SHE Monitoring Report

2021

A qualitative exploration of barriers and facilitators for the implementation of school health promotion in Europe

Schools for Health in Europe Network Foundation

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Background

The Schools for Health in Europe Network Foundation (SHE) aims to promote the Health Promoting School (HPS) approach among all schools in the European region[1]. Even though not all schools are working according to this HPS approach (yet), many schools do take efforts to improve the health and well-being of children and school staff with concrete health promotion (HP) actions/activities. Implementation of school health promotion, whether or not according to the HPS approach, is influenced by many different factors, e.g., the availability of (financial) support from the national government. Influencing factors can hinder or facilitate the implementation of school health promotion. Which factors are of influence can differ among countries, regions and even schools. To get a better insight in these influencing factors and to monitor the implementation of school health promotion, SHE conducted a questionnaire study in 2020: SHE Monitoring 2020[2]. This study was conducted among the national and/or regional coordinators of 24 SHE member countries and provided insight in the perception of these coordinators on school health promotion and the HPS approach in schools in their respective countries. The aim of the SHE Monitoring Task 2021 was to get a deeper understanding of the current influencing factors for the implementation of school health promotion. For this task, an in-depth exploration of the perceived barriers and facilitators for the current implementation of school health promotion has been conducted in five SHE member countries in September 2021. This report presents the main findings of this study and discusses insights and recommendations for further improving the implementation of school health promotion.

The five participating countries

The countries Estonia, Norway, Portugal, Slovenia, and Wales were invited to participate in the conceding SHE monitoring 2021 study based on their different approaches of the implementation of school health promotion and on their geographical position within Europe. In each country, semi-structured online interviews were conducted, based on an interview guide derived from the SHE Monitoring 2020 questionnaire. The participants were HP professionals and/or educational professionals from national or local/regional institutes in the participating countries (Table 1). They were employed as, e.g., national or regional HPS coordinator, researcher, or Minister of Education. A description of the national school system and school health promotion arrangements in each country is presented in Box 1.

Table 1. Participants in the study

Country	Participant ID	Current employment
Estonia	E1[a]	HP specialist at a national institute
	E2[a]	HP specialist at a local/regional institute
Norway	N1	HP specialist at a national institute
	N2	HP specialist at a local/regional institute
Portugal	P1	HP specialist at a national institute
	P2	Education specialist at a national institute
Slovenia	S1	HP specialist at a national institute
	S2[a]	Education specialist at a national institute
	S3[a]	Education specialist at a national institute
	S4[a]	Education specialist at a national institute
Wales	W1	HP specialist at a national institute
	W2	HP specialist at a local/regional institute

[a.] E1 en E2 were interviewed in a joint interview. S2, S3, and S4 were also interviewed in a joint interview.

Box 1. National school systems and school health promotion in the five participating countries

Estonia

National school system: Children in Estonia attend primary school from age 7 to 16 years (Grade 1-9). This is mandatory. After primary school, children go to secondary school (age 16-19 years; Grade 10-12) or vocational schools.
School health promotion: All schools in Estonia implement school health promotion actions/activities. About half of the schools in the country are working according the HPS approach. National standards and indicators exist for schools to become a HPS. Schools are supported by regional HPS coordinators, who also examine if a school fits the standards and indicators of a HPS. The regional coordinators are supported by a national HPS institute and the national government.

Norway

National school system: Children in Norway attend primary schools from age 6 to 12 years (Grade 1-7). After primary school, children attend lower secondary school (age 12-15 years; Grade 8-10) and then higher secondary school, e.g., gymnasium or vocational schools (age 15-18 years; Grade 11-13). From Grade 1 to 10, school attendance is mandatory. All children go to the same type of school, the so-called Fellesskole.
School health promotion: All schools in Norway implement school health promotion actions/activities. HP topics are part of the national curriculum. Less than 25% of the schools are working according to the HPS approach. No national standards and indicators for schools exist to become a HPS. Support to the schools is regionally coordinated. No national network for the HPS approach exist and there is minimal involvement for this approach from the national government.

Portugal

National school system: In Portugal, children from age 6 to 14 years attend basic education, which includes three cycles: the first cycle consists of Grade 1 to 4, the second cycle of Grade 5 and 6, and the third cycle of Grade 7 to 9. After this basic education, children attend secondary education (age 15-17 years; Grade 10-12). Attendance of both the basic and secondary education is mandatory.
School health promotion: All schools in Portugal implement school health promotion actions/activities. HP is part of the national curriculum. More than half of the schools are working according to the HPS approach. No national standards and indicators exist for schools to become a HPS. Support to the schools is provided by local HP teams. The national government is funding school health promotion and approves the quality of projects for schools.

