Factors influencing the contribution of staff to health education in schools

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Abstract

Understanding the contribution of the whole-school staff to health education (HE) is an important goal in HE research. This study aimed to identify the views of staff (principals; teachers; school nurses and doctors; counsellors and administrative, maintenance, canteen and cleaning staff) regarding the nature of their contribution to HE. The research is based on 207 semi-structured interviews of staff in a sample of five French middle schools (grade 6–9). Content analysis was performed using Bardin’s method. The results showed that staff members have different views of their role, three main roles were identified: (i) as an educator in everyday life issues (72%); (ii) individual support, listening (14%) and (iii) taking part in collective projects and facilitation (14%). Professional status has a significant influence on the view they have of their contribution to HE. These results show that in order to facilitate consistent implementation of HE, schools need to be supported to build HE policy (need analysis, definition of priorities and partnerships) and also to develop the means by which an inclusive and real sharing of common culture among all staff can happen; this is not limited to teaching staff but includes non-teaching staff also.

Introduction

‘Every child has the human right to education, health and security. The central role of the school is teaching and learning, but they are also a unique community resource to promote health and development for children, families and teachers’. [1]. Health and education are inextricably linked. Considerable international research has been carried out in this field, and the role of the school in the improvement of health is well established [2–5]. Healthy young people who attend school tend to learn better and a good education influences the development of a healthier population [6]. The development of school health policies at national and regional level is supported by international recommendations from the World Health Organization [7–9].

Evidence shows that a whole-school approach, where there is coherence between school policy and practice, promotes social inclusion and commitment to education and actually facilitates improved learning outcomes, increases emotional well-being and reduces health risk behaviours [6]. Fundamentally, it is most effective where the school uses its full organizational potential to promote health among students, staff, families and community members [10]. Influenced by such evidence, initiatives were taken which led to the development of the broad concept of the health-promoting school (HPS) [11]. The present paper is grounded in this framework. The nomenclature and approach differs
between countries depending on the history, objectives and structures of each country’s school system. In some countries, it is referred to as health promotion (HP) [12] while in others it is referred to as health education (HE) [13] but all include a combination of actions focused on school health policies, physical environment, social environment, community partnerships, personal health skills and integrated health services [11]. Because this study was conducted in France, the terminology used is ‘HE’ as it is so designated in the French ‘common base of knowledge and skills’ [14]. The focus is on encouraging schools to act upon what they understand as the promotion of health, within their own mission, rather than the imposition of external public health programmes in schools. From this perspective, providing consistent HE in schools is more holistic, it is not just the remit of one teacher rather it is the role of all teachers along with school management and school support staff.

Many factors govern the ways in which school health policies are developed: (i) the political will to develop an HE policy allowing sustainable commitment on the part of institutions and communities; (ii) a favourable environment such as the support and facilitation of principals, existing teaching practices and the importance given to the well-being of the students; (iii) beliefs of staff and perception of their role in HE, their perception of effectiveness and acceptability of HE programmes and belief in their own effectiveness and (iv) factors linked to the policy itself such as training and assistance given to staff [15–18]. Therefore, staff commitment plays a crucial role [19]. The success of the widespread implementation of HE in schools will largely depend on their view of their contribution and their capacity to implement it [20]. Teachers have many priorities in relation to their subject [21], and their priorities differ to those of cleaning and administrative staff, as they do from those of principals and school counsellors; thus, it is challenging to gain one clear view of the contribution of each to HE. It is therefore important to gain a better understanding of the views of school staff in relation to HE and of their contribution to it. This study was undertaken with this aim. In order to elicit the personal views from a staff perspective, a qualitative approach based on semi-structured interviews was used. The study was performed on a sample of five French middle schools.

