An examination of health promoting schools in Ireland

Sharon Moynihan, Didier Jourdan and Patricia Mannix McNamara

Purpose: This paper reports the results of a national survey that examined the extent of implementation of health promoting schools (HPS) in Ireland.

Design/methodology/ approach: A quantitative research design was adopted. A questionnaire was administered to all post primary schools in the country (n=704). Data were analysed with the support of the software packages, SPSS and MaxQDA.

Findings: A response rate of 56% (n=394) was achieved. Over half of these schools (56%) self-identified as health promoting. Schools reported success in the areas of environment and curriculum and learning, however, partnerships and policy and planning required more attention. Some models of good practice emerged from the data but these were in the minority. Many schools, when asked to describe health promotion in their school, placed emphasis on physical health (diet and exercise) and curriculum predominately rather than the broader whole school conceptualisation. Only 35% of HPS schools had a team supporting HPS developments. Only 36% identified the existence of a school policy to support HPS. This suggests that further coherence for sustained and comprehensive implementation of HPS is necessary.

Research limitations: The research was conducted with school staff, in the first instance who self-reported their school’s level of HPS engagement.

Originality/value: This paper offers the first national baseline data available in relation to engagement in HPS in Ireland. It provides a valuable starting point from which further research with schools in this field can be conducted.

Keywords: Health Promoting Schools, School, Environment, Curriculum, Policy, Partnership

Article Classification: Research paper
Introduction

Defining health promoting schools

Schools are recognised as important settings for health promotion (Mukoma and Flisher, 2004; St. Leger et al., 2010). Behaviours that have a profound effect on health status, such as physical activity and diet are established during the school years (Mohammadi et al., 2010). The foundation of health promoting schools has its origins in the Ottawa Charter for Health Promotion (WHO 1986), where schools were identified as an important health promoting setting. The principles outlined in the charter were adopted for schools by the World Health Organisation (WHO) and became known as the Health Promoting School (HPS) concept (Whitman and Aldinger, 2009). A HPS is defined as a school that is “constantly strengthening its capacity to be a healthy setting for living, learning and working by focusing on all the conditions that effect health” (WHO 1998, p.2).

In HPS the didactic approach to teaching health is replaced by a more holistic model of health education, in the hope that an all-encompassing approach will help to promote health gain. Indeed, "school health programmes that co-ordinate the delivery of education and health services and promote a healthy environment could become one of the most efficient means available for almost every nation in the world to improve significantly the well-being of its people" (WHO 1997, p.9). An effective school health education programme is one that combines health education with health-promoting initiatives in the school, and involves parents and families and the community (Stewart-Brown, 2006). This approach signals a movement away from the health class per se, as the only place of information in relation to health. HPS encourage multi-faceted approaches, as these are advocated as more effective than classroom only or single intervention approaches in achieving health and educational outcomes (Moon et al., 1999; Stewart-Brown, 2006).

Approach

Health promotion in schools can assist schools in educational attainment. Students are less likely to undertake risky behaviours if they have a positive association with their school and their teachers (St. Leger et al. 2007). The HPS is one of the most powerful approaches to promoting health, empowerment and action competence in schools (Clift and Jensen, 2005). Barnekow et al. (2006, p.13) set out the aims of the health promoting school including attention to “engaging students, teachers and parents, using interactive learning methods, building better communication and
seeking partners and allies in the community.” Members of the school community are seen to include students, their parents, teachers and all other people working in the environment. They also contextualise the HPS as facilitating healthy behaviour through policies aimed at increasing quality of life. The IUHPE (2008) identify a set of principles that underpin HPS which include attention to the health and wellbeing of both students and staff, collaboration with parents and the local community, and the importance of on-going evaluation and monitoring.

The HPS concept has faced criticism over the ability to accurately evaluate it as a system due to its inherent flexibility. As a ‘settings’ approach, HPS are loose and flexible, therefore researchers contend that as a result health education is often allowed to continue in a traditional and individualistic way (Wenzel 1997). HPS are then seen as having had limited success in terms of demonstrating their effectiveness. A differing perspective would attest to the challenges but conceptualise these challenges as existing not merely because of traditional and individualistic implementation but also because of the multifaceted, integrated and concerted nature of HPS (Deschesnes et al., 2014). There is little doubt that the HPS approach is inherently complex from a practical point of view and is a challenge with regard to its absorption within the core business of schools (Deschesnes et al., 2014). Although there are far fewer studies centred on the whole school approach as opposed to classroom only, the evidence suggests that the former is more likely to be effective in terms of a range of outcomes than a classroom based approach (St. Leger et al., 2007). Whole school approaches that demonstrate coherence between policies and practices have been shown to improve learning outcomes, increases emotional wellbeing and reduces health risk behaviours (Lister-Sharp, 1999; Young and Currie, 2009).