Slovenia

National school system: Children in Slovenia attend primary school from age 6 to 14 years (Grade 1-9). After primary school, children attend secondary school (age 15-18 years; Grade 10-12). When children live too far away from secondary school, they can make use of dormitories. School attendance is mandatory for children from age 5 to 14.
School health promotion: Many schools in Slovenia implement school health promotion actions/activities. About half of the schools are working according the HPS approach. National standards and indicators exist for schools to become a HPS. Support to the schools is provided by regional and national coordination, which is (financially) supported by the national government.

Wales

National school system: Children in Wales attend primary school from age 4 to 11 years (Grade 0-6). After primary school, children go to secondary schools (age 11-16 years; Grade 7-11). Attendance to both primary and secondary education is mandatory.
School health promotion: All schools implement school health promotion actions/activities and they are all working according the HPS approach. National standards and indicators exist for schools to become a HPS, the so-called Healthy School Scheme. Schools are supported by regional HPS coordinators. These regional coordinators are supported by a national HPS institute and the national government. In 2022 a new national curriculum will be rolled out in which health and well-being is at the same level as other topics, e.g., Maths, English, Science.

Factors related to the implementation of school health promotion

According to the participants, the current implementation of school health promotion in their country is influenced by a unique combination of barriers and facilitators depending on many contextual factors, such as the history of and support for school health promotion. Six categories were identified when analysing the perceived barriers and facilitators: *1) the HPS approach, 2) the educational staff in a school, e.g., teachers, principal, 3) the school as an organisation, e.g., curriculum, policy, 4) the partners of a school, e.g., school nurse, local health team, HPS coordinator, 5) the environment of a school, e.g., community, home-setting, and 6) the national policies*.

Perceived barriers for the implementation of school health promotion

Many different barriers were perceived by the participants from the five countries. Some barriers were present in all countries, while others were only predominant in some of the countries. Table 2 presents the perceived barriers in the five countries structured by the six categories.

Table 2. Barriers for the implementation of school health promotion, as perceived by the participants (n=12)

Perceived barriers related to the …	Estonia	Norway	Portugal	Slovenia	Wales
HPS approach: Lack of understanding about the approach	X	X	–	–	X
Educational staff in a school: Teachers having a limited focus on HP in their teaching	X	X	X	X	X
School as an organisation: Suboptimal way of working	X	X	–	X	X
Partners of a school: Lack of time from partners	X	X	X	X	X
Environment of a school: Suboptimal school environment	–	–	X	–	X
National policies: Limited involvement of and support from national government	–	X	X	X	X

Perceived barriers related to the HPS approach

In this category the focus was on the HPS approach and to what extent the HPS approach is embraced in a country. Even though many schools in the participating countries do take efforts in school health promotion to improve the health and well-being of children and school staff, the schools are not always working according to the HPS approach, as could be seen in Box 1. Perceived barriers for working according to the approach, mentioned by the participants of three of the five countries, were mainly related to the complexity of the HPS approach, leading to a school's **lack of understanding about the approach** (*Estonia, Norway, Wales*). It was perceived that schools implement HP efforts as separate actions and activities, without being aware of the need for a systematic whole school approach.

> **Estonia (E1):** *"I think a barrier is the lack of understanding about what is the HPS approach. Schools often do focus on HP, but don't do this in a very systematic way. They focus for example mainly on a sports day. They don't see the bigger picture and focus on just some activities and not the whole approach."*

Perceived barriers related to the educational staff in a school

Barriers related to the educational staff in a school were mentioned by the participants of all countries. A major perceived barrier was the lack of time of teachers (*Estonia, Norway, Portugal, Wales*). They all perceived the **workload of teachers as too high**. Another barrier mentioned was **the teachers being very much subject-oriented** (*Norway, Portugal, Slovenia*). It was perceived that teachers focus mainly on their own subject and **do not integrate HP topics in their teaching**. In their perception, teachers often felt that HP was still something additional: Another task that they had to do.

