school.

- Implementing a diversity of learning and teaching strategies.

- Providing adequate time for class-based activities, organisation and coordination, and out of class activities.

- Exploring health issues within the context of the students' lives and community.

- Utilising strategies that adopt a whole school approach rather than primarily a classroom learning approach.

- Providing ongoing capacity building opportunities for teachers and associated staff.

- Creating an excellent social environment which fosters open and honest relationships within the school community.

- Ensuring a consistent approach across the school and between the school, home and wider community.

- Developing both a sense of direction in the goals of the school and clear and unambiguous leadership and administrative support.

- Providing resources that complement the fundamental role of the teacher and which are of a sound theoretical and accurate factual base.

- Creating a climate where there are high expectations of students in their social interactions and educational attainments.

KEY REFERENCES ON PROMOTING HEALTH IN SCHOOLS


The production of this document has received financial support from the United States Centers for Disease Control and Prevention (CDC), an Agency of the Department of Health and Human Services, under Cooperative Agreement Number CDC R44 DP000769 on Building Capacity of Developing Countries to Prevent Non-Communicable Diseases. The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of CDC.

Cover Illustration: “My School”, Luton pupils’ healthy school concept, Zenderes Primary School, Luton.
Whanau Ora Approach

INTRODUCTION
Whānau Ora is about whānau taking responsibility for whānau. It places whānau at the centre and empowers them to lead the development of solutions for their own transformation. The majority of whānau are already doing this and Whānau Ora will provide opportunities for sharing and learning from whānau stories.

The heart of Whānau Ora lies in building on whānau strengths and capability, growing whānau connections, supporting the development of whānau leadership and enhancing best outcomes for whānau.

The focus on outcomes is one of the most challenging aspects of Whānau Ora. The emphasis is on results that whānau set for themselves. Progress towards these outcomes will impact positively on other whānau and communities as a whole.

Whānau Ora is influenced by a legacy of kōtahitanga, manaakitanga and rangatiratanga – bringing all these threads together for a clear goal of delivering best outcomes for whānau.

Whānau Ora Approach
Whānau Ora is an inclusive, culturally anchored approach. It will include services and opportunities to support the aspiration of whānau to become more self-managing and take responsibility for their economic, cultural and social development. It will be available to all who choose to engage where support is available. It will also explore how Whānau Ora resonates with Pacific peoples and other non-Māori groups. The Whānau Ora approach is distinctive in that it recognises the collective nature and way in which whānau organise and asserts a positive role for whānau within society. It is also distinct in that it requires a cross-sectoral approach to working with, and achieving best outcomes for whānau.

Services and initiatives funded through Whānau Ora will be accessible to all New Zealanders.

The Whānau Ora Service Delivery Model
Whānau Ora is founded on the following principles:

- Ngā Kaupapa Tuku Iho: the ways in which Māori values, beliefs, obligations and responsibilities are available to guide whānau in their day-to-day lives.
- Whānau opportunity: all whānau have chances in life that enable them to reach new heights, do the best for their people, engage with their communities and foster a strong sense of whānauangatanga-connectedness.
- Best Whānau Outcomes: the success of Whānau Ora interventions is measured by increases in whānau capacities to undertake those functions that are necessary for healthy living, and share contributions to the wellbeing of the whānau as a whole, as well as the wellbeing of whānau members.
- Coherent Service Delivery: recognises a unified type of intervention so that distinctions between services provided by health, welfare, education and housing, for example, are not allowed to overshadow wider whānau needs.
- Whānau Integrity: acknowledges whānau accountability, innovation and dignity. This principle assumes that a code of responsibility is present in all whānau, though it may sometimes be masked by events or circumstances that propel whānau into survival mode or trigger a defensive reaction.
• Effective Resourcing: underlines two important aspects of services to whānau. First, the level of resourcing should match the size of the task – whānau-centred approaches may initially be time intensive. Second resourcing should be tied to results. Effective resourcing means allocating resources in order to attain the best results and an intervention plan should include a set of indicators that can measure successful outcomes.

• Competent and Innovative Provision: skilled practitioners are able to go beyond crisis intervention to build skills and strategies that contribute to whānau empowerment and positive outcomes (Whānau Ora: Report of the Taskforce, 2010:22)

The following high level outcomes provide rationale for working with whānau to identify their goals and actions to achieve these and measure results:

• whānau self management;
• healthy whānau lifestyles;
• full whānau participation in society;
• confident whānau participation in Te Ao Māori;
• economic security and successful involvement in wealth creation; and

Many whānau may need to engage in processes of healing and connection before they are ready to set and make plans that identify their aspirations. Progress toward achievement of outcomes may not be linear, as some whānau seek to change established intergenerational patterns in challenging circumstances.

Establishing trust and rapport with whānau and increasing whānau confidence to access a range of social supports can provide a base for whānau willingness to engage in planning. The development of plans which progress whānau to high level outcomes such as self management should be accompanied by identification of indicators that will track towards these goals and meaningful measures of success.

Action Research

Action research is the research approach to be implemented for Whānau Ora. A key element to the approach is to allow those participating in the research to self-initiate actions for change and development. Programme outcomes involving action research are achieved mostly by involving people in the planning and action and by being flexible and responsive to the situation and the people.

The use of action research for Whānau Ora is a deliberate strategy to bring together government, providers and whānau, as the model provides for:

• whānau having the opportunity to participate and 'voice' their expectations from service delivery; and
• providers supported to design and deliver quality holistic services to whānau.

The purpose of action research is to work with Whānau Ora providers and whānau on services that place whānau at the centre. The broad aim of the action research activity is to gather evidence of whānau-centred service delivery and whānau development. Key objectives are to:

• work with providers to:
  o identify key aspects of Whānau Ora and particularly whānau-centred service delivery, and
  o examine action taken to implement change; and
- work with whānau to understand their needs and aspirations of whānau-centred delivery, and whānau development.

Researchers are required to act as ‘facilitators’ assisting Whānau Ora providers and whānau with defining issues and ways of addressing them. A key part of this process is to provide time for ‘critical reflection’ to look back over actions and assumptions for examination and analysis.

The research implementation will be developed by working with providers and whānau to plan and implement change, and by noting and documenting key elements of transformation. This information will be gathered to inform policy development to reinforce whānau-centred delivery. This activity will be guided by a key research question tentatively proposed here as:

*How do whānau succeed through participating in whānau development and engaging in whānau-centred service delivery?*

The key research question will be confirmed once the action researchers have been selected, and it is envisaged that the research inquiry will need to yield insights into:

- what whānau need to develop so that they can take control of their own lives (whānau development); and

- what providers need to put in place to ensure whānau-centred delivery and for whānau to engage in whānau-centred service delivery (provider capability).

Critical to the approach is the ability of action researchers to form relationships of trust with providers and whānau. While existing relationships will be advantageous, consideration needs to be given to applying a deeper inquiry into how providers plan, develop and deliver whānau-centred initiatives. This will involve questions centred on the uniqueness of operating in a holistic way and why, how processes and systems reflect this, and whether service delivery matches the needs and aspirations of whānau.