Challenges

There are generally three approaches set out by the literature that are characteristic of the HPS approach (Deschesnes et al. 2003): 1) the formal curriculum 2) the school environment 3) the school/community interactions (Nutbeam et al., 1987; Parsons et al., 1996). Of the three domains, the most focus is generally placed on the health related curriculum (Lynagh et al., 1997). This is not surprising, as it is the easiest to measure. In order to implement comprehensive school health approaches, intensive planning and co-ordination among stakeholders needs to occur (Deschesnes et al., 2003). Although this may seem a logical and relatively easy task, it can be quite a challenge given the range of interpretations people have of HPS (Mohammadi et al., 2010). One reason why the initial vision of the HPS has not been reflected in the implementation is due to differing interpretations of the concept. Perceptions and actions are closely linked and teachers’ active participation in HPS is dependent on many factors including their perspectives on the HPS approach (Adamson et al., 2006; Barnard et al., 2009). Recent international literature identifies that one of the
main problems for HPS is that school health programs are implemented by educational professionals but are created by health professionals, who may have different priorities and have a different perspective on the meaning of health in schools (Rowling and Jeffreys, 2006). Australian research (Mohammadi et al., 2010) confirms a lack of accord between the health and educational sectors, coupled with diversity within and between schools and in definitions and perceptions of HPS. French teachers indicate varying perspectives on how they see their role in health promotion which is very much dependent on their subject but also on their personal epistemologies of teaching (Jourdan et al., 2010). The importance of policy that includes cross-curricular plans for the school has been identified in Norway (Samdal et al., 2010). The complexity of effective leadership at regional and school levels have also been identified as challenging for HPS implementation in countries such as Canada, Norway and Germany (Wells, 2013; Tjomsland et al., 2013; Dadaczynski and Paulus, 2015). Sustainability in implementation has been most recently identified internationally as an important focus for effective implementation of HPS (Simovska and Mannix McNamara, 2015).

**Health Promoting Schools in Ireland**

Ireland was one of the first members to join the European Network of Health Promoting Schools (ENHPS) at its inception in 1992. Many schools were already implementing health programmes, however, these were sporadic and random in nature (Geary and Mannix McNamara, 2007; Nic Gabhainn et al., 2007). In 1993 the Irish Network of Health Promoting Schools (INHPS) was created. The INHPS was, in essence, a school driven project, with schools setting their own goals and the twelve criteria of the ENHPS were proposed as a guiding framework (Lahiff, 2000). A steering committee was established, in keeping with a partnership ethos, to oversee the network, which was in its pilot phase. Representation was sought from members of the Department of Education and Science, the Department of Health and Children and the Marino Institute of Education (Lahiff, 2000). In 1993, five second level schools were chosen at random from the eight hundred post primary schools in Ireland to participate in the pilot. The pilot programme had a three year time frame (Lahiff, 2000). Schools were asked to undertake work on three broad areas, school environment, health education programmes and the involvement of parents and community in the life of the school. Progress was witnessed in each of the key areas identified. In 1996, fifteen more post-primary schools joined the INHPS (Lahiff, 2000).

Evaluation of the pilot phase identified the need for clearer conceptualisation of HPS in Irish schools, whole staff awareness of and contribution to HPS, the importance of school management and awareness of the extent of the commitment needed, to ensure effective participation. The importance of policy was also identified, as was the need for staff development programmes to
enable teachers to properly facilitate health education classes (Nic Gabhainn and Kelleher, 1998). Since 1999, no other evaluation has been undertaken, as far as the authors are aware. The national coordinator at the time outlined that the process by which a school becomes health promoting is a complex one, and that Irish schools have difficulty with the HPS concept (Lahiff, 2000).