> **Portugal (P1):** "*Teachers consider the curriculum as a cage. Take the example of Biology, when teachers teach nutrition, for instance, this is not only about what's healthy or not. It's impossible to teach about healthy foods without considering the environment or human rights. We simply cannot educate all these topics in a cage. We should make all the connections, because every single topic has a link with something else. In Portugal, teachers tend to limit their lessons to those separate topics or cages. It doesn't work that way, because this kind of mentality doesn't help the children to develop a critical opinion.*"

Perceived barriers related to the school as an organisation

Participants of four countries mentioned barriers related to the school as an organisation. One of the major barriers that was mentioned was **the lack of a systematic HP approach** (*Estonia, Norway, Slovenia*), leading for example to **a large focus on ad hoc activities in schools**. Another perceived barrier was that, due to **an overload of options of providers and projects,** some schools find it difficult to decide which interventions to implement, and how to determine which ones are evidence-based (*Wales*). Finally, it was mentioned by several participants that HP is not mandatory in the curriculum, which leads to a **limited focus on HP in the curriculum,** according to these participants (*Norway, Slovenia, Wales*). It is then up to schools to determine if and how to focus on HP.

> **Norway (N2):** "*I think that the most important factor is that there is no saying in the Norwegian curriculum that it is mandatory for schools to work with HP. Even if it says in the curriculum that public health and quality of life should be part of every subject in the school, each school is independent in how to translate this. And there hasn't been a strong push from the Norwegian government to really focus on HP. So, I think, local schools, they do as they like.*"

Perceived barriers related to the partners of a school

Participants of all countries mentioned barriers related to the partners of a school. These barriers were all related to a lack of available time from the partners who collaborate with schools. For example, **the lack of time of supporting specialists within the school**, such as a school nurse, a social pedagogue or a psychologist (*Estonia, Norway, Slovenia, Wales*). Even though they are very helpful in promoting health and well-being on a population level in the school, they are often too busy with the care for individual students, and therefore have less time for HP. Also, **insufficient time of external partners,** such as local health teams or a HPS coordinator supporting schools, was a barrier according to some participants. As is the case with internal professionals, external partners have too many other tasks competing with implementation support dedicated to schools (*Estonia, Portugal, Slovenia*).

> **Estonia (E1):** "*Supporting specialists, such as psychologists or social pedagogues, usually work in a school and also focus on HP. However, they do not have the time for it.*"

E2: *"They can, for example, talk about mental health and organise mental health activities. They are the key person for this, but they are overloaded with supporting individual cases, so there is no time left to focus on the whole population."*

E1: *"And it is a little bit the same with our HPS coordinators. They are very busy people and don't have so much time for this coordinating work, on top of their everyday work."*

Perceived barriers related to the environment of a school

Barriers related to the environment of a school were only mentioned by the participants of two countries. Both mentioned **the influence of parents** *(Portugal, Wales)*. While this can be very supportive, sometimes parents perceive that the school is interfering with how they raise their child, which can lead to a decline in support from parents for (aspects of) school health promotion. Moreover, participants from both countries also perceived **a lack of coherence** as an important barrier (*Portugal, Wales*). For example, schools may, unintentionally, send out mixed messages to the children and their parents by implementing HP activities, which are not supported by healthy school policy. Moreover, the lack of coherence was in their perception also caused by schools being part of a community and neighbourhood but only having limited control over nextdoor-shops or -cafés offering unhealthy products or the way parents deal with foods at home.

Portugal (P2): *"Well, context is the most important barrier. A school cannot perform miracles. A school does its part of the job but then there's the world around the school. For example, we can teach about food education and forbid specific food in the school, but then when the students quit the classroom they cross the street, and on the other side of the school there's this café with a lot of nice unhealthy food."*

Perceived barriers related to the national policies

Many different barriers related to the national policies were perceived. One of the mentioned barriers was the **suboptimal collaboration between the Ministry of Education and the Ministry of Health** (*Norway, Slovenia*). Issues included, e.g., different perceptions on who is responsible for school health promotion (*Norway*), and whether HP should be part of the national curriculum (*Slovenia*). Also **a lack of a national network** was mentioned as a barrier (*Norway*): It was perceived that a national network and national organisations focusing on the HPS approach were missing. Another barrier mentioned was there being **too much focus from the government on ad-hoc problems** (*Portugal*), leading to limited time and money for longterm issues such as school health promotion. Finally, **the focus of the national government on educational outcomes**, and on academic knowledge and skills, was seen as a barrier (*Norway, Portugal, Wales*). It was perceived that due to this focus, schools are mainly evaluated on these aspects and not on HP aspects.

