Tracking down ENHPS successes for sustainable development and dissemination

The EVA2 project[1]

Final report

Danielle Piette,[2] Chris Roberts,[3] Marianne Prévost,[2] Chris Tudor-Smith[3] and Jaume Tort i Bardolet[4] in collaboration with Joëlle Hardy[2], Laurence Kohn,[2] Alain Levêque,[5] and Nathalie da Costa Maya and Anne-Sylvie Ladmirant[6]

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[2] School of Public Health, Free University of Brussels.

[3] Health Promotion Wales, now Health Promotion Division, National Assembly for Wales.

[4] Health Services of Barcelona and then Catalan Health Services.

[5] CERESP (Centre de Recherche en Santé Publique – nongovernmental organization attached to the Free University of Brussels).

[6] CDCS (Centre de Diffusion de la Culture Sanitaire – nongovernmental organization attached to the Free University of Brussels).

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The national coordinators and the interviewees were open with the EVA2 scientists, providing information on successes, weaknesses and, in some instances, failures. Moreover, the national and regional support centres organized all visits and interviews and made every effort to facilitate the work of the EVA2 scientists. They responded to many requests for information. Obviously, this trust and good will, for which we are extremely grateful, allowed us to make the best use of the finances available.

This project is an evaluation of the European Network of Health Promoting Schools, a joint project of the European Commission, the WHO Regional Office for Europe and the Council of Europe. Their representatives form the International Planning Committee (IPC) to which the EVA2 project has been accountable. IPC has been supportive of the project and always interested in the information provided, ensuring therefore a challenging but very positive climate.

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Note to the reader

Readers of this report should focus on two points: the purpose of the EVA2 project and the validity of the data. These are discussed in greater detail in section 7. This report focuses on policy development issues in the European Network of Health Promoting Schools. No one should use this document to criticize the approach on the grounds that this report does not show a health impact resulting from the process. Rather, this report indicates that the Network helps education authorities at all levels to set up conditions conducive to the improvement of health and wellbeing in schools, by tackling their individual, social and environmental determinants.

The processes of disseminating good practice to schools improved rapidly in some countries; this made assessing the Network at the end of the EVA2 project difficult. In the intermediary reports (from June and December 1998), the EVA2 scientists were cautious in their classification of the stage of development each project had reached. This prudence probably led to a slight underestimate of development. With this final report, the reverse may be the case. When asked to review the information concerning their network "at the time of the survey", some coordinators corrected the situation, usually in a more positive way. Some clearly indicated that this change occurred after the survey; in other cases, although not indicated by the coordinator, the EVA2 scientists saw that the change occurred after the survey. In a few instances, the EVA2 scientists had misinterpreted the information. When it was not clear if a new version corrected a mistake or reflected a new situation, they decided to give the best presentation of the Network.

The authors have focused most of their efforts on the products that will disseminate as widely as possible the main findings from the project.

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1. Introduction

1.1 Aim and objectives

The EVA2 project aimed to facilitate decision-making about sustained support for and/or dissemination of the European Network of Health Promoting Schools (ENHPS) in the countries of the European Union (EU). Its objectives were:

1. to ask decision-makers and key stakeholders for their assessment of the success of ENHPS in their countries;

2. to provide them with information on the conditions for the support and/or dissemination of the project;

3. to compare the situation in the EU countries, gain knowledge about the institutionalization (sustainable development) of the project and to make recommendations for policy and support at the international level; and

4. to support national teams, where appropriate, in developing their work (capacity building and empowerment evaluation).

The need to develop the EVA2 project was based on the following observations. In 1997 ENHPS comprised pilot schools in 37 countries or regions, presenting a wide diversity of projects. The ENHPS resolution, made at its first conference, states clearly that all children should have the right to benefit from the initiative, so all schools should have the possibility of joining a network. Any well planned dissemination would rely on information showing that ENHPS makes a difference in schools and affects the determinants of health and wellbeing for the school community. Various evaluation projects looking at this had been carried out at the regional, national or international level.

In 1995, the EVA1 project described the evaluation practices at school or national level within ENHPS and a protocol for a lifestyle survey, and proposed process indicators for the school level (on school and classroom management, curriculum development and community involvement). Other international efforts developed evaluation and assessment tools for examining the school health promotion process. These included the evaluation of the development of the health promotion movement in six countries by Canterbury Christ Church University College, the sharing of assessment experiences in the German-speaking countries and the United Kingdom, and initiatives such as that in Norway. Although much information was collected, it was not systematically provided for programme management and activities at the national and international levels. Similarly, no information was provided on how decision-makers view the impact of ENHPS in their countries, or the conditions for increasing support and/or dissemination of the project.

1.2 Conceptual framework

This report does not aim to reiterate concepts of school health promotion or the philosophy of ENHPS. It assumes that readers are familiar with these, and presents a short introduction to the concepts underlying social action and change.

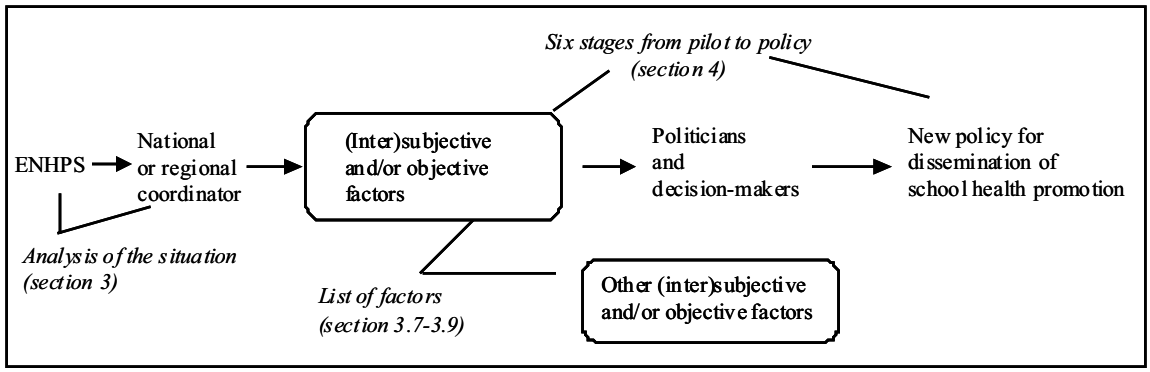
Thines & Lempereur *(1)* defined social action as well organized activities including a vision (translated into goals and planning) and norms (translated into the roles of activists, based on values, perceived norms and models). "Social action, a necessary antidote to the more static and rigid conceptions of structure" is therefore any change in a society resulting from purposeful activities and is traditionally explained by the influence on the activists of (inter)subjective factors (intersubjective factors are shared by two or more people) or by more objective conditions *(1)*. The EVA2 project focused on both the (inter)subjective and objective conditions for change in the education and health systems necessary to ensure the dissemination of school health promotion.

The central group of activists in formal policy development are politicians and decision-makers. They are influenced by factors that were not identified before the EVA2 project started. The EVA2 project was based on the following hypotheses.

- At the end of the pilot phase of ENHPS, some evidence-based evaluation information would exist or could be collected.
- Some of this information would influence politicians and decision-makers.
- The knowledge of conditions likely to influence politicians and decision-makers at the national and regional levels would provide a basis for recommendations at the international level.
- Coordinators would need support to provide suitable information to politicians and decision-makers.

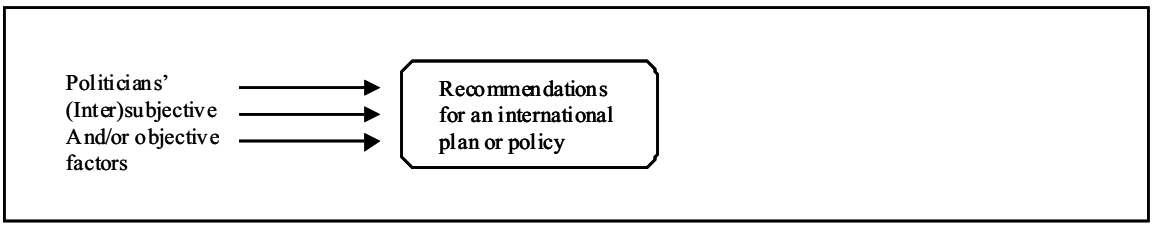
Objective 1 of the EVA2 project was to discover politicians' perceptions of the successes and weaknesses of ENHPS in their country or region, what conditions would convince them to extend the school health promotion approach and how ENHPS could influence these conditions (Fig. 1)

Fig. 1. Objective 1 of the EVA2 project: identification of factors likely to influence politicians and decision-makers towards the development of a sustainable policy for school health promotion.



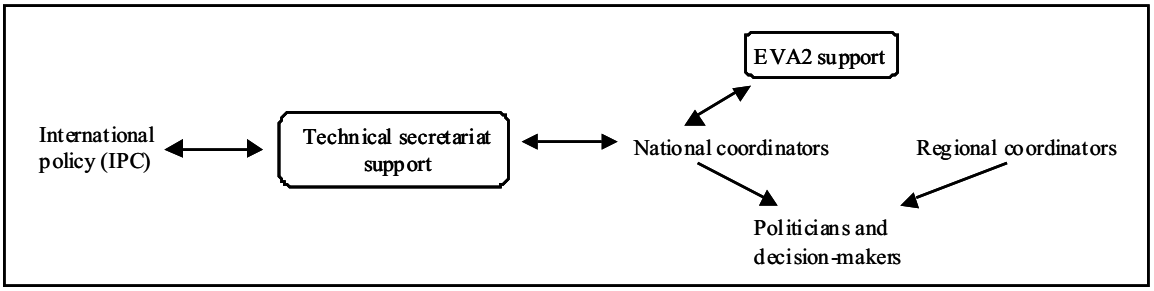
Using the information on the institutionalization of a pilot project (analysis of the conditions required by regions and countries in the EU), the objective 2 of the EVA2 project was to recommend actions for an international plan or policy (Fig. 2).

Fig. 2. Objective 2 of the EVA2 project: international analysis and recommendations for an international policy



Regional and national coordinators represent a second group of key actors. Objective 3 of the EVA2 project was to support the coordinators in their attempts to influence politicians and decision-makers directly or through the Technical Secretariat (Fig. 3).

Fig. 3. Objective 3 of the EVA2 project: support to national and regional teams, if needed, for further development



1.3 Methodology

To meet the first objective, EVA2 scientists interviewed key people, able directly or indirectly to influence action or policy in each country, as identified by the national coordinators using a shortened version of the process described by O'Neill et al. *(2)*. The information collected covered: background and contextual information on the country, ENHPS, conditions for sustainable development and dissemination, and information needs for planning. A country report was written for each visit that provided the basis for the international analysis (objective 2) and for the support to regional and national coordinators (objective 3).

The actions that were developed to fulfil objective 3 are presented in section 6, and concern further interviews, fact sheets on national or regional networks and guidelines for assisting coordinators to diagnose the political situation for sustainable development. This was the capacity-building element of the project, intended to help national teams answer their needs for the dissemination of school health promotion at regional and national levels.

The evaluation of the EVA2 project (section 5) showed that some interviews triggered change in policy development for ENHPS. For example, the interviews prompted key people to ask for more information or to suggest ways in which coordinators could develop a structured and planned dissemination process.

The EVA2 team was accountable to the International Planning Committee (IPC) of ENHPS, which comprises representatives the European Commission (EC), the WHO Regional Office for Europe and the Council of Europe (CE). The EVA2 project was carried out in close collaboration with the ENHPS Technical Secretariat at the Regional Office and national/regional coordinators.

2. Activity report

2.1 Visiting and reporting on the health promoting schools networks

For administrative reasons, the EVA2 project started in November 1998 (instead of July 1998, as planned) and continued to September 1999 (instead of June 1999). Visits to 23 networks in 17 countries were planned. Out of the 23 networks, 2 visits were not possible because ENHPS was not implemented. Two other visits were not completed (only the coordinator was interviewed – twice in the case of Flemish-speaking Belgium). The 19 others were carried out as planned (see Table 1). In four other cases, the interviews were undertaken over two visits (French-speaking Belgium, France and the Basque Country and Catalonia (Spain)). A follow-up visit was organized in two cases (England (United Kingdom) and Finland). The national coordinators have reviewed 17 reports, which were issued as internal working documents to IPC, the Technical Secretariat and the WHO collaborating centre for school health promotion (Canterbury Christ Church University College).