This initiative was enhanced by the implementation of a specific health education subject entitled Social Personal and Health Education (SPHE) in 2000. Implementation policy stated explicitly that SPHE should be implemented in the context of a health promoting school. However, the continuing delivery of a HPS approach was ad hoc, dependent on individual school commitment and on individual regional commitment through the Health Service Executive (HSE), thus implementation was less than optimal. More recently renewed interest in the HPS in Ireland has emerged through the publication of a national framework document entitled "Schools for Health in Ireland Framework" (HSE, 2013). This document outlines four priority areas for effective action i.e. environment, curriculum and learning, partnerships and policy and planning (see figure 1).

![Figure 1: Health Promoting Schools: key areas of action (Department of Education and Skills 2013, p.18)](image)

This study was conducted prior to the publication of this framework document. The focus of the present study was to gather baseline data, in order to conceptualise the state of the art specific to HPS in Ireland. Since 2000, the focus on curriculum implementation of SPHE meant in effect that HPS were left to languish, when the researchers sought to determine how many post-primary schools in
Ireland were HPS, no information was available from the HSE nor was it possible to gain insight into what the practices of Irish HPS were. This was the impetus for this study because health promotion in schools is process focused, the aim of this work was then to have a comprehensive picture of the HPS in Ireland.

The research questions that guided the study were as follows:

1) How many post primary schools self-identified as HPS?

2) What are the practices that constitute HPS in Irish schools?

This is a baseline study and it is intended to replicate it in 2016.

Methods

A questionnaire (open and closed questions) was sent to post primary schools at the national level. In order to enhance validity a pilot study was conducted using a convenience sample and questions asked using Bell's (2010) pilot framework. Following the pilot, changes were made to content and layout, according to the recommendations made by participants. A comprehensive analysis identified that no one survey was fit for purpose, but the surveys utilised by von Amann (2006) and by Geary and Mannix McNamara (2003), were both closely aligned for what was needed. Permission was sought and granted from the authors to utilize their surveys. These were adapted in order to be fit for purpose, and items specific to the HPS were drawn from von Amann (2006) while items specific to SPHE were drawn from the national instrument used by Geary and Mannix McNamara (2003).

The questionnaire was a 36 item instrument.

The first section of the survey contained seven questions, centered on demographical and background information such as school type, school location, participant expertise and experience.

The second section examined involvement in HPS. On a 5 point Likert scale from strongly disagree to strongly agree participants were asked to rate fifteen statements relating to health promotion in their school. These statements covered the extent to which all stakeholders (pupils, teachers, parents, community and board of management) were involved in school activities that promote health and well-being, as well as the atmosphere and ethos of the school, training of teachers, value of health education and provision for SPHE. This section was included to answer the first research question, how many post-primary schools self-identified as HPS?
The third section contained fourteen questions that elicited specific information on health promoting practices in the school. The participants were asked whether their school was a HPS. This question was asked directly as a way of answering the first research question. They were asked if their school had achieved a HPS award. In addition, participants were asked "How would you describe Health Promotion in your school?" This question was asked to answer the second research question, what are the practices that constitute HPS in Irish schools? This section also asked questions specific to who was involved in activities, whether teachers did this individually or as part of a team, and whether there was health related school policies in the school.

The internal reliability of the second section was tested. A principal components analysis (PCA) with Promax Rotation was used in order to study the relationship between and define scale dimensions. The adequacy indicator of the sample KMO=0.878>0.70 and the control of sphericity (Bartlett’s sign<0.001) indicated respectively that the sample data are suitable for the undergoing of factor analysis and that the principal component analysis has a sense. Two dimensions were kept, which explain 49.30% of the whole inertia. The 1st dimension is relative to SPHE, with high factor loadings for questions 8 to 15 with this factor. The 2nd dimension is relative to collective involvement, with high factor loadings for questions 1 to 5 and 7. Question 6, relative to the friendly atmosphere, is linked with both dimensions. The Cronbach’s alpha are 0.839 and 0.841 for dimension 1 and 2 respectively.