Slovenia (S1): *"The Ministry of Education and Ministry of Health can improve their collaboration on HP. Even though the Ministry of Education is quite open, they do not want to touch the national curriculum. They say that the curriculum is full – and it is, it really is – and that HP is optional: It is for schools who are interested and not for the national level."*

Wales (W2): " *'What gets measured, gets done', and I think there's still a focus on educational outcomes and educational attainment. There is a move now with the new curriculum to recognize that healthy confident individuals is as important as Maths and English, but until the system of measuring schools changes, I think health and well-being is still going to be the poor relation to educational attainment."*

Perceived facilitators for the implementation of school health promotion

The participants from the five participating countries perceived not only barriers but also a lot of facilitators for the current implementation of school health promotion in their countries. Some facilitators were mentioned by the participants of all countries, and some were most prominent in specific countries. Table 3 presents the perceived facilitators in the five countries structured by the six categories.

Table 3. Facilitators for the implementation of school health promotion, perceived by the participants (n=12)

Perceived facilitators related to the …	Estonia	Norway	Portugal	Slovenia	Wales
HPS approach: Sufficient priority-setting as part of the approach	X	–	–	X	–
Educational staff in the school: Sufficient interest and support from principal and teachers	–	X	X	X	X
School as an organisation: Sufficient focus on healthy workplaces	–	X	–	–	X
Partners of the school: Sufficient local support for schools	X	X	X	X	X
Environment of a school: Sufficient support from the community	–	X	–	X	X
National policies: Sufficient (financial) support from the national government	X	–	X	X	X

Perceived facilitators related to the HPS approach

The perceived facilitators related to the HPS approach were often only implicitly mentioned by the participants. However, the participants of two countries mentioned that **the HPS approach had helped in the priority-setting in the schools** (*Estonia, Slovenia*). This priority-setting was often done by a working group, which discusses HP in their school. They discuss which topics should get priority, but also help for example in the implementation of the actions and activities.

> **Estonia (E1):** *"In Estonia, if the school is a HPS, then they should have a health team or working group."*
>
> **E2:** *"They are responsible for the HP topics and actions and activities in the school. They can organise for example sporting activities or discuss how to make the environment healthier. The health team decides what the school will focus on: Every year they focus on one or two topics. This health team consists of the principal of the school, teachers and supporting specialists, like a psychologist or school nurse. Sometimes also representatives of parents and representatives of children join this team."*

Perceived facilitators related to the educational staff in a school

Facilitators related to the educational staff in the school were perceived by the participants of four countries, and were mainly focused on the interest and support of the principal and staff. **Sufficient motivation, interest and leadership from this principal** is, in the perception of several participants, essential to the implementation of school health promotion (*Norway, Slovenia, Wales*). However, even though the principal is in charge, he/she needs the support from teachers. Another important perceived facilitator is therefore **the sufficient involvement of teachers and how they integrated HP in their work** (*Portugal, Wales*).

Wales (W2): *"The number one facilitator is leadership from the head teacher or principal. Sometimes when schools don't engage, you literally have to wait for the head teacher to change, as you have to get through to the person in the school who has the power to affect change in the school system. But, also, you can have a very engaged and pro HP head teacher, but without the staff being on board it is very-very difficult. Because they're the ones that are closest to the children."*

Perceived facilitators related to the school as an organisation

Facilitators related to the school as an organisation were limited and mentioned by the participants of only two countries. It was pointed out that the school is also a workplace for them: **A sufficient focus on healthy workplaces** facilitates a healthy school for the children (*Wales*). Furthermore, all spearheads related to **HP topics included in the national curriculum** facilitated the implementation of school health promotion (*Norway*). Even when the included topics are limited, they still promote the agenda-setting for HP.