To facilitate openness about ENHPS and its development, the interviewees were assured that the information provided would remain confidential. The EVA2 scientists stated clearly that the report from the network visits would not be circulated or published.

When the visits were made, some coordinators seemed to lack a short presentation of their network in an easy-to-read format. The EVA2 scientists decided in these cases to write fact sheets presenting the key elements of the network and including some of the findings from the EVA2 interviews. Some fact sheets already existed or were felt to be necessary owing to major changes occurring in the organization of networks (for example, in England or Wales). In addition, fact sheets were also written to outline ENHPS and the EVA2 project.

The coordinator from Slovakia developed and reviewed guidelines for coordinators, allowing them to track their progress towards sustainable development.

2.2 Other activities

To provide a basis for studying the national networks, all available documents were reviewed to provide background information before the visits, this information being included in the reports. This review process helped to identify indicators of success used by schools and national teams from ENHPS. Other documents include the guidelines for selecting key people, as well the interview schedules for the coordinators and key people, a list of factors facilitating and hindering progress and a (draft) executive summary presenting the main finding from the EVA2 project.

Meetings between the EVA2 scientists were organized after the pilot interviews to ensure standardization of the methods used by each of the interviewers. Three meetings to discuss the descriptive and analytical findings were held in Cardiff.

Meetings with the Technical Secretariat allowed for informal progress reports, as well as planning future activities. In addition, the EVA2 coordinator met the Technical Secretariat during other events such as the annual business meeting of ENHPS. Presentations based on the EVA2 project were made at three ENHPS meetings and two conferences.

3. Descriptive analysis

3.1 Expected and observed sample

The EVA2 protocol stated that 23 networks were to be studied. As indicated previously, 2 visits were postponed, and 2 others were not completed (owing to difficulties in contacting the networks, as well as a change of coordinator); 19 visits were completed. For the completed visits, the average number of key people interviewed (including the coordinator) was 5–6 per visit.

Table 1. Activity report: visiting country networks

Network	Visit	Date (month and year)	Network report from visit	Report reviewed by the coordinator	Fact sheet
Austria	Yes	5/1998	Yes	Yes	Not really
Belgium (Flemish-speaking)	Some	7 and 8 1998 (difficult to contact; reorganization of the sector)	Short	No	
Belgium (French-speaking)	Yes	12/1997 and 1/1998	Yes	Yes	Yes
Denmark	Yes	10/1998	Yes	Yes	
Finland	Yes	10/1998 and 5/1999	Yes	Yes	Yes
France	Some	10/1998 and 4/1999	Yes	Yes	
Germany	Yes	6-7/1998	Yes	No	Not really
Greece	Yes	5/1998	Yes	Yes	
Ireland	Yes	8/1998	Yes	Yes	Soon
Luxembourg	Yes	5/1998	Yes	Yes	Yes
Netherlands	Yes	3/1998	Yes	Yes	
Norway	Yes	11/1998	Yes	Yes	Yes
Portugal	Yes	5/1998	Yes	Yes	Yes
Spain	Yes	3/1998	Yes	Yes	
Andalusia	Yes	3/1998	Short	Yes (Spanish version)	
Basque Country	Yes	3 and 7/1998	Yes	Yes (Spanish version)	
Catalonia	Yes	3 and 6/1998	Yes	Yes	Yes
Sweden	Yes	6/1998	Yes	Yes	
United Kingdom					
England	Yes	4/1998 and 9/1999	-	No	Existed
Scotland	Yes	4/1998	Yes	No answer	Soon
Wales	Yes	2/1998	Yes	Yes	Yes

Note: No visits were made to Iceland or Italy: the former joined ENHPS in 1999 and the latter has no network yet.

3.2 Description of the interviewees

Twenty-one coordinators were interviewed (Table 2) as well as fourteen representatives from the health administration or ministry. Also interviewed were 31 people from the education administration (including school inspectors) and ministry (including three ministers). Thirteen health educators or health promotion practitioners, or other health workers were also interviewed. The coordinators selected nine teachers from pilot schools or from teacher training schools. Interviews of eight evaluators were carried out. Twelve other interviewees included representatives from parents associations, teachers' trade unions, representatives from health-related nongovernmental organizations (NGOs) and people from an organization hosting a support centre.

Table 2. Description of interviewees

Network	Numbers of people							
	Coordinator	Health adminis-tration and ministry	Health sector	Education adminis-tration and ministry	Education sector	Evaluator	Other	TOTAL
Austria	1	1		1	1	2		6
Belgium (Flemish-speaking)	1							1
Belgium (French-speaking)	1	2		2				5
Denmark	1	1	2	1	1	1		7
Finland	1		1	2	1	1		6
France	1		2	3				6
Germany	1			1	1	2	1	6
Greece	1			2	1		1	5
Ireland	1	1	1	2				5
Luxembourg	1		1	2			1	5
Netherlands	1		1		1	1	2	6
Norway	1	1		2		1		5
Portugal	1	2		1			1	5
Spain	1	1		1			1	4
Andalusia	1							1
Basque Country	1	1	1	2	2		1	8
Catalonia	1	2	1	2				6
Sweden	1			3			3	7
United Kingdom								
England	1	1		2			1	5
Scotland	1		1	1	1			4
Wales	1	1	2	1				5
TOTAL	21	14	13	31	9	8	12	108

This sample comprised a good spread of key people, allowing for different perspectives on ENHPS. The number of people from the education ministry or administration selected by national or regional coordinators shows the major role that these people already play or could play in the dissemination of the principles and practice of school health promotion.

3.3 Quantitative description of the health promoting schools

The research focuses on the schools that were formal members of ENHPS. Table 3 presents data on the number of pilot schools at the beginning of the project, at the time of the survey and at the end of the EVA2 project. In some instances, the survey was conducted towards the end of the work (as in France) and this did not allow enough time for any change to occur (columns 2 and 3). Column 4 provides some information, where available, about schools' interest in the health promoting school approach.

The definition of health promoting school used in this survey is based on the principles of the Ottawa Charter for Health Promotion *(3)*. Health promotion requires a comprehensive approach to a project, problem or solution. This approach is usually wider and requires more participation than traditional health education. Health promotion and health education differ in scope, with the former including the latter.

At the time of the survey, conditions varied widely between countries or regions, which fell into four groups. Some (for example, French-speaking Belgium, Greece and Norway) had well defined networks with very few other initiatives adopting a whole-school health promotion approach (although the practice is being disseminated). Here, ENHPS initiated the approach and could therefore explain the current development of practice. Without the networks, there was no indication that school health promotion would have developed as a specific and comprehensive approach. The situation was quite different in the United Kingdom, where the school health promotion concept and philosophy originated and where many health promoting schools were not part of any network or belonged to a regional network. Local networks of health promoting schools existed in England before the beginning of ENHPS, and school health promotion would have developed in the United Kingdom without it. This was also the case in Sweden where the concept of health promoting school is very close of that of a good school, an approach being adopted by all schools. A third group of countries (such as Finland) are those where school health promotion flourished inside and outside of ENHPS at the same time. A fourth group comprised countries or regions whose network is small, not yet well known and unique (for example, the Basque Country, France and Luxembourg).

School health promotion was spreading in many countries or regions, often from one school to another, with some local networks (whose numbers of schools are unknown) forming around ENHPS pilot schools. This was the case in Denmark and Greece, for example. In contrast, Scotland had no formal network as such, although school health promotion has developed through groups of schools sharing the same project (on nutrition, for example) or on a regional basis.

Table 3. Evolution of the number of health promoting schools attached to the pilot network

Network	Participating schools			Comments on dissemination (May 1999)
	Total	ENHPS beginning	Survey	
Austria	6 130	12	39	300 interested
Belgium (Flemish-speaking)		12	36	School health promotion for all primary schools and first 2 years of secondary schools
Belgium (French-speaking)	2 536	12	18	No information on other health promoting schools but many interested
Denmark	1 680	11	11	Many regional networks
Finland	4 515	75	31	Around 150 others
France		17	25	-
Germany	39 653	29	Different	150-200 participants in new scheme
Greece	6 500	22	35	300-400 in the 58 regional networks
Ireland	4 099	10	40	Other regional networks
Luxembourg	28 secondary schools	3	3	-
Netherlands	10 000	2	0	-
Norway	8 436	10	32	Many interested
Portugal	15 870	10	660	22% of all pupils officially in a health promoting school
Spain	23 174	85	85	New dynamic network in the Canary Islands
Andalusia	-	8	17	-
Basque Country	900	3	3	-
Catalonia	3 939	8	8	-
Sweden	6 000	11	Different	130 (main mailing list); 400 interested by new scheme
United Kingdom				
England	24 573	16	16	Target: 2500 schools now and all in 2002
Scotland	2 800	12 (1996)	Different	Rough estimate in one region: 85% of schools with some school health promotion aspects
Wales	1 909	12	12	Numerous schools are interested

The number of health promoting schools therefore differed between regions, depending on the age of the network, its resources and the dynamism and type of networking (more or less formal) of the team responsible for school health promotion. Teams taking the lead in this matter may come from either health education or health promotion under the health authorities or under the education authorities.

In the future, regions could be surveyed to estimate the number of health promoting schools. For example, the woman responsible for health promotion in one local education authority in Scotland reported a network comprising 20 out of the 200 primary schools and 6 out of the 43 secondary schools. She estimated that, in her area, 100% of the special schools, 90 % of the primary schools and 80% of the secondary schools had some health promotion project (although not always labelled as such). Assuming that primary and secondary schools have similar numbers of pupils, one can estimate that 85% of schools have a health promotion component. In Wales, the coordinator knew of 1 network (with 20 schools) developed in partnership between the health promotion department and the local education authorities, and thought that others existed.

Many coordinators wanted to stress that nearly all schools from their country or regions offered some health education.

3.4 Management of the health promoting schools network

Table 4 summarizes the information in this section.

3.4.1 The support centre

The support centre was located in the education ministry (national or regional level) in eight cases, and in a teacher training institute in one case (Ireland). Five support centres were located in a national or regional health promotion agency and four others in another health institution. Two were situated within a university.

3.4.2 Profile of the coordinator

At the time of the survey, the coordinators had the following background: 12 had been teachers, 6 were social scientists, 1 was a medical doctor and 2 were biologists. In all cases but one (Portugal), the coordinators employed by the education ministry were teachers. Social scientists worked in health promotion agencies or universities. In Portugal, a medical doctor worked in the education ministry and in Finland, Scotland, England and Wales, teachers worked in health promotion agencies.

3.4.3 Steering committee

Only nine support teams or coordinators had a management or steering committee. In at least one case (Flemish-speaking Belgium), the education advisory committee from the education ministry played a similar role. The interviews provide some evidence that having a steering committee helped in developing or disseminating the pilot project. In some cases, however, it was a source of conflict. The recommendation is therefore to set up a steering committee to deal with the issue of the isolation of the pilot network and to facilitate publicity and support. Where information dissemination and alliance building can be achieved by other means, a steering committee may not be needed.