A full population sample was employed (704 schools), which meant that the questionnaire was sent to every post primary school in Ireland. Questionnaires were coded in order to be able to track responses and to facilitate the sending of reminder letters. One questionnaire, together with a letter and information sheet, was sent to the SPHE teacher in each school. A pre-paid envelope was also included for teachers to return the survey. Upon receiving the surveys, the data were manually entered into SPSS. Statistical analysis was undertaken on the closed questions while thematic analysis was used for the open questions in the survey. MaxQDA was used to aid thematic analysis of the qualitative data. Ethical approval was sought and granted by the University of Limerick ethics committee (EHSREC10-42) for the research study. The research adhered to strict ethical principles such as voluntary participation, informed consent, beneficence and non-maleficence (Cohen et al., 2007). Each questionnaire pack included an information sheet detailing to participants what was required of them, what were the benefits of the research, the risks involved, the voluntary nature of the research, the ability to withdraw their participation without prejudice, information regarding dissemination of results and contact information of the principal investigator and ethics committee involved. As the questionnaires were coded in order to allow follow up, anonymity could not be
guaranteed. However, confidentiality was assured and it was outlined that no school or teacher would be identified in the report and the coding was used only for follow up purposes.

Results

Demographics of schools

Three hundred and ninety four schools responded to the survey thus, a 56% response rate was achieved. In terms of school category, the survey is close to representation of the national stratification of school type. According to the Department of Education and Skills (2014) database during the school year 2012/2013, 35% were vocational schools, 19% were single sex girls schools, 18% were co-educational schools, 15% were single sex boys schools, 11% were community schools and 2% were comprehensive schools. Of the responses received for this study, 34% were from vocational schools, 21% were from single sex all-girls school, 18% were co-educational schools, 13% were single sex all-boys schools, 12% community schools and the remaining 2% were comprehensive schools. The survey is also representative of the national stratification of schools’ social status, 28% of post primary schools in the country are designated disadvantaged schools (Department of Education and Skills, 2014) and 30% comprised the response rate of disadvantaged schools in this study. In terms of the location of the schools that responded, 38% were situated in an urban area, while 24% were in a suburban area and the remaining 38% were located in a rural area.

The Irish HPS in 2013

1) Self-identified HPS

Over half of schools (56%) identified their school as a HPS. Of the schools who responded, 2% had achieved the national HPS award, while a further 6% were in the process of obtaining the award. Fifty per cent of respondents had not heard of the award. Figure two illuminates the findings from those schools that identified themselves as HPS.
Figure 2 demonstrates that Irish HPS reached different levels of achievement of HPS criteria such as school environment, curriculum and learning, partnership and policy and planning. Almost all schools (95%) had a focus on pupils' healthy living. In relation to the formal curriculum, all HPS schools implemented SPHE in first and second year, while 99% of schools implemented it in third year. The percentage of those offering SPHE to pupils in fourth, fifth and sixth year was lower (from 73 to 57% and 53% respectively). Parents and the community were involved in school activities that promote health and well-being in 42% and 50% of the schools respectively. There was an explicit policy aimed at promoting healthy lifestyles among pupils in 35% of the schools. Principals were supportive in 85% of schools while there was a designated team to coordinate HPS in 35% of schools. More than two-thirds of the schools considered teachers had been trained in SPHE.

The national guidelines for HPS (HSE 2013) identify four strands of a health promoting school, 1) Environment, 2) Curriculum and Learning, 3) Partnership and 4) Policy and Planning. The qualitative data were categorised mainly according to these four themes. This yielded insight into the dominant focus on environment and curriculum and learning with less focus on policy and planning and partnership. Figure 3 demonstrates the areas attended to in HPS in post primary schools in Ireland cited by school staff in their descriptions of HPS.
2) **HPS Practices in Irish Schools**

*Environment of health promoting schools*

‘Environment’ dominated and was the subject of 59% of the descriptions. This was made up the social environment (19%), the psycho-social environment (18%), the physical environment (2%), physical activity in the school (22%) and healthy eating in the school (39%). Comments relating to the social environment of the school were centred on relationships between teachers and students, teachers and teachers and teachers and management. "Very positive - whole school approach from Board of Management to student council, canteen involvement" (Q.R. 70). "Students and teachers alike are proactive in the promotion of a healthy body and mind" (Q.R. 99). "There is a friendly and respected relationship between staff and students" (Q.R. 264).

The psycho-social environment comprised the school ethos as well as the supports outlined for the students, such as the pastoral care team, the tutor system, guidance counselling and peer mentoring system; "Strong emphasis on school ethos - good atmosphere - low level of bullying".
high attendance rate. Holistic - sincere - doesn't always succeed perfectly. We're open to change and become more effective" (Q.R. 14). "Care team meetings to identify and support students emotionally, academically and mentally" (Q.R. 110). "Promotion of healthy lifestyle, development of the whole person is part of the ethos supported by teachers on a day to day basis" (Q.R. 212).