### Measuring Whānau Ora

Action research is part of a wider work stream focused on measuring the success of Whānau Ora. To help guide the action research inquiry, a Whānau Ora Outcomes Framework is being developed in line with the outcomes identified in the Whānau Ora: Report of the Taskforce on Whānau-centred Initiatives, 2010:43 (see Figure 1).
The framework exists to provide a way of looking at achievement and measuring progress. As the action research and implementation of Whānau Ora are underway, further refinements to the framework will be made to reflect the aspirations of whānau and outcomes identified by providers.
Accelerated Equity

“Reducing inequalities” is a process of speeding up (accelerating) the process of improving health outcome and accelerating educational achievement for all students in an educational context.

This means that HPS is concerned not just about student outcomes overall but also about good outcomes for all students. The figure below illustrates that the aim is to improve outcomes for all students in an education context so that the median moves from point 1 to point 2.

![Graph](image)

**Figure 2: Raising the bar**

The problem with only improving educational outcomes for students in New Zealand is that we have significant inequalities in levels of achievement for different groups within the system; PISA data from the past 25 years has shown we are the only OECD country where our bottom 20% is getting worse.

This bottom 20% are the least mobile and have been referred to as the “long tail of underachievement.” Māori and Pasifika boys are over represented in the “long tail”[1] This same long tail of poor outcomes for Māori and Pasifika young people is mirrored in our health statistics for this group too.

When we improve outcomes for all in an educational context all we do is move the median but the gap (range) between those who have the best and poorest outcomes remains the same.

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Therefore the intention is for the health and education sectors to work in partnership so that they **not only improve outcomes for all but they sped up the process of achieving equality in outcomes** as shown in Figure 3 below so that Māori and Pasifika enjoy the same levels of progress and attainment in health and education outcomes as their peers. This eliminates the “long tail” of students experiencing poor health and educational outcomes. In order to do this, the rate at which Māori and Pasifika achievement or progress in improvement must be **accelerated**.

![Figure 3: Closing the gap](image)

This will mean that the (range) between those experiencing the best and poorest outcomes is as small as possible and all young people, regardless of ethnicity, experience a similar pattern of achievement of positive outcomes.
Schools for Health Europe

“We all care about our children, they are the future of Europe. Every child in Europe has the right to education, health and security and should have the opportunity to be educated in a health promoting school. SHE contributes to making schools in Europe a better place for learning, health and living.

SHE uses the health promoting school approach as an evidence-based and comprehensive way for developing school health policy.” http://www.schoolsforhealth.eu/
Māori Values and Principles Unpacked

SET OF MĀORI ETHICAL PRINCIPLES FOR PUBLIC HEALTH

1. Implement Te Tiriti o Waitangi/the Treaty of Waitangi. Māori are tangata whenua and public health practice and policy shall embrace the provisions of Te Tiriti o Waitangi/the Treaty of Waitangi and tikanga Māori/cultural safety.

2. Rangatiratanga – public health actions and outcomes shall reflect the hopes and aspirations of Māori for self determination in respect of their own affairs.

3. Manaakitanga – public health practice shall demonstrate the ethic of care and support and reverence for all peoples – “he aha te mea nui o te ao, he tangata, he tangata, he tangata.”

4. Whanaungatanga – public health practice is about people and the relationships we have with each other in order to realise our potential and fulfil our purpose.

5. Kaitiakitanga – public health policies and practices shall reflect the custodial role we have of this planet on behalf of ourselves, our children and those generations yet to come. “Toitu he whenua, whatungarongaro he tangata – the land endures while people disappear.”

6. Wairuatanga – public health practice shall acknowledge and respect the right of all persons to spiritual freedom;

7. Kotahitanga – public health practitioners will seek to work in unity and harmony with each other and others.

8. Mana – Because mana is such an important concept in the Māori world, public health practice shall reflect an understanding and respect for it as it is applied to people (mana tangata), land (mana whenua) and spiritual matters (mana Atua).

9. Tika – public health practice will be based upon what is right and proper according to circumstance and in accordance with the common good.

SET OF MĀORI ETHICAL PRINCIPLES FOR HEALTH PROMOTING SCHOOLS

1. Whakawhitihiti Kōrero – effective communication (e.g. kahohi ki kanohi - face-to-face) is vital when establishing and nurturing relationships with principals, teaching staff, children and young people, parents and whānau, and the wider school community.

2. Whanaungatanga – Relationships in Health Promoting Schools are everything - between people; between people and the physical world; and between people and the atua (spiritual entities).

3. Mohiotanga – Knowledge of schools\(^{133}\) is essential for effective Health Promoting Schools practice.

4. Rangatiratanga – Health Promoting Schools action and outcomes shall reflect the hopes and aspirations of Māori and non-Māori within schools and communities.

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\(^{133}\) Health Promoting Schools in Action in Aotearoa/New Zealand ((2001) (Chapter Three: Aspects of Health Promoting Schools: School Ethos, Curriculum, and Community Links))
5. Tautoko / Manaakitanga

6. He Mana Tō Te Tamaiti – Health Promoting Schools practitioners shall acknowledge and accept that the child’s tapu and mana are intertwined. Where tapu is the foundation of power, mana is the power, the realisation of the tapu of the child (Mead, 2003). Furthermore, the mana of children is derived from their links with atua. These spiritual entities are their immediate source of mana (mana atua) – they are the source of the children’s tapu which also stems from their iwi, hapū, whānau (mana tangata) and from their land, their tūrangawaewae (mana whenua).¹³⁴

¹³⁴ Extract from Rita Walker’s paper presented to the 7th World Indigenous People’s Conference at Melbourne, Australia, December, 2008 – The Philosophy of Te Whatu Poka Kaupapa Māori Assessment and Learning Exemplars
Draft Values Driven Framework

VALUES DRIVEN FRAMEWORK

The HPS strategic framework above is predicated on the understanding that **sustainable improvement is achieved through values driven practice.**

We **define values** as “the ideals that give significance to our lives, that are reflected through the priorities we choose, and that we act on consistently and repeatedly” (Hall, 1994).

Values driven practice can be aligned to the moral, social and professional purpose of our professional roles within both the health and education sectors. This is described by Elmore\(^1\) (2004) as “learning to do the right things in the setting where you work.”

Figure 2 below describes how the values and beliefs should be evident at every level of the HPS community and in all HPS practices. The process is dynamic with reflection, evidence and learning informing modification of values and beliefs.