Wales (W2): *"It's interesting actually that staff well-being is often one of the last aspects that schools focus on. We see a school as an educational setting, but I always say it's a workplace as well. They think about the health and well-being of the children, first and foremost, but I need reminding them that it's their workplace, and that they are the ones that set the temperature in the school. So if you're working in a happy healthy school and your health and well-being – mental and physical – is valued, then you're going to be in a better place for the children. "*

Perceived facilitators related to the partners of a school

The participants of all five countries mentioned facilitators related to the partners of a school. All of these facilitators were related to sufficient local support for schools. Especially **the availability of support from external partners** was mentioned (*Estonia, Norway, Portugal, Slovenia, Wales*). For example, the support from a HPS coordinator, local health team, or local authorities. But also **the availability of support from internal partners**, such as a school nurse or social worker, was perceived by the participants of some countries as a facilitator for the implementation of school health promotion (*Estonia, Wales*). Furthermore, a specific form of support was often mentioned: **The availability of materials and/or training for teachers** (*Estonia, Norway, Portugal, Slovenia*). The participants indicated that these materials and training really helped the teachers in how to work on HP in the classroom. Finally, also **networking events or meetings with teachers from other schools** were perceived as an important facilitator, as the teachers can learn from one another and bring those learnt lessons back to their own school (*Norway)*.

Estonia (E1): *"The school nurses and the psychologists do not only focus on the individual but also on the whole school population. For example, they organise lectures and talk about it with individual children. They are really important for HP in the school. Especially because they are part of the school, they can sense what's happening, how children interact, and how teachers and children interact. Their connection with teachers allows them to receive immediate feedback when there is a problem in a class and they can help. Because they already know each other, it's much easier to solve specific issues."*

Portugal (P2): *"The schools get additional resources in terms of non-teaching staff. They can choose who they hire. Generally they hire psychologists, social assistance and mediators, but we now launched a programme that allows schools to also hire other specialists. We saw that they now also have chosen for artists to promote well-being in school through art education. "*

Norway (N2): "*We have meetings with teachers from each of the schools in our project. We support them in the collaboration with colleagues in relation to school health promotion: How to be more active in the school, eat healthier, and to teach pupils adopt healthier lifestyles. I think at least those teachers who are in our project, see the need for HP, and they are very eager to work with HP. They get some time in their daily schedule to work on HP with their own colleagues and they have to come to our meetings, several times per year.*"

Perceived facilitators related to the environment of a school

Perceived facilitators related to the environment of a school were limited. A facilitator that was mentioned by participants was that **aspects of HP were already part of the culture** in their country (*Norway, Slovenia*). For example, communities highly valued physical activity and it was therefore common for schools to invest time in physical activity. Another perceived facilitator were the **connections between the school and organisations in the community** (*Wales*). Many local organisations, such as sports clubs or welfare organisations, are related to HP; collaborating with such organisations can facilitate school health promotion. Moreover, parents of the children in the school are sometimes employed in these local organisations, which can make it easier for schools to create such beneficial connections in the community.

Wales (W2): "*We did for example some work in a school where there was a big general practioner (GP) practice by the school. So, we linked the school and the GP practice together. Some groups of children went there and had a visit to the GP practice. They asked the GP what he did and what the tasks of the GP practice were. We looked how far a sneeze travel, and we did some activities while we were in the GP practice. And that connection with the school, that was a good few years ago, and they've kept that going.*"

Perceived facilitators related to the national policies

Participants of four countries have mentioned facilitators related to the national policies. The specific facilitators varied between these countries, but all mentioned **sufficient funding from national government** to cover the main costs for the implementation of school health promotion as an important facilitator (*Estonia, Portugal, Slovenia, Wales*). A specific facilitator that was also mentioned was **the existence of a national public health institute** to organise the coordination for schools (*Estonia, Wales*). Even though such an institute is often funded by the government, the participants perceived this as a specific facilitator for the implementation of school health promotion. Another perceived facilitator was that **the national education department focused more on HP in their work** (*Estonia, Slovenia*). Even though this helped a lot in creating a better understanding between the departments of education and HP, it could be improved even more, according to the participants.

Wales (W1): "*We're very lucky in Wales. I realized, especially from me being involved with SHE, how fortunate we are actually in Wales to have the support from Welsh government. The Welsh government provide the funding to us as an organization, and we then distribute the grant funding to our local areas, and they then carry out the work. So, it very much comes from our government, they fund the Healthy School Scheme [national HPS programme in Wales]. Without that funding it wouldn't be possible for us to have the scheme, and to have staff in place to support the schools. And schools do really need that support from our staff to be able to work through, and really embed the whole school approach.*"

Slovenia (S1): "*We [national HP institute] cooperate more in depth with regional HPS coordinators who are leading regional networks. This is really good, because the connections with schools are more closer or in depth.*"

Finally, a good collaboration between the national HP institute and other national organisations supported school health promotion according to participants (*Wales*). For example, it was perceived as an important facilitator **to collaborate with the national education inspection body**, as they can encourage schools to embed HP or even include HP aspects in their formal school inspection. Also **the collaboration with a national research institute** was seen as a facilitator, as they can evaluate the impact of school health promotion on a national, regional and local level.