The physical environment of the school was not a common feature in teachers' descriptions of health promotion in their school. It was cited by only three teachers in the description of their HPS. This included the clean environment of the school and the physical make up of the school "A work in progress!! Between building developments, longer morning break, bags moved to classes, not left on corridors to trip people up" (Q.R. 305).

In the analysis, physical activity was coded under two themes. Where the data specific to physical activity pertained to curriculum they were coded under the curriculum and learning theme. Where the data pertained to the provision of an environment conducive to physical activity they were placed under environment. Physical activity and environment included whole school initiatives such as the "Whole school walked a mile" (Q.R. 7), physical activities offered during lunch hour and after school; "Physical exercise encouraged during lunch time and after school" (Q.R. 308) as well as encouragement of exercise based school transit; "walk and cycle to school encouraged" (Q.R. 216). Healthy eating dominated the comments. There was considerable variety in the answers received; for some, the comments pertained to healthy options available in the canteen “Health options available to students and staff at the school canteen - smoothies, salad bowl, wraps, sandwiches, milk, water, juices available (no fizzy drinks)” (Q.R. 97). For others it was the existence of breakfast clubs or free lunches offered to students in the school, "We have a breakfast club" (Q.R. 68) "Good nutritional lunches free for students" (Q.R. 266). For others it was the quality of food available and the promotion of health eating amongst the students, "Tuck shop promotes healthy eating" (Q.R. 55). Some did acknowledge that the emphasis on healthy eating meant that other areas could be neglected as a result.

There was a big focus on healthy eating a number of years ago with development of policy, removal of vending machines (only water and fruit juice now available) and while a lot of work is done on school lunches other aspects are probably neglected (Q.R. 80).

**Curriculum and Learning for Health Promoting Schools**

Curriculum and Learning was the focus of 34% of the descriptions. For some schools the responses indicated that HPS was subject based and centred on the subjects of SPHE, PE, Home Economics, Science and Religion "Constant efforts being made through subject content in PE, RE,
Home Economics, Science and SPHE departments" (Q.R. 109); "Non-existent outside SPHE class" (Q.R. 58). Other schools however, appeared to have broader implementation that ranged between cross curricular approaches; "The CSPE, RE and English curricula are supportive of the wider SPHE aims and the Science dept. work to support the RSE module" (Q.R. 315) and more whole school engagement; “Health promotion happens across the school, with great cross-curricular links between SPHE, PE and Home Economics” (Q.R. 76).

**Partnership**

Partnership was alluded to by 2% of descriptions received. The comments centred on partnerships with parents, the HSE and community groups.

*We have meetings regularly with head of canteen, parent reps. and staff (teaching) (Q.R. 26).*

*There is a committee of 2 students from each year, 2 teachers and 2 parents - each year we recruit 2 new 1st years to join (Q.R. 145)*

**Policy and Planning**

References to policy and planning made up 5% of descriptions received. Five respondents identified a range of policies in place commenting also on the updating and reviewing of policies e.g. "The policy is currently under review and is being developed beyond what it was today" (Q.R. 290). The remaining eleven cited the existence of healthy eating policies in their schools e.g. "We have a healthy eating policy for the school canteen" (Q.R. 181).

**Additional themes**

A frequent model for HPS appeared to centre on awareness weeks that were run in the school on specific themes, such as bullying, healthy eating, physical activity etc. Of the comments received fifty two mentioned the focus on these weeks to create awareness around a particular health issue. "Ad hoc although we do run an SPHE week each year with a theme eg. bullying/fitness" (Q.R. 201). "We designate a week at the beginning of the school year to health promotion with lunchtime activities, sports day etc." (Q.R. 235).

Schools appeared to rely heavily on external input for health promotion which included talks and workshops run in the school from invited guest speakers. "Healthy talks given to class groups by outsiders" (Q.R. 8); "This year we have had speakers in on: mindfulness, s ex ed., STI's/contraception (5th/6th), exam organisation/ personal motivation, Drugs, Alcohol, Mental health, G.P., Bullying - all types" (Q.R. 47).
Some comprehensive examples of health promoting schools that were indicators of good practice were provided, however these were limited.