**Relationship between core values and beliefs and practices**

![Diagram: Relationship between core values and beliefs and practices]

Figure 2: Relationship between core values and beliefs and practices adapted from Julia Atkin (1996)\(^{135}\)

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\(^{135}\) Atkin, J (1996) *From Values and beliefs about Learning to Principles and Practice*, Seminar Series No.54, Incorporated Association of Registered Teachers of Victoria
In order to achieve change, the current values and beliefs need to be surfaced and challenged both within the HPS workforce and in our work with schools. What is valued in HPS has been defined above as the following values: *kotahitanga; manaakitanga; rangatiratanga*. This was achieved through discussion, consultation and reflection in the HPS baseline survey, National Reference Group, National Hui and Roopu hui. These values form the basis of all HPS action.

**Valued outcomes in school communities**

In our research we have identified that any improvement initiative in schools that focuses on improving outcomes and practices; requires teachers and leaders, as well as students and families/whānau, to change their *beliefs or values* too rather than to just adopt new *skills or knowledge*. “It is the purposeful thinking that counts, not the mere doing.”\(^{136}\)

The values and beliefs of a school community are reflected in their practices and the kinds of outcomes that are valued. The practices and valued outcomes are often referred to as the “culture” of the school community.

Students’ learning needs are identified in relation to the valued student outcomes that have been determined by the community.

Some valued outcomes are determined at ministerial level or by the Education Review Office, while others are determined by the school community.

Sometimes we find that there is a difference between a school community’s ‘espoused theories’ (what they say they value) and ‘theories in use’\(^ {137}\) (what their actions show they value).

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**Student outcomes** are the results or evidence of students' learning experience. Outcomes may relate to knowledge or skills gained, attitudes, values, or behaviours changed, or health condition or status improved.

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**Theory of Improvement**

The next stage has been to develop a set of linked ideas about how to improve valued outcomes. This is the HPS *theory of improvement*. The values and beliefs again should be evident in the ideas, processes and practices.

If HPS is to improve both the educational and health outcomes for all students particularly those experiencing inequality in outcomes; the *valued outcomes* of the HPS process would align with improvement in students:

- **Presence**
- **Engagement**
- **Achievement** through the development of quality *relationships* between students and adults and adults and adults in the community

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These valued outcomes align with the Pasifika Education Plan\(^{138}\) (Figure 3), Ka Hikitia\(^{139}\) (Figure 4) and the valued outcomes in the New Zealand Health Strategy (reduced inequities)\(^{140}\) and Whānau Ora outcome goals and the The Whānau Ora Tool\(^{141}\).

In the health context:

- **Presence** - Students have to be present at school in order to be able to learn. There may be health related needs that are not being met that are preventing students from being present at school.

- **Engagement** - It is a well-known fact that “healthy students learn better”\(^{142}\)

- **Achievement** through the development of quality relationships between students and adults and adults in the community. This acknowledges the health concept of Hauora and wellness and a schools responsibility to ensure that all students and members of the community have a healthy and safe environment.

\(^138\) http://pasifika.tki.org.nz/Pasifika-Education-Plan
\(^139\) http://www.minedu.govt.nz/~/media/MinEdu/Files/TheMinistry/KaHikitia/MGFFramework.pdf
\(^140\) http://www.moh.govt.nz/publications/nzhs
The ultimate **measure of the effectiveness** of change needs to be **improved valued outcomes** for students.

The HPS values determine which practices and processes are chosen by HPS stakeholders over others.

**Transformational**

To raise student achievement through improved health outcomes, Health Promotion professionals schools and communities don’t simply need new information, they need to change their focus or their practices. For these changes or improvements to be sustainable it must be **transformational** rather than just informational. It is transformational learning that changes thinking and behaviours, while informational learning adds new skills and information without a change to belief systems and therefore related behaviours and attitudes.

Therefore the HPS theory of improvement and implementation reflects these elements and are underpinned by our understandings of transformational learning (Kegan 1994; Mezirow 2000), theory of change (Fullan 2006), evidence based teaching decision making (Earl & Katz 2006, Lai 2009) and large scale schooling improvement (Levin 2009).
Centre for Health Promotion

HPS Conceptual Framework
Draft theory for change, intervention and improvement 2010

THEORY FOR IMPROVEMENT

Any planned intervention for change around a common purpose must include a theory for change, intervention and improvement that explains how change will be achieved. Such theories describe a set of linked ideas about how a process will improve valued outcomes that guide the practices of groups and individuals. An explicit theory for change, intervention and improvement explains the practices and processes and allows for evaluation of the reasons for and assumptions about choosing particular practices and processes.

Evaluating theories is fundamental to effectiveness because not all theories will contribute equally to desired/valued outcomes. An HPS Theory of Improvement needs to be both relevant and rigorous for both the education and health promotion community.

A theory for change, intervention and improvement is a set of linked ideas, beliefs about how to improve valued outcomes. Sustainability is conceived as part of a theory for improvement. A theory for change, intervention and improvement is a powerful way of explaining, evaluating and improving practice.
HPS THEORY FOR CHANGE, INTERVENTION AND IMPROVEMENT (TCII)

Figure 1 below shows a draft HPS theory of improvement that explains the practices and processes that will deliver the desired or valued outcomes. This model aligns with evidence based best practice in achieving change/improvements in schools internationally and in New Zealand as well as the approach taken with the Whānau Ora initiative from the perspective of educators146 and health promoters. The 2010 IUHPE conference and a PHP have highlighted the need for HPS to have a theory for change, intervention and improvement147. It is further explained in the following paragraphs.

HPS Draft Theory for Change, Intervention and Improvement (TCII)

Pre-requisites to engagement: TCII, relationships, understand school context (valued outcomes), NZ up to date evidence of how educational goals have been achieved through addressing health issues within an educational framework

Define Need: Current understanding of the need, contributing factors, context and effective ways to address the need

Proposed solutions to address the contributing factors which directly relate to the need, and which are understood by all involved

Rationale for solutions: including evidence of likely effectiveness to address the particular need

Valued outcomes and success indicators: against which progress can be monitored & evaluated

Way to monitor progress towards outcomes

Theory of sustainability: process of organisational learning to improve outcomes already achieved

Figure 1: Draft HPS Theory for Change, Intervention and Improvement

148 http://repository.library.ualberta.ca/dspace/bitstream/10048/1501/1/Gleddie_Douglas_Fall+2010.pdf
PRE-REQUISITES TO HPS ENGAGEMENT WITH SCHOOL COMMUNITIES

There are four pre-requisites to engagement with school communities. The first is health promoters in school communities need to have a clear theory of improvement (Figure 1) and understanding of the implementation process (Figure 2) before they go into school communities. Secondly an understanding of the current school context/setting in New Zealand is needed if Health Promoters are to gain credibility, trust, meaningful engagement and improvement. Thirdly health promoters need to establish relationships that are interdependent and based on trust and challenge. Finally health promoters must be able to articulate and provide recent NZ evidence that shows how a reciprocal relationship between health promotion and education has supported schools to achieve better outcomes for their students.