> **Wales (W1):** *"Estyn, the inspecting body for schools in Wales, are a crucial partner to us because schools very much look to Estyn to be guided. We work closely with Estyn to ensure that they understand what it is we're doing, the importance of healthy schools, so that when they're inspecting the school, they can encourage schools to really embed HP in their school. … It's very difficult for us to actually demonstrate the impact we're having. However, we work closely with DECIPHer [national research institute in Wales] and SHRN, the School Health Research Network. They go in the schools and they conduct a health and well-being survey, with all our children in Wales at secondary school every two years. Within that they cover all health topics and we can influence what questions go into the survey. Every pupil in Wales will complete that survey. And that's amazing for us, because it's a way of showing where the need is, and what it is we should be focusing at. "*

Impact of the COVID-19 pandemic

Since spring 2020, the COVID-19 pandemic has been disrupting the way of working in schools in SHE member countries. It has resulted in the closing of many schools during national lock-downs and the need for online education for children. Currently, countries are still combating the pandemic and even though with schools being open, they are still dealing with many challenges brought on by the pandemic. Logically, the pandemic has also had its impact on the implementation of school health promotion. Even though the five participating countries were very different, the participants perceived quite comparable barriers and faciliators for the current implementation of school health promotion as a result of the pandemic.

Perceived barriers related to COVID-19

A common barrier mentioned by the participants was that **the pandemic further restricted the limited time that was available for the implementation of school health promotion**. Teachers, principals, and supporting staff had even less time to focus on HP. But also local and national organisations that support schools in implementing school health promotion, had to focus mainly on COVID-19 due to a shift in tasks. Another common barrier was that local organisations that provide support to schools had **more difficulty to get a good connection with schools**. From behind a screen it is much more difficult to see and hear what is going on in a school, and what issues the people in a school were dealing with. Furthermore, **the cancellation of all special days, like a sports day**, was mentioned as a barrier, as this had its impact on the enjoyment in children and teachers. Also, many group activities were not possible due to higher chances of infection. Finally, several participants mentioned an **observed decline in the health behaviours of children, and an increase in sedentary behaviour due to lock-downs.** (School) health promotion is even more needed now.

> **Norway (N2):** *"Teachers and principals had to focus very much on home teaching and all other aspects around COVID-19. And I think HP was suffering from this."*

Perceived facilitators related to COVID-19

Even though the abovementioned aspects hindered the current implementation of school health promotion, in other ways the COVID-19 pandemic also facilitated school health promotion. A major perceived facilitator was that teachers, principals, children, and parents all got **a higher sense of urgency for (school) health promotion**. It suddenly became a topic that society spoke about and acknowledged the need for. Also, the importance of and skills required in teaching was more visible to parents, for example due to the forced online education at home. This resulted in **higher appreciation for schools from parents**. Another perceived facilitator was the possibility of online meetings. It had its disadvantages in terms of limited access and personal contact, but positive aspects were mentioned as well. **Online meetings saved a lot of time and money, mostly in terms of travelling to meetings,** which made work more efficient. Also, it had a positive effect on participation rates: **Online meetings for teachers and/or parents showed a much higher attendance** than physical meetings. Finally, a common facilitator for the current implementation of school health promotion was that it **encouraged many teachers to teach outside the classroom**. Before the pandemic teachers mainly saw obstacles, but due to the pandemic, outdoor learning became a valued and safe form of teaching.

> **Portugal (P1):** "*People become to think and look at health and HP with larger horizons. They understand that we have to work altogether in HP. It's not only an issue for health services, it is more than that. It is also about health education and health knowledge. Nowadays, people have more knowledge about health and about all that kind of relationships and links between health and other aspects in live. I think it's the biggest promotion that we can have.*"

> **Estonia (E2):** *"In springtime quite a lot of school nurses gave lectures to parents, for example. Or some schools organised online workout lessons. And because the meetings were online, the participation of parents was quite good. It was easier for parents, you don't need a babysitter, you can stay at home with your child, you just need your phone or internet connection, and you can listen what the school nurse or some other specialists says."*