Table 4. Management of the health promoting schools network (at the time of the survey)

Network	Location of support centre	Profile of coordinator	Has a management or steering committee	External evaluation team
Austria	Education ministry	Biologist	Yes	Yes
Belgium (Flemish-speaking)	Health promotion agency	Social scientist	Yes	Yes
Belgium (French-speaking)	NGO (Red Cross)	Biologist	No	Yes, but inactive
Denmark	University	Social scientist	No	Yes
Finland	Health promotion agency	Teacher	Yes	Yes
France	School, then education ministry	Teacher	No	No
Germany	University	Teacher	Yes	Yes
Greece	Institute of child health	Social scientist	No	No
Ireland	Education institute	Teacher	Yes	Yes
Luxembourg	Education ministry	Teacher	No (to start in autumn 1999)	No
Netherlands	Health promotion institute	Social scientist	No	Yes
Norway	University	Social scientist	No	No (internal team)
Portugal	Education ministry	Medical doctor	Yes	Yes
Spain	Education ministry	Teacher	No	Yes
Andalusia	Education ministry	Teacher	No	Yes (nationally)
Basque Country	Education ministry	Teacher	No	Yes (nationally)
Catalonia	Education ministry	Teacher	No	Yes (nationally)
Sweden	Public health institute	Social scientist	Yes	Yes
United Kingdom				
England	Health promotion agency	Teacher	No	Yes, external and internal
Scotland	Health promotion agency	Teacher	Yes	Yes
Wales	Health promotion agency	Teacher	Yes	No (internal team)

3.4.4 Evaluation team

Sixteen networks had evaluation teams (one of which was inactive). In Norway and Wales, evaluators were employed in the support centre. In England, there were external and internal evaluation teams.

3.5 Relationships between health and education ministries concerning health promoting schools

This section is based on established agreements (formal agreements between the health and education sectors, and sources of funding) and on information provided by the coordinators. Table 5 shows the relationships between the health and education ministries concerning ENHPS.

In France, two problems were observed. The first pertains to the centralized nature of the education sector, which made it difficult for a head teacher to be a coordinator as, for administrative reasons, he or she could not easily carry out some actions attached to the coordinator function (such as managing a budget or deciding when to travel abroad). The second problem was the relative lack of interest shown by several education ministers (and civil servants from the ministry) in the project. The coordinator changed during the survey and is now the civil servant from the education ministry with responsibility for health matters. Nobody had attended an ENHPS meeting since 1997.

The problem encountered in the Netherlands is presented in section 4.

In ten cases, the ministers of health and education had a formal agreement focusing on school health promotion. In England, the white paper on public health (which included a section on health promoting schools) was a document from the Government and could therefore be considered a formal agreement, albeit of lesser significance, as school health promotion formed a small contribution to a large document. In Spain, the relationship between the education and health sectors was not always considered very satisfactory but nevertheless offered a basis for intersectoral development.

At the time of the survey, in 9 cases out of 19, there was no formal national or regional health promotion structure (around a national health promotion centre) by which a project could be disseminated. It did not follow that relationships were built instead with NGOs active in the health field. In general, ENHPS was isolated when there was little cohesion between agencies or teams active in school disease prevention and health education or promotion. With the exception of Finland, Scotland and Wales, networks had no relationship with other school health promotion networks.

In some countries, health education was compulsory, often based on drug and HIV/AIDS prevention. Even where this was the case, however, relationships were limited in their development. The pilot phase progressed in relative isolation, with minimal contact with other teams active in health education or health promotion. In most cases, the reason was that the support centre focused all its efforts on the process in the pilot schools, leaving little time for other activities. In some instances, however, competition between ENHPS and other projects contributed to this isolation.

Table 5. Relationship between the health and education sectors at the time of the survey or at the end of the pilot phase

Network	Education sector	Health sector	Informal relationship between the two concerning ENHPS	Formal agreement or relationship between health and education sectors	Relationship with health promotion structure	Continuous relationship with health-related NGOs involved in schools [a]
Austria	Funds	Funds	Yes	Yes	Not relevant [b]	No
Belgium (Flemish-speaking)	Yes	Funds	Yes	No but changing	No but changing	Yes
Belgium (French-speaking)	Yes	Funds	No	No	No	No
Denmark	Funds	No	Yes	No	Not relevant	No
Finland	Yes	Funds	Yes	Yes	Yes	Yes
France		No	No	No	Some	No
Germany	Funds	No		No	Yes, regional	No
Greece	Yes	Funds	Yes	No	Not relevant	No but changing
Ireland	Yes	Yes	Yes	Yes	Yes	No
Luxembourg	Funds	Yes	Yes	No	Not relevant	No
Netherlands			No	No	No	No
Norway	Yes	Yes	Yes	Yes	Not relevant	No
Portugal	Yes	Yes	Yes	Yes	Not relevant	In some cases
Spain	Funds	Yes	Yes	Yes	Not relevant	No
Andalusia	Funds	Funds	Yes	Yes	Not relevant	No
Basque Country	Funds	Yes	Yes	Yes	Not relevant	No
Catalonia	Funds	Yes	Yes	Yes	Not relevant	No
Sweden	Yes	Funds	No	No	Not relevant	No
United Kingdom						
England	Yes	Funds	Yes	Yes	No	No
Scotland	Yes	Funds	No	No	Yes	No
Wales	Yes	Funds	No	No	Yes	No

[a] NGOs different from those forming the support centre

[b] Not relevant: there was no formal health promotion structure

Note: the light grey areas in the first two columns indicated where the support centre was located (health or education sector). The dark grey areas indicated where the EVA2 researcher observed a problem likely to block the development of school health promotion, in ENHPS or somewhere else

3.6 School health promotion criteria

Twelve criteria were offered to schools as a framework for developing health promotion (Table 6). These criteria were originally the following (the list used for the survey):

1. pupils' self-esteem
2. pupils' relationship with staff and each other
3. social goal of the school
4. challenging activities
5. healthy environment
6. relationship between the school, pupils' families and the community
7. link between primary and secondary schools
8. staff health promotion
9. staff's work as role models
10. nutrition and canteen
11. link with a health promotion structure
12. school health services.

In Catalonia, Finland and Norway, all 12 criteria influenced the project. Most networks had some problems with criterion 9, which was not well understood or difficult to operationalize. The network in France even found it opposed to the health promotion philosophy, as it blamed the teachers. When no school services existed, criterion 12 was often adapted to a relationship with primary health care.

In Ireland, the pilot schools addressed all criteria to some extent, with particular emphasis on criteria 5 and 6 (school environment and links between schools and the wider community). These criteria were integral to recently issued curriculum guidance and heavily influenced by the health promoting schools in Ireland. There was no information about how these criteria were implemented by schools outside the network.

Schools in Denmark focused on three major principles: action competence, democracy and an international dimension. While some of the 12 criteria clearly overlapped with these principles, the support team did not see the presentation of health promoting schools strands in 12 criteria as being important to the Danish project. There was another unique feature in Denmark: the IVAC (investigations, visions, actions, changes) approach to school health promotion, which underpinned the pilot network and all regional networks that have developed more recently.

In Scotland, where the concept and practices of health promoting schools were spreading before ENHPS was established, the 12 criteria were seen as a base, not as guidelines. To enter ENHPS, schools proposed a nutrition project within a health promotion framework (nutrition was the key policy theme of the support centre at that time). The idea was to create groups of schools working on the same type of project, whatever the topic happened to be. In addition, the criteria were modified in England to reflect more accurately the level of school health promotion development that has been achieved, as well as to focus more on the school curriculum. In Wales, a thirteenth criterion was added: the health promoting nature of the school environment and the tenth criterion, originally limited to nutrition, was widened to incorporate policy relating to smoking and bullying.

Table 6. Twelve criteria specifically addressed by ENHPS nationally (N), by all schools (A), by most schools (M), by some schools (S), or not addressed (No)

Network	Criterion											
	1	2	3	4	5	6	7	8	9	10	11	12
Austria	N,A	N,A	N,S	N,A	N,S	N,S	N,S	N,S	N,S	N,M	N,S	N,S
Belgium (Flemish-speaking)	A	A	A	A	A	A	S	S	S	M	S	S
Belgium (French-speaking)	N,A	N,M	M	A	M	N,M	S	N,S	S	M	A	A
Finland	N,A	N,A	N,A	N,A	N,A	N,M	N,A	N,M	NO	N,M	N,M	N,A
France	N,M	N,M	N,S	N,M	N,M	N,S	N,S	N,S	NO	N,M	N,A	N,A
Greece	N,A	N,A	N,S	N,A	N,A	N,A	N,S	N,A	N,M	N,M	N,A	N,S
Ireland	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A
Luxembourg	1	1	2	3	3	1	No	1	No	3	3	1
Norway	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A
Portugal	A	A	A	A	A	A	A	A	?	M	A	A *
Spain	Yes	No	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Andalusia	A	M	A	A	M	M	A	S	M	A	A	No
Basque Country	3	2	3	3	2	3	3	No	3	2	3	2
Catalonia	M	M	M	M	M	M	M	M	M	M	M	M
Sweden	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A	N,A
United Kingdom												
Wales	N,A	N,A	N,A	N,A	N,A	N,A	N,S	N,M	N,M	N,A	N,A	N,M

Note: The criteria in Denmark, Germany and England and Scotland (United Kingdom) were changed. For the Netherlands, pilot schools had not been selected by the time of the survey. The numbers given for Luxembourg and the Basque Country reflect the numbers of schools addressing each criterion.

In Sweden, all schools were expected to consider each of the criteria, not to work on all in depth. Nevertheless, the criteria were not felt to have been hugely influential in the development of the Swedish project.

Although the 12 criteria provided the background for the work in Germany, the schools focused on the 9 steps that were thought necessary to pass through from initiating to implementing the health promoting school process.

It should be noted that the 12 criteria are no longer the reference for ENHPS; the ENHPS resolution has replaced them.

3.7 Evidence-based evaluation

During the interviews, key people were invited (unprompted) to explain how they thought ENHPS had been successful in their country or region. Their responses should be looked at seriously, as they represent issues that the interviewees saw to be important and/or because these items represented major successes that would probably be acknowledged by others associated with the network concerned.

The list in Table 7 presents a range of characteristics. The interviewees largely referred to short-term successes. For example, no local impact, such as teachers' satisfaction, was listed by people in a country where a decree has been issued for school health promotion, as it went without saying. Some items (such as pilot schools remaining in the network) were presented as successes by some people, while others reported them as observations (they would not expect drop-outs and therefore do not see this as evidence of success). The list should therefore be seen as indicative and might be useful for designing a quantitative survey to capture success in a more systematic fashion. Table 7 provides an indication of important issues rather than a quantitative estimate. Some general points can be made from the list.

1. The evaluators, teachers and others showed more interest in the impact of ENHPS at the school level than at the national level.
2. Those who felt able to list numerous successes tended to be the coordinators, school inspectors and those who visited a number of schools (both pilot and others) and were therefore able to compare schools.
3. Evaluators who were interviewed were cautious, reluctant to suggest major successes, even when they focused on process instead of impact, as they had little evidence to compare the situation with reference schools (quasi- or experimental design). This might also reflect the fact that evaluations were not yet complete.
4. Items such as improving teachers' health and wellbeing were not mentioned (despite being a focus in some instances, as in 3 schools out of 11 in Norway).

Table 7. Evidence-based evaluation concerning the national level, and pilot schools individually and in comparison with other schools (14 networks)

Signs of success	Coordinator	Evaluator	Health sector	Education sector	Teacher	Other
National level						
Interest from a minister	xx					
Impact on the new curriculum/decree	x		x	xxx	x	
Increased/improved relationship health and education	x		x			
Training			x			
Influence on trade unions					x	
Pilot schools						
Increased relationship/sharing	xxx		xx	xx	xxx	
One school to other schools/regional network				x	xxx	
Individual pilot schools						
Teachers' know-how, teaching, empowerment	x			xxx	xxxx	x
Opening of schools to parents	xxx			xx		
Opening of schools to community	xxx	x		**X**x		xx
Teacher-pupil relationship	xx			x	xx	x
Concept of health; approach to problems	**X**x	x	xx	xxxx	**X**xx	xxx
Pupils' self-esteem	x				x	x
Project by whole schools (all different)	x	x		xx	x	
General satisfaction			x			x
Change in teachers' role (working together)		x			x	
Health coordinator in each school		x				
International dimension	x				x	
Pilot schools compared with others						
Atmosphere, ethos					x	
Type of activities, methodology				xx	x	
Coherence in the project				xxx		

Note: An x represents a response from one or more people within a network. An **X** represents at least five small x's, and xxxx, at least four responses

3.8 Indicators

This section is developed from the evidence-based evaluation materials included in all country reports. The indicators relate to steps towards a decision-making framework for sustainable development (see section 4) and more should be added to create a comprehensive list.