We promote our school as a happy, healthy school where good learning can take place in a safe and secure environment. We see the benefits of health promotion as better learning results, increased self-esteem, improved attendance, positive school environment. Health ed. -highlighted and promoted. Awareness of importance of physical and social environment of our school. Promotion of positive behaviour, encourage healthy eating and a healthier lifestyle in our school. Our school is a happy, healthy school (Q.R. 71).

Health Promotion involves range of things; Warm supportive atmosphere, good relations between staff and students, timetabled SPHE classes, mental health week each year, range of student support policies in place, active student council, good canteen food, promotion of resilience, organised speakers for parents, links in with Headstrong and community groups, promotion of extra-curricular activities (Q.R. 198).

Challenges

Some challenges in relation to HPS were identified. For some, buildings were not fit for purpose "Rooms are damp and mouldy; students are sitting in cramped conditions" (Q.R. 57). Time and resource constraints were proving a challenge. "A lot of positive disposition towards Health Promotion through the school but time and resource constraints are proving more and more difficult to withstand while still offering a full range of services" (Q.R. 184). In some schools health promotion was up to individual teachers, "Depends on whether a teacher decides to do so or not. No policy in place. No specific planning" (Q.R. 101) "Disjointed and lacking co-ordination. Some subjects and some teachers carry the burden of this and others ignore it" (Q.R. 275). Lack of teacher training was a barrier, "Health promotion is not prioritised. Attempts have been made by the SPHE dept but we have not been successful. I feel however that because our SPHE teachers are not all trained in SPHE, they don’t themselves value the effort others make" (Q.R. 102).

The broader challenges facing the teaching profession today were thought to be taking a toll on teachers’ own health and wellbeing and adversely impacting upon their capacity to provide holistic education.

"I feel it used to be better 5 or more years ago. With the cutbacks we have less and less people available to deal with individual cares, 1-to-1. Also I am under more time constraints with more work, corrections, Croke Park hours, extra out of school activities. I’m running out of steam! To a point my own health has suffered I am currently on medication for depression related to stress (Q.R. 92).

Discussion

The aim of the research was to illuminate the current state of the art of post primary HPS in Ireland. Having received information from 56% of schools nationally the data are particularly relevant.
The data are promising with over half of schools (56%) identifying themselves as a HPS. The data are less promising, specific to the national recognition of HPS with only 2% of schools having achieved the national HPS award and 6% in the process of obtaining the award. Interestingly, these numbers are similar to the experience in Hong Kong where in a recent survey 8% of post primary schools were participating in the Hong Kong Healthy School Award Scheme in 2010 (Lee et al., 2014). Fifty per cent of schools in Ireland who had not received the award cited lack of awareness of its existence. This is unsurprising given the lack of emphasis on HPS in Ireland in recent years. The renewed interest of HPS, evident in the publication of the two strategic national policy documents (HSE, 2013; Department of Education and Skills, 2013), should prompt greater awareness and engagement with health promoting schools in the future. It is imperative that more awareness and funding support for the development and implementation of HPS is facilitated amongst post primary schools. It is noteworthy that the emphasis was particularly on environment, followed by curriculum and learning, while partnership and policy and planning featured minimally in respondents’ answers.

Environment

Schools in the study evidenced strong awareness of the importance of the environment for HPS. Emphasis was placed more on the social and psycho-social environment than on the physical one. The Department of Education and Skills (2013, p.18) conceptualise the physical environment for HPS from quite a limited perspective when they describe it as: warm, safe, well kept, clean/tidy, plants and trees (see figure 1). A more comprehensive conceptualisation of the physical environment for Irish Health Promoting Schools is clearly necessary. This can be supported by drawing on the WHO (2004) documentation on The Physical School Environment an Essential Component of a Health Promoting School, which offers a more comprehensive understanding of the physical school environment. For teachers, the psycho-social environment featured strongly, although the emphasis that respondents placed on the psycho-social environment is not reflected in the recent policy documents for Irish HPS (HSE, 2013; Department of Education and Skills, 2013). Teachers, however, clearly feel that this is an important aspect. Healthy eating was a dominant theme amongst responses and was reflected frequently in the data. Clearly, this is an important area and given the national focus on obesity (HSE, 2008), it is unsurprising that it appears to have permeated schools. Given the priority placed on global obesity issues, education for healthy nutrition and access to healthy food is essential. It is important however, that over emphasis on obesity and healthy eating does not occur to the neglect of other areas of HPS.