Insights and recommendations

This report presents the results of the SHE Monitoring 2021, in which an in-depth exploration was conducted regarding perceived barriers and facilitators for the current implementation of school health promotion in five SHE member countries. The identified factors are related to six categories: 1) *the HPS approach, 2) the educational staff in a school,* 3) *the school as an organisation*, 4) *the partners of a school*, 5) *the environment of a school*, and 6) *the national policies*. All categories showed barriers and facilitators, which demonstrate the many factors and involved stakeholders that are influencing the implementation of school health promotion. This makes it a complex process that is unique in each country and even in each school. Therefore, **conducting a context-specific analysis of the barriers and facilitators** can be suggested in order to obtain a detailed insight in what can be done in a specific country or school to further improve school health promotion. When conducting such a context-specific analysis, it can be helpful to structure the barriers and facilitators by the six categories that were identified in this study. Moreover, even though only five countries participated in the current study and many of the perceived barriers and facilitators were unique for each country, similarities could be identified. These similarities have led to insights and recommendations, which can already provide some guidance to the SHE member countries when further improving the implementation of school health promotion.

The findings of the current study indicated that **creating sufficient time and local support for schools** is beneficial for the understanding and implementation of school health promotion. Many different kinds of support from internal and external health professionals were mentioned by the participants, such as advice, materials, and

training, but often a lack of time to provide the support was observed. The findings showed that this local support is organised in a unique way in each country, but that in all participating countries it is perceived as a crucial factor in implementing school health promotion. Moreover, **improving regional and national coordination and knowledge exchange** seems to help to provide the local support to schools.

Furthermore, the findings indicated that teachers are crucial in implementing school health promotion: They are the ones who are closest to the children. Therefore, **creating a healthy workplace for school staff** can be seen as an important factor, as well as **creating awareness that HP can be part of every lesson**. Currently, many participants perceive that teachers are often too much subject-oriented and are having an overly high workload, resulting in a limited focus on HP in their teaching. According to these findings, **promoting the inclusion of HP as a basic element in teachers' education** can be recommended to educate new teachers from the beginning how to integrate HP into their regular teaching routine.

The findings of the study also showed that the national curriculum plays an important role in the implementation of school health promotion. It was indicated that, when HP is not a formal part of the curriculum, schools can decide for themselves if and how they focus on HP. However, when it is included in the curriculum, HP becomes mandatory for schools. Therefore, **promoting the explicit integration of HP in the national curriculum** can be helpful in further improving the implementation of school health promotion.

Furthermore, the findings showed that **persuading the national government to support school health promotion** can be beneficial as their support seems to be crucial in creating optimal conditions for its implementation. Financial support, a good relation between the different Ministries and having a national HP institute were all perceived as supportive. Moreover, **cooperating at a national level with a research institute and the education inspection body** seems also to be beneficial to the improvement of school health promotion.

Specific barriers and facilitators for the current implementation of school health promotion as a result of the COVID-19 pandemic were also presented in this report. It was shown that the perceived barriers mentioned by the participants were mainly temporary ones, and hopefully these will be resolved when the COVID-19 pandemic has ended. It also was shown that many schools have to catch up on a lot of work, as a decline in health behaviours in children was perceived. The perceived facilitators specifically related to the pandemic seem to be more sustainable ones. More understanding about HP and the higher appreciation for schools will (hopefully) not simply disappear when the pandemic is over. Also, new options became available because of the pandemic, such as the possibility for online meetings. These online sessions turned out to be a good solution in specific situations, as they can improve participation rates and can save time and money. The challenge for each country is **becoming aware of the positive developments and trying to find ways how to sustain the positive effects,** even after the pandemic has ended.

Conclusion

This report describes the findings of an in-depth exploration of barriers and facilitators for the implementation of school health promotion. It can be concluded that even though in each country other (combinations of) factors influence the implementation of school health promotion, similarities do exist. These similarities have led to a number of insights and recommendations, which may be helpful for all countries. And while the unique context of a specific country or a specific school should always be leading, these insights and recommendations may be helpful and can be considered when further improving the implementation of school health promotion.

References

1. SHE. Available from https://www.schoolsforhealth.org/
2. Bartelink, N., Bessems, K., & Prevo, L. (2020). *SHE Monitoring Report 2020: Overall report of the SHE member countries.* Haderslev, Denmark: Schools for health in Europe network foundation.

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