Another input needed to define indicators is the objectives of each network. Not all networks had the same short- and medium-term objectives. Some countries had already integrated the school health promotion approach and were focusing on improvements in the quality of their work while others were trying to reach consensus on the health promotion concept. Nevertheless, a small number of generic indicators useful across the networks can be proposed.

Different steps should be identified for building indicators (Table 8):

- the vision, based on what a health promoting school is (or at least should be), which could be summarized by the ENHPS resolution;
- the broad objectives or criteria, based on the list of 12 criteria (amended to reflect the ENHPS resolution); and
- standards, where possible (operationalizing the objectives).

Indicators identified to reflect standards should also reflect the stage of development of the project in the country or region: pilot, institutionalization or sustainable development. They should also reflect the level of observation (school or national) and of their use as objectives: standards may differ from one level to another.

Indicators can also be derived from the analysis of the EVA2 data gathered from the interviews. Table 9 presents such indicators, although these have yet to be linked to vision and objectives.

3.9 Perceived problems of ENHPS

The comments in section 3.7 concerning the methods used to collect evidence of success apply to this examination of problems (Table 10) as well: unprompted responses carrying some importance, non-exhaustive list, qualitative interpretation with some estimate of the common characteristics between countries. Frequently observed comments include: the emphasis of the curriculum on literacy and numeracy, the lack of resources in the education system and the lack of planning skills in the coordinators (such as skills for managing a regional network, developing policy and liasing with others). Other items, mentioned less frequently but still important, included the acknowledgement that the coordinator may need a new role once the network is integrated in the education system, and that pedagogical material, related to topics such as drugs or HIV/AIDS and congruent with a health promotion approach, was lacking, as was differentiation between health education and health promotion.

Table 8. Example of vision, objective, standard and indicator

Vision	Objective or criterion	Standard	Indicators
Democracy	Involvement of parents	Parents' association in all schools	Parents' association in all schools
		Parents associated in decision-making	% decisions made with input from parents
		Parents associated in implementation	Change in the number of parents involved over time

Table 9. Indicators used at national/regional and school levels

Objective	Standard	Indicator	Comments
National/Regional level			
Relevance to needs	Schools stay in the network (no drop-outs)	% continuity (number of schools/number of schools that started)	Comparison with other pedagogical networks
	Variety of projects	Number of different projects on number of schools	Compared with projects from other networks
Impact	Change of policy in favour of school health promotion, such as health promotion in the curriculum	New mention of health education, health promotion, network of school health promotion, ENHPS	Could be in the education policy, other policies or whole government policy
	Money for dissemination	Whether is available, for how many years, in what amount	Trends
	Absenteeism	Trend in pupil and staff absenteeism in health promoting schools	Compared with similar schools
	Skills, methodology of staff in developing project	% applications for funding coming from health promoting schools	Compared with other schools
		Coherence of projects	Assessment by school inspectors
Visibility	Publicity of evaluation results		
School level			
Impact	School policy	New health-related policy since joining the network	Schools should not have a tradition of defining policy
Visibility	Publicity of evaluation results	Documents, meetings	
Structure	Improvement of school structure	New health team, coordinator or communication channels since joining the network	
Commitment	Involvement of school board	Declaration, attendance of head teacher and others	

Lack of resources applied both to the support centre and the education system as a whole, but not to individual schools. People usually felt that schools could not be paid for developing health education or health promotion, as activities were likely to stop with the financing. Schools should receive and could benefit from support, training, information and time, but not necessarily money.

Differences appear among different groups of key people in Tables 7 and 10. For example, evaluators did not seem concerned with dissemination, and people from the administration and ministry of education usually had a broader and better view of ENHPS than those from the health sector.

3.10 Anchoring health promotion in education policy or programmes

People were asked where health education and/or health promotion could be integrated in the education curriculum or specific programmes. Different possibilities were observed (Table 11), depending on whether national-level programmes made use of:

1. specific topics (for example, in Greece and the United Kingdom): when some teaching is explicitly devoted to health (often drugs and HIV/AIDS or reproductive health in secondary schools and nutrition or injury prevention in primary schools);

2. transversal or cross-curricular topics (for example, in Portugal and Spain): when health is included with other topics such as democracy or ecology, as a theme that should be covered by compulsory topics such as language or biology;

3. personal, affective or social education (for example, in the United Kingdom), education on religion or ethics (for example, in Belgium), civic education (for example, in Greece), which addresses topics such as democracy, tolerance and some determinants of health, such as self-confidence and communication skills;

4. free curriculum time (for example, in Portugal, Greece): when schools had to define the content of some school time that could be allocated to formal teaching, sport, art or any project (concerning, for example, health or ecology);

5. compulsory school projects: when each school had to define a project every 2–3 years involving the whole school community (all pupils and staff); and

6. other possibilities, including awards, extracurricular activities or freedom for teachers to devote some hours to any topics or activities.

Table 10. Problems with ENHPS: general and related to the education system, network management and dissemination (14 networks).

Problems	Coordinator	Evaluator	Health sector	Education sector	Teacher	Other
General						
General cut in public services	x					x
Education system						
Organization of school system (time at school)	x		x	xx	x	x
Bureaucracy	xxx					x
Too much pressure for formal curriculum	xx			**X**xxx	x	x
System with no possibility of change	xx				x	x
Teacher status (too low)	xx				x	x
General lack of resources	xxxx	x	xxxx		xx	
General health education/health promotion situation						
Lack of health education or health promotion mention in the curriculum	x	x			x	
Competition between health project	xx	x	x	xx	x	xx
Lack of health promotion materials (related to drug, etc.)		x	x			x
Lack of differentiation between health education and health promotion	xx		xx	x	x	x
Lack of teacher training in health education/health promotion	x	x	xx		xx	x
Network management						
Isolation:						
• no attention to guidelines etc. from outside		x		xx		
• lack of partnership health and education	xxxx		xx	xx		x
• lack collaboration with other networks	x			xx		x
• not enough sharing of decision-making				x		
• lack of international dimension in regional network	xx			x		
• not enough involvement of parents			x	x		xx
Coordinating skills:						
• lack of planning skills	xx	x	**X**x	**X**xx		
• lack of management of regional net (big country)	xxx		x	x		
Other:						
• not enough resources for the support centre	x		x	x		
• not enough attention to training inspectors				x		
• lack of attention to health content		x	x			
• lack of attention to pedagogical content		x				

Dissemination					
Too-small coverage of the project	x		x	xxx	
Cost of an intermediary dissemination structure				xx	
Keeping the international dimension	xx			xxx	xx
New role of the coordinator (outside education system)				xx	
Keeping the sharing between schools in extended networks					x
Quality standard in extended networks				x	
Lack of international incentives	xx		x	x	

Note: An x represents a response from one or more people with within a network. An **X** represents at least five small x's, and xxxx, at least four responses.

Table 11. Possibilities for the integration of health into the formal (compulsory or not) school programme

Network	Specific topic	Transversal topic	Social education	Free time	School project	Other
Austria	x	x	x		x	
Belgium (Flemish-speaking)	x		x		x	
Belgium (French-speaking)	x		x			
Denmark						
Finland	x	x	x	x	x	x
France		x				
Germany		x				
Greece	x	x	x	x	x	x
Ireland			x			
Luxembourg	x	x		x		Spiral curriculum[a]
Netherlands	x	x	x	x	x	
Norway		x	x	x	x	
Portugal	x	x	x	x	x	
Spain		x				
Andalusia		x				
Basque Country		x				
Catalonia		x				
Sweden	x	x	x			
United Kingdom:						
England	x		x			x
Scotland	x		x			x
Wales	x		x			x

[a] A spiral curriculum revisits subjects throughout the education process.

The ideal situation would be to set up health promotion projects with some time devoted to them in the curriculum, both specifically and/or integrated into basic teaching, as well as in social education. When health is not a compulsory topic, it must often compete with other important topics, such as democracy, preparation for working life, ecology or civic education.

In addition, no single programme or curriculum for health education or health promotion could be developed for use throughout Europe. Health needs to be more methodically integrated with education in different situations; issues include:

- programmes;
- how to cover types of activities that are not compulsory;
- how to review the curriculum (guidelines for school inspection); and
- minimum standards for teacher training.

3.11 Distinguishing characteristics of ENHPS

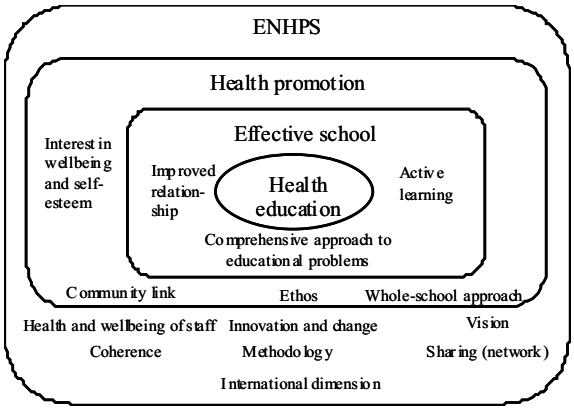
National or regional coordinators and the other interviewees were asked what the differences were, if any, between ENHPS in their country or region and other school health promotion projects or other health-related networks. Identifying the specific features of ENHPS seems important to put forward reasons for supporting its development and to build a strong innovative identity.

Some key people, including coordinators, found it difficult to name the distinguishing characteristics of ENHPS. Schools' inspectors answered much more easily and gave interesting answers: they and health promotion practitioners mentioned coherence, vision and methodology. Because these people often visit all schools in particular areas, they were in a position to make comparisons. Sharing of ideas and the international dimension were the most frequent answers. The criteria concerning the health of school staff was also a specific interest of ENHPS, but few raised it as a key difference.

Projects sharing characteristics with ENHPS were mainly the safe schools project in the Netherlands (which could be seen as a health promoting school set up to prevent violence and focusing on a narrower topic than ENHPS), the effective school (in the United Kingdom) and the environment school movement (in Sweden).

These comments, as well as Fig. 4, concerned the pilot network. In the dissemination phase, some projects thought carefully about the name (for example, in Norway) or adapted the process. The main example of the latter is probably the local healthy schools scheme in England, where the work focused on building an interdisciplinary team at the district level (at least with the health and education team) to develop school health promotion. In Germany, too, the main principle was the organizational development of the schools (the OPUS project) with a dimension recently emphasized: opening up to other partners.

Fig. 4:



3.12 Information needs

People with responsibility for decision-making were asked what information they wanted or needed to support ENHPS in their country or region. Directors of education clearly said that they would reallocate existing resources or even find some additional resources where projects clearly solved a problem, helped reach specific objectives or met policy requirements. These vary from one country to another and include: the efficiency of using schools' free curriculum time, the efficiency of integrating health as a transversal topic, the improvement of teaching methods and the link with parents and the community. Once they were convinced of the relevance of ENHPS, they were concerned with the feasibility of extending the work and the support structure needed to do so, including the costs of dissemination and ensuring the quality of school projects.

Directors or senior civil servants in the health sector required information on the impact of school health promotion on health (mental health and wellbeing), the determinants of health (such as smoking) or the possible increased of efficiency of preventing drug use if carried out in a health promoting school setting. Two asked for information about the relationship at the local and regional levels between health and education professionals.

If a country or region has enough resources and competences, it seems relevant to provide both the education and health sectors with an evaluation adapted to their objectives and policies. Before the EVA2 project, however, little attention was paid to the wishes or information needs of the education and health authorities. The evaluation questions were defined by those promoting a project or by scientists. As well as fulfilling the needs of national and international agendas, evaluation should ideally document the impact and process of school health promotion, as defined by the people involved in the projects, such as staff, pupils, families, communities and (school) health services.

3.13 Miscellaneous

Table 12 presents information on: the existence of a school inspection system, the publication of school health promotion guidelines (which could benefit all schools) by the support centre or other structure, and any work undertaken with a teacher training school.