Theory for improvement

There is no silver bullet for improvement in a school community context. But recent New Zealand research shows those school communities who are most successful in improving outcomes;

- Use a range of evidence to inquire into the effectiveness of everyone’s current practices
- Decide what should stay because it is working
- Decide what needs to change and how it needs to change.
- Provide opportunities for the school community to plan actions that will address the changes
- Check the effectiveness of everyone’s efforts
- Identify new challenges that form a new cycle

This also aligns with the Health Promoting Schools conceptual framework (appendix 7) and Health Promoting Schools process steps (appendix 8).

Theory of sustainability

A theory for change, intervention and improvement should include a theory of sustainability for valued outcomes

Sustainability is the process of organisational learning to improve outcomes already achieved (Lai et al., 2009). Sustainability is NOT planned after an intervention it needs to be planned from the beginning of the process.

Relationships

Russell Bishop in the Kotahitanga project in NZ has identified that “Culturally Responsive Pedagogy of Relations” provides the key to improvement in outcomes for Māori. These relational practices have also been shown to provide significant gains for Pasifika as well. An understanding of these practices is important when considering improvement in outcomes for both Māori and Pasifika students.

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149 http://www.educationcounts.govt.nz/publications/series/9977/9454
Evidence shows that successful partnerships between Health Promoters and school communities are more likely to be productive if they are based on:

- Managed interdependence
- Trust and challenge

**Managed interdependence**

Managed interdependence involves complementary and mutually informed relationships between the school community, health promoters, and other outside agencies with specialist expertise. In this relationship the school community is in the driving seat of inquiry and change. Health Promoters provide a partnership characterised by on-going support and health promotion expertise. As the school community develops greater capability in providing their own solutions they are able to make decisions and inquiry into whether their current practices are working or not without as much support.

**Trust and challenge**

Trust involves personal respect, integrity and carrying out mutual agreements. Tony Byrk and colleagues (1998) identified having a base level of trust developed through day to day exchanges, as being fundamental to success. Trust also comes with a great deal of mutual accountability.

As evidence and inquiry are at the heart of the theory for change, intervention and improvement and inform the process, it is important that ideas, beliefs, evidence and understandings are challenged as part of this relationship. Challenge requires that rigorous debate of the ideas put forward and the evidence that underpins them takes place at all levels of the community including Health Promoters and other HPS providers in the dialogue. When trust is established these discussions will be respectful and productive leading to new understandings or clarity.

**Understanding the school setting**

The HPS “whole school/socio-ecological/setting based approach” is consistent with all the education interventions/improvement initiatives that have been happening in schools. There are currently over 20 separate initiatives operating in schools which have included: (ICT clusters, Extending Higher Standards, Literacy, Numeracy, Restorative justice, the Pasifika Education Plan, Ka Hikitia, Professional Learning and development, Strengthening student achievement, National Standards; Ngā Whanaketanga Rumaki Māori - National Standards in Māori-medium education; Positive Behaviour for Learning, The National Digital Strategy, Ultra-fast Broadband in Schools etc)

Schools in New Zealand are currently focused on accelerating achievement particularly in literacy and numeracy, through evidence driven inquiry processes at every level.

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Inquiry is fundamental to effective professional practice in schools and school communities. It involves students, teachers, principals, boards and communities’ investigating what is working well for student and why, so it can be continued, and what is not working well and why, so it can be changed. There is ample evidence in NZ research that engagement in this cycle has been shown to result in improved student outcomes. (2010 Timperley, Parr) It is a recursive process and describes the task of evidence-based decision-making and the process by which decisions are made, plans or actions implemented and reviewed in a school setting.

In schools evidence refers to more than data on student learning or engagement. It also includes professional knowledge and practices, and what is known about making the most difference, particularly for those experiencing the greatest inequity.

Evidence based health promotion refers to the use of information from formal research and systematic investigation to identify causes and contributing factors to health needs and the most effective health promotion actions to address these in given contexts and populations. (WHO)

**At all levels- evidence-based inquiry processes & decisions provide new learnings**

**Figure 2:** Evidence based inquiry processes at all levels in a school
Self review

- School boards of trustees have a responsibility under the National Administration Guidelines to review their school’s performance.
- Reviews should be cycles of connected and focused processes to gather evidence and act on the results:

  - Strategic self review
  - School - regular self reviews
  - Emergent reviews

**Figure 3:** Evidence based inquiry drives review processes for Boards, Principals and Staff

Evidence –based teaching inquiry

**Figure 4:** Teaching as Inquiry “The New Zealand Curriculum”
Figure 5: Draft HPS student inquiry learning cycle

NZ unique context

International HPS research and practice is not always immediately transferable as it often relates to:

1. Euro-centric school contexts and homogenous school communities
2. Countries that do not have a formal agreement and partnership with the indigenous people
3. State governed schools and school regions
4. Geographically isolated

By comparison NZ has an increasingly diverse student population. Over the next two decades:

- New Zealand's Māori, Asian and Pacific populations are projected to grow.
- The 'European or Other (including New Zealander)', Māori, Asian and Pacific populations are projected to age, which is reflected in rising median ages and increasing proportions of people in the older ages.\textsuperscript{152}

No other nation has a formal agreement with the indigenous people of the land. In New Zealand the Treaty of Waitangi outlines the formal agreement between Māori and the Crown. Included in this agreement is for Māori to enjoy a health status at least as good as that enjoyed by non-Māori. Both Health and Education sectors are expected to demonstrate commitment to this agreement in both policies and practices.

New Zealand is the only country in the world to have “self-governing schools”, which is the most devolved model in the world. This means that schools are autonomous and responsible to their local community. The development of self-governing schools was driven by the desire for flexibility and responsiveness and a belief that the local school community knows best. Recently this has been accompanied by greater community and government scrutiny and expectation that schools should be able to show that they are “raising the bar and closing the gap” In addition there have greater attempts by the Ministry of education to cluster schools and encourage networks and professional learning communities through policy initiatives. This provides a unique school setting that is not replicated anywhere else in the world.

Finally New Zealand does not share the proximity to other nations that European countries do. Our isolation provides us with a unique set of social, political, economic and educational circumstances or imperatives that impact on every facet of our lives.

Building a strong ongoing evidence base

One of the shortfalls of the HPS internationally and in New Zealand has been the lack of rigorous and robust evaluation at all levels delivery. Most evidence has emerged from international topic-based research and evaluation studies rather than a whole school process. As evidence informs inquiry within HPS there needs to be a deep commitment to evaluation and building critical review processes into all HPS actions. In this way evidence continues to inform future practice. A commitment to evaluation requires development of a framework for evaluation that considers:

- Triangulation of data/evidence
- The theory for improvement
- The context (physical, social, cultural, political)
- The process (identifying, planning, acting, monitoring, reporting and evaluating/reflecting on outcomes as a basis for on-going improvement)
- The outcomes (positive changes in knowledge, attitudes, skills, behaviours, social and physical environment reflected in engagement, participation and achievement through quality relationships.)

This strategic framework also considers the development of a range of SMART tools for national, regional, local and individual monitoring, reflection and evaluation.