### Materials and methods

#### Context

In France, HE is not taught as a separate subject but as a part of citizenship education [14,22–24]. It does not, therefore, require specialist teachers but is a part of the everyday activity of all school staff. It is focused on the ability to make enlightened and responsible decisions. ‘Unlike conditioning, health education aims to help young people to gradually build personal capacity in terms of making decisions, adopting responsible behaviour, for themselves and with respect to other people and the environment. It also makes it possible to prepare young people for playing a responsible role in society where health matters are of major concern’. [22]. HE can only assume full meaning if it is incorporated into a wider approach. Since the early 1990s, schools rely on an additional resource: the health and citizenship education committee (HCEC) which provides a coherent articulation of school health policy from an HP perspective. The HCEC aims to ‘bring together prevention actions, mobilize those involved in the education community, strengthen links with other services, improve the climate and relations within the schools …’ [23].

#### Schools and participants

The study was conducted in the Auvergne region in France. Eligibility for participation in the study included all the staff employed by one of the five middle schools included in the sample. The schools were involved in a national research programme called ‘apprendre a mieux vivre ensemble’ (learn to live together) which aims to analyse the impact of an HE training programme on the practices of staff, student competencies and partnership between schools and families.

The research programme was implemented in both primary and middle schools. A representative
sample of French primary schools was formed on the basis of the sociological features of the schools (size, location and socioeconomic environment). The students of these 22 primary schools went to five middle schools. All five middle schools were concerned by the present study. All these schools have agreed to participate in the programme, and the present data were collected before any intervention took place. Schools’ characteristics are described in Table I. At the time of the study, 402 people worked in the five schools of the sample. The absence rate was 6%, the percentage of staff working in more than one school was 8 and 13% were part-time workers [25].

**Data collection**

This study is based on semi-structured interviews with staff (principals; deputy principals; teachers; school nurses, social workers and doctors; counsellors; administrative, canteen, maintenance and cleaning staff). The protocol is described in Fig. 1.

The interview guide was built by the research team in reference to the work of St Leger [11]. It was tested in three middle schools and approved after being reviewed. It included two sections. A common section including open-ended questions to assess staff’s views of the role, current practices and knowledge of the school’s policy run by the HCEC. A second section was specifically designed to analyse the views of staff on the ethical issues raised by HE practices. This paper focuses only on the results of the analysis of the first section of the interviews. Data were collected between February 2006 and May 2007.

**Data analysis**

Interviews were tape recorded and transcribed verbatim. Content analysis was done according to the three-step method proposed by Bardin [26] by two different research assistants (both of whom hold Masters in HE) and was validated after discussion by the research team. A codebook of major themes was developed. Coded comments were synthesized into overall themes and these themes were further subdivided and categorized. Only themes related to staff contribution to HE are reported here.

**Ethical considerations**

This study was approved by the chief education officer of the region and the ethics committee of the ‘apprendre a mieux vivre ensemble’ programme. The content of the interview guide and the information letter and the organization of data collection were validated by the school principal. All staff were free to take part or not in the interviews. All data were kept confidential. The transcripts of the interviews are anonymous.

**Results**

Two hundred and seven semi-structured interviews of staff (principals; deputy principals; teachers; school nurses, social workers and doctors; counsellors;

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<td>School</td>
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<td>Students</td>
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<td>Staff</td>
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<td>Percentage of success rate at the exam DNB</td>
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<td>Percentage of families with low SES</td>
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<td>HE school policy (number of actions in 2006/2007)</td>
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School characteristics. Number of students, staff, percentage of success rate at the exam DNB (national exam at the end of middle school), percentage of families with low SES (socioeconomic status) are from the local education authority. The number of actions officially included in the HE policy of the school (i.e. participation in community programmes on road safety or drug addiction prevention, specific projects on AIDS or nutrition driven by the school, etc.) has been chosen as the main indicator of the existence of a school policy. Ten to 15 different actions correspond to an average level of activity in HE.
administrative, canteen, maintenance and cleaning staff) were completed (52% of the total staff of the schools). Due to the fact the absence rate was 6%, the real workforce at a given time is 378. It means 55% of the people potentially present in the schools took part to the interviews. Ten people explicitly refused to take part to the interviews (the reasons provided were lack of time due to overloaded workload, imminent change of school, imminent retirement and no interest in HE). The interview guide for the principals included a question on the potential explanations of the response rate. Principals cited other reasons: schedule, sick leave, in-service training, school trips, part-time staff, staff working in two or more schools (doctors, nurses and teachers) and those deliberately avoiding the interviews. Part-time staff and staff working in two or more schools represent 21% of the staff (84 people).