Table 12. Miscellaneous

Network	School inspection	ENHPS guidelines for school	ENHPS works with schools for initial teacher-training
Austria	Yes	Yes (decree)	No (only with teachers from ENHPS)
Belgium (Flemish-speaking)	Yes	Yes	No
Belgium (French-speaking)	Yes	Yes	Yes
Denmark	No	Yes	Yes
Finland	No, self evaluation	Yes	Yes
France	Yes	No	No
Germany	No	Yes	No, but developing
Greece	No	Yes	Yes
Ireland	Yes	Yes	Yes
Luxembourg	No	No (in preparation)	No (but all training session opened to any teacher)
Netherlands		No	No
Norway	No	Yes (new national curriculum)	Not yet
Portugal	Yes	Yes	Yes, sometimes
Spain	Yes	No	Yes
Andalusia	Yes	Yes	No
Basque Country	Yes	No	No
Catalonia	Yes	No	No
Sweden	No	No	Yes
United Kingdom: England	Yes	Yes	No
Scotland	Yes	Yes	Yes
Wales	Yes	Yes	Not yet

4. Sustainable development

4.1 Introduction

To examine the stage of development of ENHPS in the EU in more detail, it is necessary to introduce and define some concepts: diffusion, dissemination and sustainable development. In this context, diffusion is the process of providing information either formally (through mass-media campaigns, etc.) or informally (from one person to another) while dissemination refers to the process of developing good practice or improving a wider audience's understanding of the health promotion approach. Observation of the development of ENHPS in the EU indicates that sustainable development may take various forms.

The first possibility is ensuring the conditions for continuing a pilot project, or making the project independent of external conditions. In other words, whatever happens to the support centre or the network, the project continues in the pilot schools, as everyone is convinced of the benefits and sees the value of having a lasting structure. This structure ensures continuity and a way forward with local resources. Second, some of the knowledge gained from the pilot project can be used to benefit others: for example, by training teachers from other schools or by convincing a teacher training institute of the need to integrate health promotion in the curriculum. In this case, dissemination concerns an isolated aspect of the school health promotion approach, and/or is carried out on an informal basis (no policy for all), or may not last for very long. A third possibility for sustaining the development of school health promotion is to disseminate the approach to other schools, informally and voluntarily (for example, by increasing the size of the network).

Fourth, a policy can be developed to sustain some aspects of school health promotion (for example, by requiring the inclusion of health promotion in teacher-training curriculum or a commitment to increasing pupils' self-esteem in all schools). Finally, a comprehensive process of school health promotion can be developed and offered to all schools. In this case, a new policy is likely to be necessary to involve all schools, on a compulsory or voluntary basis.

The dissemination of ENHPS has four phases, with EVA2 concentrating on the second:

1. pilot phase
2. decision-making to set up the conditions for dissemination
3. sustainable development
4. full integration.

The third phase emphasizes information, training, quality assurance and evaluation. This is followed by the integration of school health promotion in the curriculum and management of all schools. This phase is achieved when school health promotion is no longer seen as an innovation, but is accepted as standard practice in the education sector. The integration of topical health education should start during phase 3 and become common practice during phase 4.

4.2 The types of sustainable development observed in ENHPS

The five types of development observed in ENHPS include:

1. lasting conditions in pilot schools;
2. isolated benefits to outsiders;
3. informal dissemination of school health promotion on a voluntary basis;

4. policy to sustain benefits to outsiders: and
5. policy for the dissemination of school health promotion (to offer school health promotion to all schools).

The EVA2 project was largely concerned with the fifth possibility: the process of decision-making after the end of the pilot phase. This classification is somewhat arbitrary, as, for example, it places the informal dissemination of the school health promotion approach before a policy to ensure that some aspect of it is used by all schools. This was not a problem, however, as this classification did not present a linear path that must be followed: one can go from 1 to 2, 4 and 5, etc. Table 13 presents the situation as observed at the time of the survey. The overall picture probably improved after the survey.

Information was provided for the 21 networks visited. In 17 networks, it was estimated that pilot schools would continue (or have continued in some cases, such as France) to adapt the health promoting schools approach, no matter what happened in the health or education sectors. Twelve coordinators had offered some activities to school communities outside the network, for example, by accepting teachers from non-pilot schools in training sessions, disseminating material (such as the manual for affective development) or integrating health promotion in initial training of teachers in one school. In 14 cases, the size of the network had increased or there was an informal spontaneous dissemination around the pilot schools.

So far, a policy ensured the existence of some school health promotion aspects (such as a compulsory curriculum in school health promotion in teacher-training schools) in three cases. In three cases (at the time of the survey) and in ten cases (by May 1999), a policy was in place for all schools to become health promoting schools. In four cases, the policy resulted in different content (such as new scheme, awards): the diffusion was adapted to the specific circumstances.

As noted before, a network could go from type 1 to type 5 without any other intermediary development, but this does not mean that all schools could move directly from the pilot phase to sustainable development. In the United Kingdom, school health promotion is now developed through other initiatives than regional networks. In Norway, for example, it could be done via training teachers and/or health professionals and integrating health promotion into a range of other projects; since the EVA2 visit, support to implement national policy has been available.

4.3 Towards a policy for sustainable development

4.3.1 Six-stage process

The process of moving to a policy for sustainable development has been separated into six stages: identity, information, credibility, relevance, feasibility and policy (Table 14). This last stage encompasses both the decision to draft a policy and the adoption of the policy. Differentiating these two elements of the final stage could become necessary. The EVA2 project did not address the implementation of the policy and future development.

Table 13. Types of sustainable development in ENHPS (at the time of the survey)

Network	Sustained pilot schools	Benefits for outsiders	Informal dissemination of school health promotion	Policy to sustain some benefits	Policy for dissemination
Austria	Yes	Yes	Yes	Yes	No
Belgium (Flemish-speaking)	Yes	Not yet	Yes	Yes	No
Belgium (French-speaking)	Yes	Yes	No	No	No
Denmark	Yes	Yes	Yes	Yes	No
Finland	Yes	Yes	Yes	No	No
France	Yes	No	No	No	No
Germany	Yes	Yes	Yes	No	Yes
Greece	Yes	Yes	Yes	No	No
Ireland	Yes	Yes	Yes	Yes	No
Luxembourg	Yes	No	Yes	Not yet	No
Netherlands	No	No	No	No	No
Norway	Yes	Yes	Yes	In progress	No
Portugal	Yes	Yes	No more at present	Yes	Yes
Spain	Yes	No	No	No	No
Andalusia	Yes	No	No	No	No
Basque Country	Yes	No	Yes	No	No
Catalonia	Yes	No	No	No	No
Sweden	No	No	No	Yes	Yes
United Kingdom: England	No	Yes	Yes, but[a]	No	No
Scotland	Not relevant	Yes	Yes	No	No
Wales	Yes	Yes	Yes	No	No

[a] Yes, but: yes, but with a different project.

Table 14. Stages and indicators of the process towards a sustainable policy

Stages	People concerned	Examples of indicators
1. Identity	Those who know the project well (all of them): teachers, person responsible for national or regional health education or promotion, school inspectors	Saying and explaining what works and why Reporting on the satisfaction of those involved, etc.
2. Information	Key decision-makers and politicians: all of them	Key people provide a piece of information mentioning activities and responding positively to them.
3. Credibility	The key people who really have power, and in any case, someone with the highest rank in the education sector (from the government or a director of education) The process of selection of key people works as those persons were interviewed in countries when stage 2 was reached	Key people express interest and a desire to know more.
4.Relevance	The key people who really have power, and in any case, someone with the highest rank in the education sector (from the government or a director of education) The process of selection of key people works as those persons were interviewed in countries when stage 2 was reached	People say why they are interested by school health promotion in relation with the education policy or the solving of problemsencountered in the education sector. They should express the wish to see, for this reason, the project extended to all schools.
5. Feasibility	The key people who really have power, and in any case, someone with the highest rank in the education sector (from the government or a director of education) The process of selection of key people works as those persons were interviewed in countries when stage 2 was reached	The different possibilities to extend the network are discussed and at least one possibility is proposed as feasible; this is a planning stage.
6. Policy	No specific people are concerned here	There is a policy already accepted but not necessarily implemented.

The task for the first stage is to ensure a positive image for the pilot project among those aware of the work. In the EVA2 study, these people were not necessarily politicians or decision-makers. Most of those who knew of the project, however, viewed it as worth while.

When politicians and decision-makers perceive this positive identity, stage two has been reached: the information stage. This does not necessarily mean that coordinators had informed various groups of people, but that key people were aware of the project.

Key people's knowledge of some of the benefits arising from the project or interest in its characteristics represented progress to the following stage: they showed interest in the project and attached some credibility to it.

When this interest was focused on some specific characteristic(s) that provided answers to some specific problem or objective of politicians and decision-makers, the fourth stage had been reached: relevance. The ENHPS project helped to fulfil some policy of the education sector, either directly (for example, if schools were encouraged to develop projects for the whole school community) or indirectly (for example, because it brought coherence to transversal topics in the curriculum). This is why, at that stage, politicians and decision-makers will be convinced that the project should be extended to all schools.

Stage 5 was reached when politicians and decision-makers were convinced of the feasibility of either extending the network (or regional networks) or setting up a structure to support the offer to all schools to become health promoting schools. The last stage concerns making a decision to develop a policy ensuring the widest possible development of school health promotion practice.

4.3.2 Situation in the EU

Interviews of those with senior positions and the greatest knowledge of the networks allowed an examination of the stages of decision-making towards policy extending school health promotion to all schools. Sweden and England, Scotland and Wales were exceptions in the sense that school health promotion would have been developed there even without ENHPS. Nevertheless, ENHPS had some impact on the definition of the project. The perception of relevance by politicians and/or directors of education is identified as a key point for making progress.

The results presented in Table 15 are based on observations at the time of the survey and those in Table 16, in May 1999 or later. The analysis revealed that development of ENHPS was slow (sometimes blocked) at various stages. The passage from interest to relevance was described as the most difficult and time-consuming development. This is the key point for improvement and support.

There was no positive identity attached to the network in France, the Netherlands, Spain, partly Finland and perhaps Catalonia. This situation could be improved in the short term without help in Catalonia and Finland, but probably not in the other three. No senior civil servants or politicians were informed in Luxembourg, where ENHPS had started without any agreement between the ministers of education and health. Interest and credibility, but not relevance, had been reached in Greece, where the situation was likely to improve slowly without external assistance.

Table 15. Stages of adoption of a policy for sustainable development at the time of the survey

Network (N=21)	Identity	Information	Credibility and interest	Relevance	Structure (feasibility)	Sustained development (policy)	International action needed
Austria	Yes	Yes	Yes	Yes	Nearly	Nearly	
Belgium (Flemish-speaking)	Yes	Yes	Yes	No			
Belgium (French-speaking)	Yes	Yes	No				
Denmark	Yes	Yes	Yes	Yes	Yes	Nearly	
Finland	No	No					
France	No						Yes
Germany	Yes	Yes	Yes	Yes	Yes	Yes	
Greece	Yes	Yes	Nearly				Yes
Ireland	Yes	Yes	Yes	Yes	Nearly	No, but[a]	
Luxembourg	Yes	No					Yes
Netherlands	No						Yes
Norway	Yes	Yes	Yes	Yes	Nearly	No	
Portugal	Yes	Yes	Yes	Yes	Yes	Yes	
Spain	No						Yes
Andalusia	Yes	Yes	No				
Basque Country	Yes	Yes	Yes	No			
Catalonia	Yes	No					No (Spain's is enough)
Sweden	Yes	Yes	Yes	Yes, but[b]	Yes but	Yes, but	
United Kingdom:							
England	Yes	No, but	No, but	No, but	No, but	No, but	
Scotland	Yes	Yes	Yes	Yes	Yes	No, but	
Wales	Yes	Yes	Yes	Nearly	No, but	No, but	
Total[c]	17	14 (+1)	11 (+2)	7 (+3)	4 (+6)	3 (+6)	

[a] No, but: no, but progressing towards it.
[b] Yes, but: yes, but with a different project.
[c] Total number of network completing a stage (plus those embarked on it).