It is important to develop a centralised repository of HPS best practice case studies and up to date research, particularly within the New Zealand context, so that Health Promoters and school communities can draw upon the evidence so as to identify what is most likely to work in a given context.

153 NatCen (2009) Evaluation of the National Healthy Schools Programme Department Of Health, UK
HPS Current Process Steps
Draft Implementation 2010

PROCESS OF IMPLEMENTATION

Figure 2: Draft Implementation Process –Inquiry Cycle

The HPS inquiry cycle

This section details the reflective inquiry cycle (action research based) that will be co-constructed, delivered and progress reviewed by Health Promoters and the school community. The process reflects the steps already identified in the Health Promoting School Process steps (Appendix 8) and mirrors the action research model used in Whānau ora. It is designed as a model that school communities can use independently in planning future HPS development.

**Differentiation** of delivery means adapting strategies and processes to meet the needs of the various stakeholders.

**Co-construction** is two or more independent entities working together equitably towards a common goal.

We briefly describe the five stages: engagement, inquiry; decisions made during the co-construction of the HPS actions to be included in the schools strategic and annual plan (Appendix 4); differentiated delivery that is actioned; evaluation, review, reflection and sharing. Each stage is further unpacked to describe the process within the stage, the nature of the support for the stage and who will be engaged in the particular stage. So the actual content will be differentiated as well the nature of the support so as to meet the specific school community’s needs.
Māori Health Models

TE WHEKE

Traditional Māori health acknowledges the link between the mind, the spirit, the human connection with whānau, and the physical world in a way that is seamless and uncontrived. Until the introduction of Western medicine there was no division between them.

The concept of Te Wheke, the octopus is to define family health. The head of the octopus represents te whānau, the eyes of the octopus as waiora (total wellbeing for the individual and family) and each of the eight tentacles representing a specific dimension of health. The dimensions are interwoven and this represents the close relationship of the tentacles.

Wairuatanga - spirituality
Hinengaro - the mind
Taha Tinana - physical wellbeing
Whanaungatanga - extended family
Te Whānau - the family
Waiora - total wellbeing for the individual and family
Mauri - life force in people and objects
Mana ake - unique identity of individuals and family
Hā a koro ma, a kui ma - breath of life from forbears
Whatumanawa - the open and healthy expression of emotion


TE WHARE TAPA WHĀ

One model for understanding Māori health is the concept of ‘te whare tapa whā’ - the four cornerstones (or sides) of Māori health.
With its strong foundations and four equal sides, the symbol of the wharenui illustrates the four dimensions of Māori well-being.

Should one of the four dimensions be missing or in some way damaged, a person, or a collective may become ‘unbalanced’ and subsequently unwell.

For many Māori modern health services lack recognition of taha wairua (the spiritual dimension). In a traditional Māori approach, the inclusion of the wairua, the role of the whānau (family) and the balance of the hinengaro (mind) are as important as the physical manifestations of illness.

**Taha Tinana (physical health)**

The capacity for physical growth and development. Good physical health is required for optimal development.

Our physical ‘being’ supports our essence and shelters us from the external environment. For Māori the physical dimension is just one aspect of health and well-being and cannot be separated from the aspect of mind, spirit and family.

**Taha Wairua (spiritual health)**

The capacity for faith and wider communication.

Health is related to unseen and unspoken energies.
The spiritual essence of a person is their life force. This determines us as individuals and as a collective, who and what we are, where we have come from and where we are going.

A traditional Māori analysis of physical manifestations of illness will focus on the wairua or spirit, to determine whether damage here could be a contributing factor.

**Taha Whānau (family health)**

The capacity to belong, to care and to share where individuals are part of wider social systems.

Whānau provides us with the strength to be who we are. This is the link to our ancestors, our ties with the past, the present and the future.

Understanding the importance of whānau and how whānau (family) can contribute to illness and assist in curing illness is fundamental to understanding Māori health issues.

**Taha Hinengaro (mental health)**

The capacity to communicate, to think and to feel mind and body are inseparable.

Thoughts, feelings and emotions are integral components of the body and soul.

This is about how we see ourselves in this universe, our interaction with that which is uniquely Māori and the perception that others have of us.

**TE PAE MAHUTONGA**

Te Pae Mahutonga (Southern Cross Star Constellation) brings together elements of modern health promotion.

In the diagram below, the four central stars of the Southern Cross represent four key tasks of health promotion:

- Mauriora (cultural identity)
- Waiora (physical environment)
- Toiora (healthy lifestyles)
- Te Oranga (participation in society)

Under each of these there is a five pointed star with a domain connected to each point. For example under Mauriora the domains are: usage; social resources; economic resources; language and knowledge, and culture and cultural institutions. The two pointers represent Ngā Manukura (community leadership) and Te Mana Whakahaere (autonomy).
NGA POU MANA HEALTH MODEL

The Nga Pou Mana health model was introduced 1988 by the Royal Commission on Social Policy. This model was developed in the area of social policy rather than health. The four supports of this model were: whanaungatanga (family), taonga tuku iho (cultural heritage), te ao turoa (physical environment), and turangawaewae (land base). Durie (1998) however, believed that the inclusion of turangawaewae and te ao turoa may have reflected issues of this era in which some landmark decisions were made by the Waitangi Tribunal, including claims against the Crown relating to the pollution of tribal waterways.

TUHA -NZ

Tuha NZ was produced by the Health Promotion Forum of New Zealand (2002). It uses Treaty articles as goals under which objectives, strategies & performance indicators can be developed. The framework clarifies the meaning of each article in relation to HP & outlines issues to consider. TUHA-NZ gives examples of three specific goals related to the Treaty articles:

1. Achieve Māori participation in all aspects of health promotion

http://www.nzca.ac.nz/resources/tikanga-practices
2. Achieve the advancement of Māori health aspirations

3. Undertake health promotion action which improves Māori health outcomes.

The process of setting objectives and strategies to meet identified goals is a practice many health promotion workers will already be familiar with. Being able to identify strategies for Treaty-based practice will support diverse and individual strategies. Importantly, health promotion organisations and individual health promoters will be able to determine strategies that are appropriate, achievable and measurable at programme and organisational levels.

- Goal One: Achieve Māori participation in all aspects of health promotion.
- Goal Two: Achieve the advancement of Māori health aspirations.
- Goal Three: Undertake health promotion action which improves Māori health outcomes.

Having identified specific goals from the articles of te Tiriti o Waitangi, the next step of the TUHA-NZ framework is for health promoters to identify achievable and appropriate objectives and strategies to achieve these goals. Each goal is a general aim for which to strive.

Objectives relate to these goals and are the results a programme seeks to achieve. Strategies and performance indicators are set to measure progress towards achieving these objectives. They specify what is to be achieved by when27.

A Goal: states the overall purpose of the programme.

Objectives: identify what it is that the programme seeks to achieve.

Strategies: identify how the objectives will be achieved.

Performance Indicators: identify specific targets such as who, where, how much and when.