Curriculum and Learning
The dominance of SPHE in the responses was foreseeable, given that Ireland has a discrete curriculum dedicated to health education/promotion. It was always intended that SPHE would be implemented within the context of HPS (Department of Education and Science, 2000). There is however, a danger when a discrete subject exists that teachers are less inclined to perceive the need for the whole school approach, as it is understood to be catered for within the SPHE class. Such a curricular emphasis could also mean that health promotion is engaged with on a cross curricular basis and yet still lack whole school implementation. In just 18% of schools health education was addressed as both subject specific and cross-curricular. It is important, therefore, when introducing a subject like SPHE that its intersection with HPS is adequately conceptualised and articulated for teachers. There is however, a more problematic trend emerging in Irish schools. Under the current reform agenda, the subject of SPHE will no longer be compulsory in post primary schools and is dependent on the interest and commitment of individual school principals. This could be considered a regressive step, with the potential to undo the significant achievements made in implementing a health promoting curriculum in Irish schools.

Policy and Planning

Policy and institutional planning is an important implementation component of the HPS (Samdal and Rowling 2011). Respondents outlined a range of individual policies such as substance use, anti-bullying, healthy eating. However, existence of one coherent HPS policy, under which, these themes could be addressed was lacking. Interestingly, the Department of Education and Skills (2013), in their model (see figure 1) does not advocate for one coherent policy for HPS. A specific HPS policy would provide coherence for all the activities related to health promotion in schools. It could also serve to provide a clear conceptualisation of the HPS in practice and in this way garner the support and commitment of management and all school personnel. It could also facilitate clarity among stakeholders in working towards achieving HPS objectives (Heward et al., 2007; Mohammadi et al., 2010).

Other key factors for successful implementation include school leadership support, staff training and a designated team for HPS. In 85% of the schools in this study the principal was supportive which is an important implementation factor (Barnekow et al., 2006). In terms of staff training, which is very important (Jourdan, 2011), 70% of the SPHE teachers had been trained, which still left a deficit of 30% untrained. A designated team to develop and implement HPS has been identified as critical (Firth et al., 2008; Rowling and Samdal, 2011). The Australian experience identified that successful teams had certain characteristics which included, inclusion of management, holding regular meetings in school time, drawing team members from a range of areas within the school,
retaining most of the members over at least three years and having clear roles within the team as well as shared responsibility (Firth et al., 2008). It is therefore problematic that, 65% of schools had no such team engagement. According to Samdal and Rowling (2011) a team is very important for collaborating with other stakeholders to bring about the organisational change needed for HPS. Close collaboration between management and the coordination team is deemed critical for such organisational change (Samdal and Rowling, 2011).

The lessons that can be drawn from the Norwegian, Canadian and German experience about the central importance of leadership are noteworthy (Tjomsland et al., 2013; Wells, 2013; Dadaczynski and Paulus, 2015). For successful and sustained implementation, commitment from management and a strong co-ordination team is essential. It is recognised that there are increasing demands placed upon teachers, most particularly in terms of accountability for their time and this makes the creation of HPS teams increasingly more difficult. Yet the success of HPS rests on resources and adequate time because they are essential to support schools to plan effectively for health promotion school implementation.

**Partnership**

Partnership is a key principle of HPS and the importance of involving parents is widely advocated (Clelland et al., 2013). Forty two per cent of HPS agreed that parents are involved in school activities that promote health and wellbeing. However, when asked to describe health promoting activities, parents were visible in only 2% of responses. Therefore, it is clear that considerable work needs to be done, not only in raising awareness among schools about the role and practice of partnership for HPS, but also in helping schools and parents to work in a partnership model to achieve their HPS aims. There was some evidence of seeking partners and allies in the community, in support of health education/promotion as Barnekow et al. (2006) advocate. Relying on external input (i.e. talks and workshops) was a common theme. However, descriptions of more meaningful partnerships with the local community were limited and are clearly an area requiring better support. External input has a role to play but it needs to be done in a contextualised and sustained manner. It is recognised nationally that outside facilitators who contribute to health education/promotion can play a valuable role in "supplementing, complementing and supporting a planned, comprehensive and established [health] programme" (Department of Education and Skills 2010, p.2). However, care is advocated so that schools are not over reliant on outside agencies, as national and international research has consistently shown that "the qualified classroom teacher is the best placed professional to work sensitively and consistently with students and that s/he can have a powerful impact on influencing students’ attitudes, values and behaviour in all aspects of health education" (Department
of Education and Skills 2010, p.1). The results align with those of Tudor-Smith et al. (1997) who found that schools appear to place a heavy reliance on talks given by external speakers in their national survey of Welsh post primary schools. Health themed awareness weeks were common practice in schools and have merit but in order for sustained engagement with their benefits they need to be implemented in a larger whole school context, that is health promoting. While these weeks certainly can be useful to highlight specific issues, there is also the potential for schools to assume that their health promotion work is ‘done’ in specific weeks, rather than in an integrated and sustained manner.