Table 16. Stages of adoption of a policy for sustainable development in May 1999 or later (after the survey)

Network (N=21)	Identity	Information	Credibility and interest	Relevance	Structure (feasibility)	Sustained development (policy)	International action needed
Austria	Yes	Yes	Yes	Yes	Nearly	Nearly	
Belgium (Flemish-speaking)	Yes	Yes	Yes	No			
Belgium (French-speaking)	Yes	Yes	No, but[a]				
Denmark	Yes	Yes	Yes	Yes	Yes	Nearly	
Finland	Yes	Yes	No, but				
France	Yes	Yes	Yes				Yes
Germany	Yes	Yes	Yes	Yes	Yes	Yes	
Greece	Yes	Yes	Yes	Yes	Nearly		Perhaps[b]
Ireland	Yes	Yes	Yes	Yes	Nearly	No, but	
Luxembourg	Yes	Yes	No, but				Perhaps
Netherlands	No						Yes
Norway	Yes	Yes	Yes	Yes	Yes	No, but	
Portugal	Yes	Yes	Yes	Yes	Yes	Yes	
Spain	?						Yes
Andalusia	Yes	Yes	No				
Basque Country	Yes	Yes	Yes	No			
Catalonia	Yes	No					
Sweden	Yes	Yes	Yes	Yes	Yes	Yes	
United Kingdom: England	Yes	Yes	Yes	Yes	Yes	Yes, but[c]	
Scotland	Yes	Yes	Yes	Yes	Yes	No, but	
Wales	Yes	Yes	Yes	Yes	Yes	Yes, but	
Total[d]	19	18	14 (+3)	11	8 (+3)	5 (+5)	

[a] No, but: no, but progressing towards it.

[b] In Greece and in Luxembourg, lack of differentiation between health promotion and health education means a possible lack of a comprehensive approach to health and wellbeing.

[c] Yes, but: yes, but with a different project.

[d] Total number of network completing a stage (plus those embarked on it).

At the time of the survey, a variety of factors played a reinforcing role in explaining such problems: the size of the network (too small in the Basque Country and Luxembourg), heavy bureaucracy (in France, Greece and Spain), lack of differentiation (and understanding) between health education and promotion (in France, Greece, Luxembourg, the Netherlands and Spain), poor understanding of the dissemination process by coordinators, and a lack of effective working relationships between the support centre and the health and education administration. In the Netherlands, the competition between projects and agencies, as well as other characteristics (lack of perceived pedagogical credibility from the education sector for the agency hosting the support centre and lack of funds), made it difficult to market ENHPS.

It is difficult to say whether the education system was in transition in every country, but changes were underway in many countries at the time of the survey (for example, school programmes in Greece and school programmes and regionalization in Spain). These changes could be used as leverage for introducing school health promotion. Other strategies (such as a pedagogy using the Internet) may be investigated.

Fig. 5 and 6 present a global picture (with no mention of the name of the network) of the development of phase 2 at the time of the survey and in May 1999.

Fig. 5. Stages of decision-making towards a policy for sustainable development, at the time of the survey

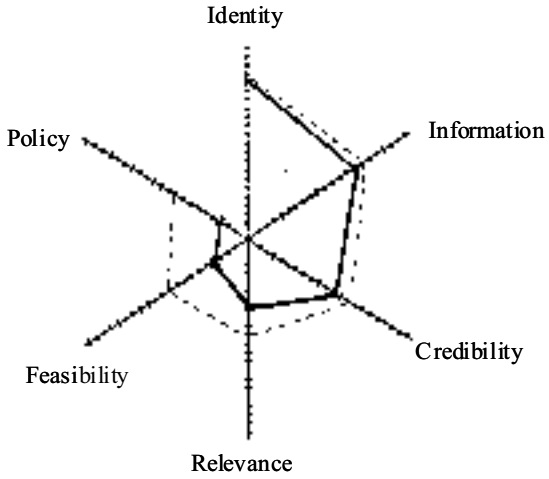
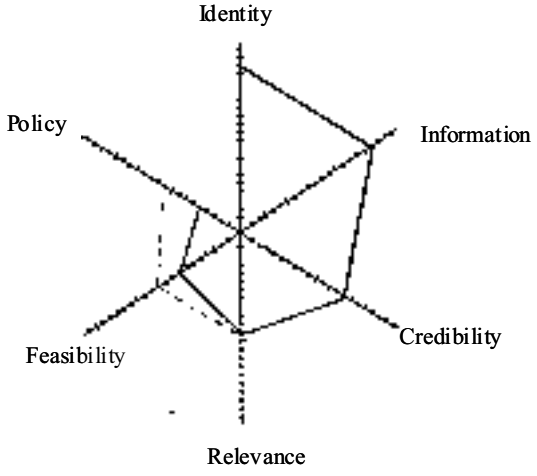


Fig. 6. Stages of decision-making towards a policy for sustainable development, in May 1999



5. The evaluation of the first objective of the EVA2 project

Evaluation in each country or region started and, as often as possible, finished with a discussion between the coordinator and an EVA2 scientist. A few weeks or months after the survey, the EVA2 team sent a report with a concluding section summarizing the comments, conclusions and recommendations drawn from the interviews. The coordinator could then review the report. Once the changes suggested by the coordinator (minor except in one case) had been integrated into the report, the final draft was forwarded to the coordinator, IPC, the Technical Secretariat, the WHO collaborating centre at Canterbury Christ Church University College and the EVA2 team. The report and in particular the ensuing discussion provided the coordinator with a series of proposals intended to assist the dissemination of school health promotion in the country or region.

During spring 1999, a first draft of sections 2–4 of this report was sent to the coordinators to check the data concerning their networks. Coordinators were not asked to comment on the discussion and recommendations. An evaluation form accompanied the draft in 19 cases. It was not sent to the two networks where only the coordinator was interviewed (Andalusia and Flemish-speaking Belgium). Four other evaluation forms were not included because the coordinators did not answer or the evaluation was not completed in time.

Without exception, the responding coordinators described the report for their network as moderately or completely accurate (Table 17). Discrepancies largely concerned the education system, which proved quite difficult to summarize in some countries or regions. The EVA2 scientists, however, believe that providing such background material was of benefit, giving a flavour of the country or region before the interviews. This material was never intended to be published.

The EVA2 project had numerous positive effects. For example, two coordinators said that a budget was allocated to them following the EVA2 visit to their network.

Table 17. Evaluation of the EVA2 country visits by coordinators

Network	Country report	Information from the interviews	Conclusion from the EVA2 scientist	Changes after the eva2 results	Comments
Austria	Mostly/Moderately accurate	Not very useful	Not very interesting	No	Own evaluation just before the EVA2 visit
Belgium (French-speaking)	Mostly/Moderately accurate	Useful (information about key people)	Interesting (external view) and not very interesting (too superficial)	Yes, some (methodology, indicators)	Coordinator has changed and interviews served as a pilot
Denmark	Completely/Mostly accurate	Useful	Interesting	No, as already in the same direction	Clear and fair description; nice work
Finland	Mostly/Moderately accurate.	Report not very useful but discussion with EVA2 scientist very useful	Interesting view from outside	Yes, a bit (reorientation of objectives)	Need more time to understand the report
Greece	Mostly moderately accurate	Useful	Interesting	Yes, some	It was useful
Ireland	Completely accurate	Very useful (future planning)	Interesting	No as in the same direction	Useful process
Luxembourg	Mostly/Moderately accurate	Very useful (information on key people; new involvement of those interviewed)	Interesting (external opinion)	Yes, a bit (adoption of a more comprehensive approach)	Good timing with other events
Netherlands	Completely accurate	Useful	Very interesting	No; different from ENHPS	
Norway	Completely accurate	Very useful (information on key people)	Interesting (confirmation of own conclusion)	No, not yet (report to be discussed)	EVA2 = positive incitement and interest raised
Portugal	Mostly/Moderately accurate	Useful (information on key people)	Very interesting (different view)	Yes, a bit (adaptation to key people interests)	Strategically interesting; good feeling of being part of a [WHO Regional Office for Europe] project

Spain	Mostly/Moderately accurate	Useful (information on key people)	Interesting (future planning)	Yes, some (confirmation of own conclusion)	
Basque Country	Completely accurate	Useful (planning the dissemination)	Interesting	Yes, some (future planning more concrete and precise)	EVA2 is a good project
Catalonia	Mostly/Moderately accurate	Very useful	Interesting	Yes, some	Very good understanding of a complex situation
Sweden	Mostly/Moderately accurate	Useful	Interesting	No	Done before with similar conclusions
United Kingdom: Wales	Mostly/Moderately accurate	Useful (information on key people)	Interesting	Yes, some (more time for the network; 2 days meeting for all allies)	

6. Discussion

6.1 Methodology

6.1.1 Relevance of the approach

The methodology was developed to meet the project objectives of examining the information needs of decision-makers, comparing the situation across EU countries and gaining a better understanding of the processes involved in the sustainable development of school health promotion. The project went beyond identifying information needs by defining the steps involved in moving from a pilot project towards a policy for dissemination of health promotion practice.

The country visits were generally organized without major problems, although making the arrangements was a time-consuming exercise for the EVA2 team and the coordinators. Arranging all interviews from a country or region in a two- or three-day period was nevertheless easier than expected. People responded openly during the interviews and gave the time required to cover all the topics. Working with the coordinator before and after the interviews with key people was very helpful in preparing for the interviews and obtaining additional information where needed. It also provided an opportunity to discuss with the coordinator some recommendations that might otherwise be unclear.

The fact that coordinators suggested only minor changes to the reports reflected a good level of understanding of the situation in each country. To date, the background information (prepared from various existing documents) from only one country has been seriously modified, as the coordinator wanted to correct mistakes found in books and documents. In one other case, the report was delayed owing to major problems between the people interviewed: the coordinator wanted to answer critics (conflict between people involved in this network) and one key person wanted to be interviewed again. A degree of conflict, however, is not surprising.

Another methodological issue relates to the difficulties faced by the EVA2 team in drawing relevant recommendations on international policy, given a lack of awareness of the policies, objectives and possible actions of the organizations represented on IPC. A study (similar to this work in the networks) could be made with international organizations and could provide a basis for more relevant recommendations.

A further issue was the presence of five interviewers, three of them undertaking fewer than three country visits. This limited number of visits did not allow the researcher to become fully involved in the comparative data analysis (objective 2). The other problem attached to the relatively large number of researchers was the different timing of the visits. This resulted in differing speeds and paths in the level of understanding of the dissemination process. Questions not foreseen during the planning phase were progressively added, and the data have been included where possible.

6.1.2 Further use of the protocol

The same approach could be used in other countries (those in central and eastern Europe for example) or in the same countries to study the development of policy in other areas. The visits were not always beneficial for the coordinator. As would be expected, some did not need the survey to understand the process of dissemination. In other countries or regions, the EVA2 work was not only a study but also an intervention that changed the perspective or priorities of the work of coordinators and, in some cases, influenced decision-makers that were interviewed (see section 5).

6.2 The pilot phase of ENHPS

6.2.1 The necessity

The pilot phase of ENHPS was necessary to built a positive identity around the project. Influencing the education system seems impossible without providing some evidence that the approach works and that those involved found it relevant to their needs or those of the school community. As a comprehensive approach to health in and by the school community, the work has been innovative and the pilot phase allowed the coordinator to develop the necessary expertise. At the end of the pilot phase, ENHPS was credible and the coordinator often highly praised.

6.2.2 The isolation

Coordinators and support teams were so involved in working with schools that they did not pay enough attention to or had insufficient resources to focus on the situation outside the network. Few coordinators set up a managing or steering committee and used it to build alliances for the project. None attempted to work with existing school health promotion initiatives or networks or to collaborate with other school-health-related projects even when they were compulsory (such as projects to prevent drug use).

Combining work with schools and lobbying/networking with politicians, civil servants and health promotion specialists may have been difficult, but some future recommendations for coordinators should draw attention to the benefits of a working steering committee. Some work could also be undertaken at the international level to facilitate the integration of topical health approaches in the health promotion framework (such as drug-use prevention and reproductive health in secondary schools, injury prevention in primary schools and nutrition in all schools).