Health promoters and health promotion organisations will need to each consider the responsibilities and implications of evaluation and monitoring. In developing objectives the principles of effective planning continue to apply. The components of the planning acronym SMART are useful to bear in mind. Objectives should be Specific, Measurable, Achievable, Relevant and Timebound.

Copy Tuha nz http://www.mentalhealth.org.nz/file/Policy-Advocacy-etc/PDFs/Tuha-nz.pdf pg 16
Pasifika Health Models

Some Pacific Models

- Fonofale – Karl Pulotu Endemann (Samoan)
- house as a symbol of holistic model
- Fa afaletui – Carmel Peteru and Kiwi Tamasese (Samoan)
- 3 views from mountain, coconut tree, and canoe
- ascertaining facts/knowledge in the houses of elders
- Tivaevae – Teremoana Mausa-Hodges (Cook Islands)
- quilting of diverse facts and perspectives
- Kakala – Konai Helu-Thaman (Tongan)
- Cultural process of kumi/search, tui/plaiting, luva/giving of a Tongan garland or kakala


Fonua Model

Fonua: The cyclic, dynamic, interdependent relationship (va)
between humanity and its ecology for the ultimate
purpose of health and wellbeing.

Aim: harmony and wellbeing of life

Values:
Fe ‘efo’ofi – love
Fetokoni aki – reciprocity
Feta’aga api aki – respect
Fatapoto – wise & prudent

Laakanga (Phases):
Kumi Fonua – exploratory
Langa Fonua – formative
Tuahi Fonua – maintenance
Tufunga Fonua – reformation

Dimensions & Levels

- Laumalie (Spiritual) / Taunatahi (Individual)
- ‘Atamai (Mental) / Famalii (Family)
- Sino (Physical) / Kolo (Local)
- Kangia (Community) / Fonua (National)
- ‘Atakai (Environment) / Manawa (Global)

Colors, Shapes & Meaning

Blue – Moana/Oceans/Pasifica
Brown – Pasifika peoples, fonua
Green – plant kingdom/life
Red – life, people
Circle – shape of wisdom and holism
Concurrent circles – interdependent & Connectedness of the web of life

S. Tu’i’itahi, 2007

Applying the Fonua model

- Identify and scope health issue or need
- Identify parties concerned and parties affected
- All parties consult
- Identify causal/contributing factors
- Identify affected dimensions and levels
- Identify and apply related values
- Generate solutions
- Plan and implement
- Review, close or plan again


Fonua Model

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Applying the *Fonua* model

- Identify and scope health issue or need
- Identify parties concerned and parties affected
- All parties consult
- Identify causal/contributing factors
- Identify affected dimensions and levels
- Identify and apply related values
- Generate solutions
- Plan and implement
- Review, close or plan again
Appendix 3: The Egmond Agenda

A new tool to help establish and develop health promotion in schools and related sectors across Europe.

“The Health Promoting School improves young people’s abilities to take action and generate change. It provides a setting, within which they can gain a sense of achievement, working together with teachers and others. Young people’s empowerment, linked to their visions and ideas, enables them to influence their lives and living conditions.” (WHO, 1997)

PRINCIPLES INTO PRACTICE

The first European Conference on Health Promoting Schools was held in Greece in 1997. It proclaimed that health promoting schools (HPS) are an investment in health, education and in democracy.

The outcome of that Conference was a set of principles. They defined the values and purposes of HPS, and set out methods that could be used to establish those principles in practice.

THE CORE PRINCIPLES

- Partnership
- Equity and access
- Empowerment and action competence
- Health knowledge and understanding
- Safe and supportive environments
- Health promoting teaching and learning methodologies
- Curriculum based health promotion
- Democratic practices and participation
- Involvement of stakeholders, communities and parents
- Evaluation for building on success

EVIDENCE

Many partners in European countries have worked to introduce, strengthen and sustain distinctive HPS approaches. Evidence is now available to show:

- how successful and sustainable HPS approaches are built
- how they might be supported by policies that establish the process within health and education sectors
THE EGMOND AGENDA

A Conference was held in 2002 to consider progress made and to take the HPS process forward. It took place at Egmond-an-Zee in the Netherlands. It included participants from 43 European countries – and representatives from many of their national ministries. As one result, this tool embodies the best evidence and practical steps understood as essential in building successful HPS programmes.

It is clear that the most successful outcomes arise from programmes developed through collaboration between health and education sectors.

There are three main components to this Agenda:

- **CONDITIONS**
- **PROGRAMMING**
- **EVALUATION**

Each component is essential to develop and sustain health promoting schools. There is no priority order for their implementation, but some may be seen as important early steps.

**CONDITIONS**

**ONE: SITUATION ANALYSIS**

It is important to carry out a national analysis of the situation concerning the status of HPS development. This analysis should look at needs and available resources, current practices and methods for data collection. Such information can be collected through assessments of:

- knowledge, attitudes, skills, competencies, behaviour and health status of young people
- the contributions of health and education sectors to health promotion
- involvement of other agencies and related sectors
- financial resources needed
- available experience of other countries
- the “functional health” status of schools as organizations

**TWO: PARTNERSHIP**

For an HPS initiative to achieve lasting success, partnership must operate in a fair and transparent way at several levels.

The experience in Europe has shown that HPS initiatives are most effective when true partnership is practiced within and between all players in the process. This should include ministries, their institutions, pupils, teachers, NGOs, stakeholders and interested parties in relevant communities.

At national level the two most influential partners are generally the Ministries of Health and Education. For example, effective partnership has been demonstrated when partners agree which agency should lead a programme depending on national circumstances. Alternatively, a consensus based collaborative model may prove more appropriate.
It is important to achieve clarity about mutual objectives and ensure that resources are dispersed fairly. Partners need to agree on the advantages that they bring to a programme, and recognize where additional expertise is needed, so some flexibility is helpful in setting agendas. This will help to instil an authentic sense of ownership, which will add to sustainability.

THREE: ADVOCACY
Introducing and adopting the HPS approach is best understood as a process. The framework of a Health Promoting School enables effective, comprehensive programmes of health promotion and education to be established. Moreover, there is evidence that programmes on specific health topics offered by other agencies can be more effectively introduced in an HPS framework.

But that evidence alone may not be enough. Policy-makers need a range of good reasons to support HPS approaches. Decision-makers need to be convinced that investing in HPS programmes is worthwhile – and contributes to policy objectives in related sectors. Furthermore, the process should be sustainable so as to withstand political, economic and social change. Broad based advocacy is necessary to achieve this.

Stakeholders from health, education and other sectors involved or in supporting or delivering HPS programmes need to be involved in the advocacy process, being instrumental in advocating for investment in HPS programmes.

FOUR: THEORETICAL BASE
A sound theoretical base is essential for implementation of a national HPS approach. Effective programmes are based upon a theory of building comprehensive health promotion approaches. Such approaches address factors that provide protection from risk as well as those that cause risks to health.