Conclusion
The data evidenced that there are examples of good HPS practice in post primary schools in Ireland but that there are also significant challenges. There is great diversity across schools, in terms of health promotion practices. The results in this research study are reflective of the situation in other countries where "the lack of specific implementation guidelines makes it difficult for the schools to identify concrete actions to achieve a whole school health promotion approach and results in a wide array of practices across schools and countries" (Samdal and Rowling 2013, p.23). More promotion, coherence and awareness are needed for the success of HPS in Ireland.

Schools appeared to demonstrate some success in discrete areas, such as curriculum or healthy eating, but less so from a whole school perspective. Coherent whole school implementation of HPS was not greatly apparent. This reflects the findings of the international literature which suggests that whole school implementation has been problematic (Rowling and Jeffreys, 2006). In order for more effective implementation of HPS in Ireland from a whole school perspective, Irish policy needs to conceptualise the whole school approach more clearly. Although the general criteria outlined in the national framework are useful for schools, considering the diversity of health promotion practices between schools, it would be helpful if the specific indicators for each HPS component were outlined. The indicators provided by Lee et al. (2014) are useful as well as the nutrition example provided by St. Leger (2004).

Schools need to be supported in their endeavours to become health promoting. It is also important however, that any current resurrection of health promoting schools in Ireland is cognisant of the struggles that Irish teachers now face. The teacher who responded: “I am running out of steam! To a point that my own health has suffered...” is a cautionary tale for all. Health promoting schools internationally advocate for schools as health promoting for all (Barnekow et al., 2006). A support framework for teachers within which to implement HPS should be a corner stone of any national HPS implementation, to avoid teacher burnout. The international literature tells us that
working within and with other HPS has positive effects for implementation (Viig et al., 2012). Young (2005) advocates a strong need for political will and supportive policy framework in order to support teachers and schools. Lee et al. (2014) have advocated for partnerships between academic institutions and schools and offering comprehensive training programmes for teachers as a means to achieving successful implementation. All of these have merit and it is the authors’ hope that national policy in Ireland will be influenced by evidence of successful implementation factors such as these.

Further research needs to examine how the HPS descriptors in this study align with the purposes and objectives of schools. The inspectorate holds a valuable place in the education system. The Scottish example of mandating inspectors “to review and report on the HP work of the school” (Inchley et al. 2013, p.161) is useful in demonstrating national commitment to the endeavour. Similar potential exists in Ireland in order to optimise implementation.

This study provides benchmark data as to current practice in post primary schools in Ireland. The concept of HPS is now over a quarter of a century old and there remains lack of consistency, as to how it has translated into daily school practices. It is clear from the data received that more work needs to be done in understanding the health promoting school concept which needs to be driven not only from the HSE but the education sector if it is to have any real meaning, value and sustainability in schools.

Limitations

The questionnaire was a self-reporting instrument which may have had an impact on the answers received, as self-reporting instruments carry with them several sources of potential bias which include selective memory, attribution and exaggeration. It would have been valuable to gain the perspectives of other stakeholders such as, principals, parents, pupils and other teachers. Due to time constraints it was not possible to do follow up interviews with schools but this would have been useful to clarify points, explore areas in more depth and triangulate the results of the questionnaire.

References


St. Leger, L., Young, I., Blanchard, C., and Perry, M. (2010), *Promoting health in schools: from evidence to action*, Saint Denis, IUHPE.

Stewart-Brown, S. (2006), “What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting school