Collaboration between networks can be initiated internationally and examples are available. This is also true for strengthening links between practice and research. For example, it would be useful to strengthen the relationship between ENHPS and studies such as the WHO cross-national study of health behaviour of school-aged children (HBSC) or the BIOMED2-funded CAS (control of adolescents smoking at school) project.

6.2.3 A problem of role and planning

As already noted in the first, intermediate report, some coordinators never believed that their role was to network with and lobby decision-makers. Some coordinators, who did not occupy senior position and were from large organizations, refused to accept the idea of carrying out advocacy work. If offering all schools the chance to become health promoting schools is an objective, however, there is no alternative to regular contact and discussion with decision-makers.

In addition, some coordinators lacked planning skills, mainly in relation to the dissemination of information and practice. Some coordinators referred to a dissemination plan that was really little more than a list of objectives, with no indications of means, resources, timetable, etc. More thinking at the international level is required to help solve these problems and to ensure effective dissemination.

6.2.4 Facilitating factors

General factors facilitating an efficient pilot phase include:

- a lack of school health promotion outside ENHPS (that is, no competition);
- a clear conceptual differentiation between health education and health promotion; and
- political will to give some freedom to schools to decide on project or curriculum content.
- Characteristics of ENHPS that had a positive influence on the pilot phase included:
- the size of the network: not too small (as it is, for example, in the Basque Country and Luxembourg) and not too big (as, for example, in Finland and Spain);
- the location of the support centre and the profile of the coordinator (either a health professional in an education agency or vice versa); and
- a coordinator with some autonomy but also a clear framework of accountability to schools and the health and education sectors.

6.3 Between the pilot phase and sustainable development

6.3.1 Main results

The EVA2 project focused on what happened between the pilot phase and the decision to develop an ENHPS project. Shortcomings in planning this phase have been emphasized already. The two main results were the lack of policy analysis (to indicate the relevance of ENHPS for education) and the lack of institutional analysis (to identify a support structure). The latter was more difficult to explain to some coordinators, who were convinced that dissemination could be informal. It cannot; if a very dynamic coordinator from a small country were to organize five training modules per annum, each attended by 20 teachers, working for a few days with 1 teacher from each school would take some 50 years. Good will cannot be the major element in a strategy to disseminate school health promotion.

6.3.2 Key features for policy development

General factors with a positive influence on decision-making included:

- a regional education structure with a support team that could take over the dissemination of school health promotion practice;
- a clear policy for health in schools (transversal topics, etc.); and
- a good working relationship between the health and the education sectors.

Characteristics of ENHPS that facilitate dissemination include:

- coordinators' planning, management and communication skills;
- evidence-based evaluation that could meet the policy and quality requirements of the education sector;
- a network of allies;
- coordinators' charisma; and

- direct communication with decision-makers (likely to exist when the support centre is not located in a big agency) and the opportunity to advocate and lobby.

6.3.3 Ownership of the project

The smaller the size of the agency hosting the support centre, the more likely the coordinator was to identify herself or himself with the network and to find it difficult to facilitate a shift of ENHPS coordination from her or his agency to the education sector. Some coordinators tended to mix their professional future with the development of the network. This difficulty also arose when the support centre was located in the department for innovation in an education ministry; once disseminated, it would leave this department.

These problems were less likely to happen in a big organization where people were used to working on successive projects. In these cases, however, people and money could be shifted from one interest to another, following a top-down policy in which coordinators had little say.

Innovative ways need to be found to assist coordinators to reorient their careers while using their competences for school health promotion. For example, one could offer some recognition to coordinators who lose the project by placing them in a position officially to advise IPC, chair a new national steering committee or remain an international contact for school health promotion in their country or region.

6.4 Dissemination and sustained development

This phase should be planned with the same attention as the pilot phase. The main challenge is to maintain the philosophy, vision and principles while ensuring high-quality work. Action that could be taken might include:

1. increasing the visibility of the project and communication with decision-makers and allies;

2. evaluating dissemination at school level and the supporting structure at regional level;

3. collaborating with and/or integrating other health-related networks and projects;

4. publishing guidelines for integrating topical health education in the curriculum of a health promoting school;

5. making clear recommendations for minimum standards for the initial and continuing training of teachers; and

6. training school inspectors to review school health promotion.

Another direction for development could be to work with nursery schools, special schools, higher education or universities.

6.5 Conceptual definition

The semantic fields of health education and health promotion are theoretically different, as are the practices they encompass. Both approaches are necessary and complementary. One major factor that slowed down the dissemination of school health promotion was a lack of understanding of the concept, with a reliance on health education. Where this was the case, as health education existed already, it was nearly impossible to develop health promotion that did not appear to duplicate existing practices.

This problem could and should be solved quickly at the international level by an information campaign, although this will need to respect different cultures. For example, in France health promotion is rejected as having too commercial a connotation and in Norway the health part of the health promoting school concept is replaced by another concept meaning something between health and wellbeing.

When producing information on school health promotion, it would be an asset to begin by illustrating the differences between this approach and that of health education. Emphasis on self-esteem, skills or wellbeing should be avoided, as health educators also focus or want to focus on these factors. Working with the community or improving teachers' wellbeing might be more appropriate.

6.6 Adaptation

Developing a European dimension in a project does not necessarily mean a strong homogeneous international project. The EVA2 study showed that education policy differs from one country to another, allowing different means of integrating health in the school programme. Moreover, regional structures to support education or health promotion vary, as do traditions of public health, health education and disease prevention and speeds of integrating change.

The added value of ENHPS cannot prevent adaptation to different situations to increase the relevance and quality of innovation. The 12 criteria, for example, were discussed and adapted to local situations by very few networks and were used as presented by others. For the latter, this meant the loss of the opportunity to develop consensus around the ENHPS project in their countries or regions. The systematic addition of a phase for the adaptation of the international project would answer those who dismissed ENHPS (or any other WHO or EU project) as not relevant or too theoretical for their country or region.

Similarly, the support offered to countries should be adapted to their particular circumstances. Political and financial incentives at the international level seem necessary for France, the Netherlands and Spain (and possibly for Greece, Italy and Luxembourg) to allow a new start for the project towards or throughout phase 2.

Adaptation of international projects by countries and regions should be encouraged. Misunderstanding should be avoided by taking account of cultural diversity. For example, the criterion of teachers as role models was not popular in Norway, as it could be viewed as an infringement of civil liberties.

Although still used and useful, the 12 criteria are now replaced by ENHPS resolution as the start for consensus on engaging in school health promotion. The resolution is more open than the criteria and facilitates adaptation to specific situations.

7. Final comments on ENHPS dissemination and the EVA2 project

7.1 Effectiveness of ENHPS

Evaluating effectiveness has many different meanings, from a diffuse assessment of impact to an evaluation with an experimental design. When scientists talk about evaluating effectiveness, they usually mean an evaluation of the degree to which set objectives were met, with data comparing an intervention and a control group. A (quasi-)experimental design of school health promotion is difficult to implement. There are many reasons, including:

- time: the time-lag between starting and achieving a process of participation, with turnover of key actors, and the time needed to implement change and to be able to measure it (from curriculum, policy and environment to behaviour and lifestyle);

- the sample: the sample size (large numbers of pupils are likely to be needed to detect any effect), the definition of the sample with various cohorts of pupils (including those who enter or leave the school during the intervention), the turnover of pupils in some secondary schools (with absentees and drop-outs), and the difficulty of defining the true target for each objective (those with lower self-esteem, pupils from one grade or migrants, etc.);

- the methodological complexity of assessing changes not only in behaviour but in the determinants of health (intention, values, beliefs, knowledge, skills, physical and social environment) for each aspect of health-related behaviour and wellbeing; and

- the nature of the project, in which objectives (such as improved relationships) may be difficult to define and validated indicators may be scarce (for example, does truancy measure school wellbeing?).

Other problems include contamination of the reference groups, which are often not free of any intervention, as well as the money and competence required to carry out a (quasi-)experimental design of such complexity.

Some countries have set up a quasi-experimental design comparing data from the pilot schools with reference schools (from the HBSC sample in the case of Norway and Wales; from a control group in England). Their findings illustrate the difficulties noted above.

In England, the published research report showed evidence of positive trends in knowledge and attitudes in both intervention and reference schools, but change in behaviour could not be demonstrated *(4)*. Some change is reported from in-depth case studies carried out in intervention schools, but supporting data are not presented (for the decrease in absenteeism mentioned above, for example). There is no information on activities in reference schools. The same quantitative evaluation protocol was applied to all, independently of the objectives of the projects of individual schools. Recommendations from the EVA2 study include a revised analysis of the data from the intervention and reference schools. The authors reported that pupils from intervention schools were more critical about the school environment during the final survey. This does not necessarily mean that the situation worsened during the project, as one could argue that the intervention (or the evaluation) had raised their awareness of such issues. This was not investigated and provides another illustration of the complexities involved in adopting a traditional (and thus rigid) evaluation protocol to a very flexible and participative project (with different school objectives and processes).

There is little evidence of outcome in terms of health and wellbeing status, but the EVA2 project identified some evidence of success in terms of perceived relationships, truancy, nutrition and other policies, and curriculum improvements (see section 3.6). There should be further investigation here, along the lines suggested by Tones *(5)* and Parsons *(6)*.
The EVA2 project demonstrated that decision-makers from the education sector were interested in education outcomes such as curriculum development and teaching methods, while health professionals were usually interested in impact on health status. Evidence-based evaluation should be sensitive to the needs of these decision-makers and based on their objectives and interests.

A major difficulty is that health promotion has goals such as establishing a good school environment, while short- and medium-term evaluation focuses on improved health status. Insufficient attention is paid to the time issues referred to above. Working to improve the living and learning environment of the school setting is a characteristic of school health promotion (as compared with the health education approach). This is not only a question of philosophy or vision. It is a question of equity and strategy *(7,8)*.

Health education benefits mainly or only those who are regularly present at school. Absentees are known to be more likely to adopt health-damaging behaviour than other pupils *(5)*. In general, pupils have greater academic success if they perceive their school as supporting them and if they like being there *(9–12)*. Offering better school conditions might affect truancy levels and should be seen as a basic equity requirement.

During the EVA2 interviews, coordinators and decision-makers reported some competition with school disease prevention programmes. The winner is not necessarily the most-needed project, but the one that succeeded in gaining entry to the school. Moreover, for a school, working with a NGO on AIDS (or drugs, safety, etc.) often, if not always, results in little attention being paid to other topics. This does not seem an effective or efficient way to plan health projects. Adopting a health promoting school approach was seen as a means to provide a framework for programmes and to ensure that a programme is adopted following a school diagnosis of its needs, not a successful marketing campaign by an NGO.

If health promotion is accepted as a strategy to keep pupils in school and a means to select health projects relevant to needs, then evaluation should assess these parameters and not the long-term impact on health status. Assessing impact on behaviour, health and wellbeing may come later, once the living and learning conditions have improved, once an operational structure is able to foster health projects that are truly needed and once a topical project has been carried out long enough to affect pupil and staff health and wellbeing.

Another problem was studies that attempted to demonstrate the effectiveness of the whole health promoting school approach with sample sizes too small to detect an impact. To be able to measure an increase of 10% from an unknown initial percentage, a sample size of 325 is required (see the EVA1 report). This means 13 similar classes of 25 pupils. This figure is difficult to obtain in pilot schools, often selected for their social and geographical diversity.

The study of the other existing literature on the evaluation of ENHPS results in similar conclusions *(13–17)*.

7.2. Effectiveness of the dissemination of ENHPS in the EU

7.2.1 It works

This is the main finding: ENHPS has been a success. While barriers have prevented research demonstrating the impact of health promotion on the health status of pupils and staff, the EVA2 project has been able to reveal the success of the health promoting school as a movement for improving school conditions. The three key indicators (see sections 3.3, 4.2 and 4.3) were:

- no (or very few) schools dropping out of the project, where it is common for schools to leave other networks with a focus on pedagogical innovation (one network diminished in size but did not drop out);
- an increase in the size of the network and informal dissemination of the philosophy and practices; and
- institutionalization of innovation through policy.