The approach is implemented through health and education programmes that

- Create safe and supportive environments
- Establish a health education curriculum
- Foster relationships with families and communities
- Prepare young people to cope with demands of everyday life

This implies an understanding that change and development are integral tools of the process. There are political implications related to the process such as conflicting policy areas and priorities, resource allocation, theoretical and philosophical direction.

PROGRAMMING

FIVE: PROGRAMME CONTENT AND OBJECTIVES
Policy development should result in long-term national objective setting and action programming for school health. Key elements of a national action programme for school health are:

- information exchange on activities and initiatives;
  - linking with current national policy development in education and health (life skills, competence development, effective schools, safe schools, child friendly schools, health targets and priority setting, participation, action-oriented teaching and learning)
- advocacy such as rights based education, in line with the Convention on the Rights of the Child, Education For All, Millennium Development Goals, the UN Special Session on Children outcomes etc.
networking

initiatives to improve the quality of HPS programmes, to foster health and support quality education, and to create positive school cultures and environments.

SIX: LONG TERM PLANNING
Evidence shows that the development period of a national HPS programme can be from three to eight years. This, therefore, requires long term planning and sustainable political commitment.

It is recommended to develop a national action programme within a planning cycle of three to five years, when objectives and outcomes can be assessed and, if necessary, redefined.

A national structure combined with a regional/local structure for health promoting schools has been found to be most effective. This provides support to schools, creates synergies, enables management and coordination, and helps innovation and implementation of programmes.

Effective collaboration between Ministries of Health and Education is critical to success. This process enables integrated use of resources, shared financial and political support, and the engagement of agencies and institutes from both sectors in joint initiatives.

SEVEN: TEACHER EDUCATION AND PROFESSIONAL DEVELOPMENT
An HPS programme introduces concepts and methodologies that may be unfamiliar to officials in health and education ministries and other actors such as teachers. Successful HPS initiatives have developed extensive education programmes for teachers, trainers and health workers.

Building the capacity of personnel and providing opportunities for professional development has been shown to be an effective strategy in HPS policy. It has shown tangible benefits for learning, skills development and social capital.

This should apply to all involved, but particularly to teacher training before and during service, and should include accredited courses that include the broader public health themes underpinning health promoting schools.

This vital component requires investment and strengthened links between relevant institutes to ensure effective course design, evaluation and development of the evidence base.

EVALUATION

EIGHT: EVALUATE
Monitoring and evaluation are essential parts of a national action programme for health promoting schools. Evaluation that accompanies theoretically based programmes and provides evidence of effectiveness has been seen to influence success in developing sustainable school health policy. Good evaluation, which includes both process and outcome evaluation, has been seen to aid the progress of action plans in becoming nationally implemented programmes.

Embedding the values of ethical, evidence-based research is consistent with overall HPS approaches and offers learning and related benefits within school communities.

A school is, of course, fundamentally a place of learning. But it is also a unique social and cultural meeting place for people from many backgrounds. A Health Promoting School embodies practical and conceptual links between education, health and participatory values. It relies on input, experiences and decisions at local levels, yet learns from and contributes to wider goals, objectives and developments.
There will always be new challenges to be faced. An HPS programme can never be complete, or stop learning from others. The policy cycle: - “design – implement – monitor – evaluate” is crucial to sustainable success.

Therefore it is planned that the Action Points related to the Egmond Agenda will be developed, offering a practical tool, guide, encouragement – and perhaps even inspiration - for existing or potential participants and policy makers, wherever they feature in that cycle.

The European Network of Health Promoting Schools is a partnership programme between European countries, with international institutional support from The Council of Europe, The European Commission and the World Health Organization Regional Office for Europe.

Technical support for the ENHPS is provided by the Technical Secretariat to which all enquiries concerning the programme may be directed.

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Denmark
Tel: +45 39171235
Fax: +45 39 171818
E mail: bdm@who.dk Web site: http://www.euro.who.int/enhps
Appendix 4: School Planning Documents and Processes

The Charter

Mission statement
Values statement
Vision statement

Strategic section
3-5 year plan

Annual targets

Annual report

Legislation

Government requirements

- National Education Guidelines (NEGs)
- National Administration Guidelines (NAGs)
- National Curriculum Statements

(submitted to MoE annually)
Appendix 5: The Pasifika Education Plan

Compass for Pasifika success

Ensuring Pasifika students and young people are present, engaged and achieving is a shared responsibility.

Pasifika people have multiple world views and diverse cultural identities. They are able to operate and negotiate successfully through spiritual, social, political, cultural and economic worlds. Success in education requires increasing Pasifika diversity within an enabling education system that works for young people, their families and communities. This requires the education system, leadership, and curricula to start with the Pasifika learner at the centre, drawing on strong cultures, identities and languages.
## Appendix 6: Ka Hikitia

### The Measurable Gains Framework: Monitoring the effectiveness and progress of Ka Hikitia [DRAFT]

<table>
<thead>
<tr>
<th>1. MOE’s Sector Leadership Role</th>
<th>2. Culturally Relevant and Responsive MOE Activities &amp; Initiatives (Direct Actions and Contracted Initiatives)</th>
<th>3. Effectiveness Focus (Immediate Aim(s) of Each Initiative)</th>
<th>4. As Māori Learner Outcomes</th>
<th>5. Longer-term Strategic Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.1 Māori learner outcome focus:</strong></td>
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<tr>
<td>Outcomes for Māori learners prioritised across MOE and sector</td>
<td>2.1 Educational institution, teacher &amp; sector focused activities and initiatives:</td>
<td>3.1 Effective teaching for Māori learners</td>
<td>4.1 Māori learner progress &amp; achievement</td>
<td>5. Māori enjoying education success as Māori</td>
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<tr>
<td>Monitoring and evaluation with a Māori enjoying education success as Māori lens</td>
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<td><strong>1.2 Policy development &amp; improvement:</strong></td>
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<tr>
<td>Highly effective policy development for Māori learners (in Māori-focused and general population initiatives)</td>
<td>2.2 Whānau-focused activities &amp; initiatives:</td>
<td>3.2 Effective educational leadership, culturally responsive learning contexts and systems</td>
<td>4.2 Māori learner attendance, retention and engagement</td>
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<tr>
<td>Serious attention to improvements and full use of all system accountability levers to enhance outcomes for Māori learners</td>
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<td><strong>2.3 Learner-focused activities &amp; initiatives:</strong></td>
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<td>Learner engagement in education and learning</td>
<td>2.3 Effective whānau partnerships</td>
<td>3.4 Effective parent, whānau, iwi engagement informed, demanding, determining</td>
<td>4.3 Career-focused Māori learners and whānau, well informed about options</td>
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<tr>
<td>Specialist support and early intervention</td>
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<td>Career and education pathways</td>
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<tr>
<td>2.4 Effective Māori learner support, information &amp; advice</td>
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<td>2.5 Effective Māori learner partnerships</td>
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<tr>
<td>2.6 Effective &amp; relevant service provision for Māori learners</td>
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Appendix 7: Previous HPS Framework
Appendix 8: HPS process steps

Steps to becoming a Health Promoting School:

- The HPS Co-ordinator raises awareness within the community
- Seek commitment from Board of Trustees, Principal and staff to adopt HPS
- Appoint the school’s HPS leader
- The school raises awareness within the school community
- Form a HPS Team

Create a shared vision

Conduct a needs assessment

Prioritise issues and develop a plan of action

Implement the plan. Evaluate progress and plan for the future

SIX KEY FACTORS AS CRITICAL TO ENHANCING AND STRENGTHENING ENGAGEMENT BETWEEN SCHOOLS AND COMMUNITIES

- Leadership: Leadership is crucial in creating meaningful and respectful partnerships. Engagement between schools and their communities works well when there is vision and commitment from school leaders to working in partnership with all parents.

- Relationships: Supportive relationships both formal and informal are at the heart of effective partnerships. Mutual trust and respect are critical to relationships in which all adults share responsibility for children’s learning and well-being.

- School culture: School culture reflects the values and attitudes that underpin home-school relationships. Schools that are committed to being inclusive enable all parents to be actively involved in decisions affecting their child, and respond to parents’ concerns and questions promptly.

- Partnerships: Teachers work in partnership with parents, providing opportunities for them to learn about and share in their child’s learning and achievement. Learning partnerships strengthen parents’ understanding and involvement in their child’s education. Parents feel their contributions are valued. Effective learning partnerships can have positive impacts on student outcomes.

- Community networks: Schools are an integral part of their communities. Parent and community expertise is valued and contributes to programmes and activities in the school. Schools are involved in community activities and events. Consultation is integral to engagement, and there is a shared understanding about the priorities for student achievement.

- Communication: Schools communicate with parents in ways that are timely, useful and easily understood. Opportunities for exchange of information are both formal and informal and appropriate for those involved. Barriers to effective communication are actively identified and overcome.
<table>
<thead>
<tr>
<th>Year</th>
<th>International</th>
<th>New Zealand</th>
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<tbody>
<tr>
<td>1948</td>
<td>WHO International Conference on Primary Health Care</td>
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<tr>
<td>1960</td>
<td>Health promotion work began in Europe</td>
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<tr>
<td>1966</td>
<td>European Commission (EC) Promotion of Health Education</td>
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<tr>
<td>1968</td>
<td>Council of Europe (CE) pilot project “Education for Health” collaborative work</td>
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<tr>
<td>1969</td>
<td>EC resolution implemented in schools</td>
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<tr>
<td>1970</td>
<td>1st international conference on HPS in Ottawa, Canada. HPS charter developed</td>
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<tr>
<td>1981</td>
<td>Conference on health education &amp; disease prevention in schools funded by the EC</td>
<td></td>
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<tr>
<td>1989</td>
<td>1st conference of European network of Health Promoting Schools (ENHPS) formed.</td>
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<tr>
<td>1990</td>
<td>UN Millennium Goals 2000-2015</td>
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<tr>
<td>1991</td>
<td>IUHPE publication of “The Evidence of Health Promotion Effectiveness”</td>
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<tr>
<td>1994</td>
<td>UK implementation of Fit &amp; Slim</td>
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<tr>
<td>1996</td>
<td>WHO, CDC and IUHPE update of guidelines for promoting health in schools</td>
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<tr>
<td>1997</td>
<td>IUHPE Guidelines for Promoting Health in Schools</td>
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<tr>
<td>1998</td>
<td>WHO Commission on social determinants of health – final report “Closing the Gap”</td>
<td></td>
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<tr>
<td>2000</td>
<td>IUHPE guidelines updated in 2009</td>
<td></td>
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<tr>
<td>2001</td>
<td>EU implementation of FS 2005</td>
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<tr>
<td>2002</td>
<td>MoH funded 3 year pilot of Health Promoting Schools</td>
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<tr>
<td>2003</td>
<td>MoE pilot of Healthy Community (HC) based on research into how achievement of students in 9 decile 1 secondary school could be improved, HEHA Strategy 2003</td>
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<tr>
<td>2004</td>
<td>Youth Affairs Youth Development Strategy</td>
<td></td>
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<tr>
<td>2005</td>
<td>FiS programme roll out incorporating HPS framework</td>
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<tr>
<td>2006</td>
<td>Mission On launched</td>
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<tr>
<td>2007</td>
<td>Nutrition Fund launched</td>
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<tr>
<td>2008</td>
<td>‘Health Promoting Schools: a New Zealand perspective’ Cushman, P</td>
<td></td>
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<tr>
<td>2009</td>
<td>MoH &amp; MSD took over funding of AIMHI HC initiative</td>
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<tr>
<td>2010</td>
<td>Evaluation of HPS in AIMHI schools</td>
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<tr>
<td>2011</td>
<td>Evaluation of FiS and HPS whole school approach</td>
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<tr>
<td>2012</td>
<td>Report by Youthline for Counties Manukau on Effectiveness of Youth One Stop Shop</td>
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</tbody>
</table>

**New Zealand Context**

- **1978**
  - 1980
  - 1982
  - 1986
  - 1990
  - 1992
  - 1994
  - 1998
  - 2000
  - 2002
  - 2004
  - 2006
  - 2008
  - 2010
  - 2015

**Appendix 10: Timeline of translation of international recommendations and research on HPS into the New Zealand context**

1. WHO international conference on primary health care, Alma Ata, Kazakhstan, Declaration of Alma Aza.
2. Council of Europe (CE) pilot project “Education for Health” collaborative work.
3. European Commission (EC) resolution implemented in schools.
4. 1st international conference on HPS in Ottawa, Canada. HPS charter developed.
5. Conference on health education & disease prevention in schools funded by the EC.
6. 1st conference of European network of Health Promoting Schools (ENHPS) formed.
8. IUHPE publication of “The Evidence of Health Promotion Effectiveness.”
9. Evaluation of UK government NHS pilot plan to develop in schools national 5 a day programme to include fruit and veggie consumption.
10. UK implementation of Fit & Slim.
12. WHO, CDC and IUHPE update of guidelines for promoting health in schools.
13. IUHPE Guidelines for Promoting Health in Schools.
14. WHO Commission on social determinants of health – final report “Closing the Gap.”
15. IUHPE guidelines updated in 2009.
16. EU implementation of FS 2005.
17. MoH funded 3 year pilot of health promoting schools.
18. MoE pilot of Healthy Community (HC) based on research into how achievement of students in 9 decile 1 secondary school could be improved, HEHA Strategy 2003.
20. IUHPE publication of “The Evidence of Health Promotion Effectiveness.”
22. MoH funded 3 year pilot of Health Promoting Schools.
23. MoE pilot of Healthy Community (HC) based on research into how achievement of students in 9 decile 1 secondary school could be improved, HEHA Strategy 2003.
27. MoH funded 3 year pilot of Health Promoting Schools.