7.2.2 It could work better

The EVA2 findings indicate several barriers to progress. These were concerned mainly with the relationship between practice, evidence-based success and policy. One particular problem was the reliance on traditional approaches to evaluation, which prevented evaluators and coordinators from responding to the information needs of decision-makers. This was also true for those who concentrated on process evaluation.

As one minister commented, there is no way back now. On several occasions, people have said that, when schools see the relevance of a project, they are likely to continue it, with or without support. European school health promotion is developing and will develop further, but the findings suggest a need for strong external and internal support. There are four main reasons. First, this will ensure that coordinators focus when relevant on educational policy and changes in policy, as well as on institutional analysis.

Second, schools taking up school health promotion without any help are likely to be more dynamic, resourceful and/or change-oriented than others. To avoid increased inequities, positive discrimination should enable all schools to participate in the movement.

Third, the study of the dissemination of innovation shows the importance of the conditions in which the project develops in a new setting (evaluation of external validity). A support team external to the school is necessary to facilitate the adoption of these conditions through policy.

Fourth, school health promotion as developed through ENHPS concentrated not only on curriculum content but also on a clear vision of the school's social goals, the principles of health promotion and change in the school's physical and social environment. Updating this framework and issuing guidelines for quality control will be necessary. Similarly, input to the initial training of teachers and the in-service training of teachers, head teachers and school inspectors, will be needed. Only a formal policy will sustain these activities and guarantee (participative) control of their quality.

7.2.3 Local, regional, national and international support

Improving the conditions conducive to successful school health promotion can take place through a subsidiary agreement. The subsidiarity concept has three key elements:

- leaving as much decision-making as possible to the level closest to the population (the school in this case);
- making sure that this level has the means to implement its policy (such as training, sharing curricula or teachers' time, etc.); and
- implementing at other levels what cannot be achieved at the level closer to the population.

This way of working can be seen in ENHPS (see Piette et al. *(9)* and the EVA1 report) and explains the regional, national and European added value that schools can gain from taking part, rather than working in isolation.

Subsidiarity should continue to be a characteristic of the movement if IPC wishes to ensure the sustainable development of school health promotion. If the first stage (pilot schools) has ended in many countries, the goal of offering each school the chance to be a good and efficient health promoting school has not been achieved. In most countries, support is required for the next phase as for the previous one.

7.3 Assessment of the EVA2 project

The first objective of the EVA2 project was the assessment of how politicians perceive the successes and weaknesses of ENHPS in their countries or regions, which conditions would persuade them of the need to extend the school health promotion approach and how ENHPS can assist in this process. Information on these questions is presented in sections 3 and 4.

Objective 2 focused on recommendations for developing international policy. Sections 6–8 suggest what action should be taken to develop policy for the sustainable development of school health promotion. The country reports describe specific actions needed by individual countries. Informing other international organizations about ENHPS, lobbying for possible sponsors and advocating the need for the project among EU and national politicians may be activities to which IPC may wish to pay more attention. The fact sheets and the brochure may help IPC and the Technical Secretariat in this role.

Regional and national coordinators represent an important group of activists. The third EVA2 objective was to seek ways to support them in influencing politicians and decision-makers, directly or through the Technical Secretariat. National and regional coordinators should be guided to sections 3 and 4.

The Technical Secretariat is capable of developing its own thinking about dissemination. As the EVA2 team worked closely with the Technical Secretariat, however, intermediate reports (such as those from 1998 annual meeting, which covered dissemination, and the 1999 annual meeting, which looked at the concepts of health education and health promotion) are likely to have informed the team's work to some extent.

The true impact of the EVA2 project cannot be assessed now. Later, it should be possible to see if recommendations have been followed.

7.4. In the literature

7.4.1 The stages of change

The identification of stages between the end of the pilot phase of the network and the development of policy to sustain school health promotion would appear to be similar to the process described by Prochaska *(18)* for behavioural change: awareness, interest, trial, decision, adoption, maintenance. Further research might usefully examine the role of politicians and decision-makers in the policy development process, with reference to the field of healthy public policy.

7.4.2 Coordinators' tasks during dissemination

In a manual published in 1994, the United Nations Educational, Scientific and Cultural Organization (UNESCO) presented guidelines to enhance the multiplier effect of an associated schools project *(19)*. The manual clearly states that efforts should focus on both quantitative growth and the extension of qualitative impact. To achieve this goal, several tasks were suggested:

- keeping the philosophy and principles of the approach at several hierarchical levels;
- ensuring visibility and evaluation;
- pushing lasting changes in the education system;
- helping to translate policy decisions into teaching practices and school projects; and
- pushing the project onto the agenda on a regular basis for new initiatives (such as health promotion in pre-service training).

The manual's recommendations are similar to the EVA2 recommendations (see section 8), but phases 2 (from pilot to policy), 3 (sustainable development) and 4 (institutionalization) are not well identified. The EVA2 project revealed that clear planning for each phase should improve this process.

7.4.3 The theory of dissemination

Rogers' *The diffusion of innovation (20)* offers a basis on which to develop evaluation and assessment of the dissemination process of ENHPS. It has been applied successfully in the health field, for example, by Steckler et al. *(21)*, Brink et al. *(22)*, Parcel et al. *(23)* and Rissel et al. *(24)*, and can be adapted by those wishing to monitor the development of school health promotion in a rigorous manner.

7.5 The way forward: from seeds to gardens and forests

The following considerations are detached from any political and organizational realities, but provide a useful framework for reading the recommendations in section 8. The logo of ENHPS is a seed. This seed has germinated and produced different fruits. It is now time to acknowledge and sustain the resulting gardens and forests (Table 18).

Gardens have designs. They are often well delimited and need regular care. The gardens originating from ENHPS may be new networks or subnetworks, with new titles, identities, logos and purposes. Groups of countries can concentrate on, for example: integrating nutrition or drug education in a health promoting school, developing health promotion as a cross-curricular topic, contributing to the design of minimal requirements for curricula for training teachers, designing

user-friendly evaluation tools, and collecting information and documenting the impact of school health promotion on education policies. Subnetworks should have a plan and exist for a given number of years.

The forests are all health promoting schools that are not currently in a formal (sub)network (or garden). They need relatively less care than the gardens, but still need some care and control. Health promoting schools, once disseminated and sustained by policy, will need quality assurance and flexibility to adapt to changing needs. They will also need to cooperate with others at the regional, national and international levels.

During the next two years, resources can be divided equally between organizing new networks and setting up an infrastructure for the other health promoting schools (the Internet being a relevant channel for the latter). Once the potential of the Internet is realized, more resources should be available for specific and time-limited networks.

8. Recommendations

8.1 Strengthening the links between health and education sectors at all levels

1. The links between the health and education sectors should be strengthened at all levels of the EU; this work should include:

    - organizing a meeting of health and education ministers to reach a consensus on joint involvement in health promoting schools;
    - facilitating joint workshops of members of the European Parliament (MEPs) from the health and education groups;
    - developing a joint venture between Directorate-General (DG) V and DG XXII, identifying and publicizing areas of complementary work;
    - if relevant, involving other DGs and/or ministers responsible for specific areas or projects (such as the transition from school to work, adolescent drug use and participation in sports); and
    - joint ventures between projects from different units on particular topics (such as drugs and HIV/AIDS) or particular settings (healthy capitals).

2. Within WHO, programmes focusing on different topics (such as health promotion, drugs, AIDS, etc.) and settings (cities, schools, prisons, etc.) should develop joint projects.

3. IPC should:

    - renew agreements with the ministers of health and education for the pilot stage (done for all but France, Germany, Luxembourg and the Netherlands), policy for dissemination (for all that have not yet reached the policy stage, but at least for Spain) and sustainable development;
    - facilitate the relationship between health and education in the regions (and at least in Spain); and
    - develop joint ventures with UNESCO and/or the United Nations Children's Fund (UNICEF).

4. The ENHPS Technical Secretariat should:

- plan and work on phase 2 as was the case with phase 1;
- work with national coordinators to develop and ensure progress from credibility to policy, in close collaboration with the health and education sectors in each country or region;
- for larger countries, work with national coordinators to ensure that regional school health promotion coordinators receive training in managing, expanding and evaluating networks;
- prepare new agreements between ministers of health and education for the pilot networks in France, Luxembourg, the Netherlands and Spain, and agreements for phase 2 in the development process for most countries and regions and for phase 3 for those who have advanced further; and
- develop its work with other organizations: increasing the collaboration between different teams such as Canterbury Christ Church University College and the School of Public Health at the Free University of Brussels and developing formal relationships and joint ventures between WHO, EC and CE research networks and ENHPS.

8.2 Facilitating the decision-making towards a policy

5. To promote progress from policy to implementation, the same process as the EVA2 project (studying and preparing the path from pilot to policy) should be followed at the international level to win the interest and support of MEPs and senior EU civil servants. This process should involve using materials such as the country fact sheets, lobbying (using existing structures such as the Liaison Office of the European Network of Health Promotion Agencies – ENHPA) and networking between country politicians and European politicians by national ENHPS teams and ENHPA teams. This requires a support structure for each network or regional development, which may be based on a renewed consensus among the health and education ministers and an agreed content. The theoretical background, guidelines and tools should be provided for the latter two phases, as they were for the first.

8.3 Marketing

6. The health promotion concept should be more widely known and understood. Politicians cannot be expected to finance health promotion if they do not see its differences from the health education work already being financed, and the health promotion process cannot be imposed at the expense of topical health education. The diffusion of the health promotion concept should be widened through:

- providing information in Europe on how health education and health promotion are complementary;
- helping national coordinators to distinguish clearly between the two concepts;
- working with countries that do not differentiate between health promotion and health education (defining a strategy for change with the coordinator); and
- doing some action research on merging and integrating topics such as HIV/AIDS and drug use in the school health promotion programme.

7. To market school health promotion, lobbying at the international level should complement advocacy at the national or regional levels. With briefing from the ENHPS Technical Secretariat and each country, the ENHPA Liaison Office could play a major role. Fact sheets may be regularly updated for national and international use.

8.4 Other recommendations

8. Guidelines on school health promotion should be issued for school inspectors, school health services, primary health care teams and personal and social education teachers (helping them to expand into other fields). These guidelines should also be incorporated into teacher training (initial and in-service training).

9. A new evaluation protocol should be initiated on, for example, quality assurance (with the assistance of Canterbury Christ Church University College) and impact assessment (with HBSC). Specific efforts should focus on innovative evaluation tools enabling all actors at all levels to assess their progress. This recommendation includes families as well as ministers or MEPs.

10. To ensure continuity in country work, all national coordinators should secure official back-up from politicians and/or senior civil servants for their plans and policies, to ensure that school health promotion work is not disrupted by changes of ministers, directors of education or even national coordinators.

11. More thinking should take place at the international, national and regional levels on the potential for collaboration between the public and private sectors, including health-related NGOs. In addition, international health-related NGOs should be involved in future developments in school health promotion.

12. Documents should be issued and widely disseminated on good practice concerning each point of the ENHPS resolution and, if possible, each of the 12 ENHPS criteria.

13. Pedagogical work should be started on health promotion and health education in the following formats: specific health education courses, cross-curriculum topics, personal and social education, school projects carried out in free time in the school curriculum, voluntary or compulsory extracurricular school projects, awards, etc.

14. ENHPS should developing thinking with its partners on the differences, similarities and complementary elements of school health promotion, school health education, the effective school, the safe school, etc.

15. ENHPS should make extensive use of the Internet, which enables the wide dissemination of its philosophy, principles and guidelines. Schools from a particular region or country can use the Internet to learn from the materials available and to find other schools with which to share their experiences.

This should include not just placing all available information on ENHPS on the World Wide Web but also developing, implementing and assessing a new Internet pedagogy. This could facilitate regional development (which many national and regional coordinators believe to be important), minimizes the need for bureaucracy and may help to lower costs.

The dominance of the English language will remain an obstacle to the full achievement of this goal for some time. All schools have English teachers, however, and working on health promotion issues on the Web in English (or other languages) could form an interesting pedagogical tool for language instruction.

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