The interviewed population cannot be considered to be representative of the overall staff. Such representativeness was not an objective of the study since the research aimed at analysing the contribution of staff rather than examining the relationship between and among variables.

Participants were predominantly female (66%). The mean age of the sample was 43 and the length of service in the school 8 years. The status of professionals taking part in the interviews differs. While 100% of the principals and deputy principals took part in the interviews, 77% of counsellors, 67% of school nurses, social workers and doctors, 64% of canteen and cleaning staff, 55% of administrative staff and 39% of teachers participated (Table II).

The results section describes the main findings of the content analysis. The focus is on what participants had said about HE and is not based on
pre-existing categories (deductive method). Participants differentiated between current contribution and their perceived role in HE. In addition, they linked their action to specific themes. Consequently, the data were organized into three sections: current contribution, perceived role in HE and emergent themes. Therefore, results are presented in that order. For each quotation, the school (first number of the code), individual code (letters and number) and the status are given.

**Current contribution to HE**

The content analysis of the interviews revealed varied perspectives of participants’ contribution to HE: 10% perceived they had no contribution, 24% perceived their contribution was very limited and 66% perceived they had a significant contribution.

Typical of those who believed they had no contribution were comments such as:

That’s not my office (5-S3 Administrative staff). One quarter of the professionals considered their contribution to be very limited. Their status did not give them the opportunity to make an important contribution but they still believed they could do small actions contributing to the everyday life of the school:

I don’t take part in specific actions; I have a minor role in HE as a math teacher. I feel more concerned as a class tutor (1-ES1 Math teacher).

I intervene when I’m the witness of incivility or violence but I don’t do anything about the other at risk behaviours (2-EL7 French teacher).

Sometimes, I don’t put toilet paper in a WC, I’ll explain why to you. During the period when I saw too many rolls of paper in the toilet or too much waste, I could stay 8 days without putting paper in this WC but there always paper in the nearby WC. I try to lead them to respect a little bit more (5-A6 Cleaning staff).

Two thirds of the staff considered they had a significant contribution:

Concerning the section of the curriculum devoted to diet, I make it very comprehensive. I mean I work on fats, proteins and carbohydrates (3-ES5 Biology teacher).

I think I’m already committed to HE in doing what I’m doing all over the year, with my students, my players, in spending a lot of time with them […] saying, for example, don’t use illegal

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<th>Table II. Participant’s characteristics</th>
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<td>Length of service (mean)</td>
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<td>Participation of teachers</td>
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<td>Participation of principals and deputy principals</td>
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<td>Participation of the administrative staff</td>
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<td>Participation of counsellors</td>
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<td>Participation of the canteen and cleaning staff</td>
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<td>Participation of nurses, social workers and doctors</td>
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Table of participants shows the characteristics of the interviewed population. The first part of the table is related to the overall population which took part to the study. Due to the fact that the participation of the professionals differs from a status to another, the number of participants within the status is showed in the second part of the table.
drugs (doping), don’t smoke, remind them of those things everyday (2-AP1 Physical education teacher).

I have made a contribution to AIDS prevention for a long time, since the beginning of the eighties (4-AS1 Social worker).

The project AIDS […] all the class took part, it was group work with groups of 2, 3 or 4 students. … the works are exhibited at the moment in the library, we have created pieces of a puzzle […] a sculpture will be created by an artist (4-E2 Art teacher).

Perceived role in HE

The content analysis of the interviews revealed that staff members had different views of their role in HE. Two main groups were defined: staff who perceived that they had no role in HE (8%) and those who think they had (92%). In the latter group, three subgroups were identified (educators in everyday life issues, individual support or listening and take part in or act as facilitators of collective projects). Status had a strong influence on role perception.

1. I have no role in HE.

Only 8% of the participants said they had no role in HE. They usually explained this in terms of it not being part of their job description:

No, I have no official role, some can speak about that but it’s only blablabla. I have no defined role in that matter (2-VS5 School counsellor).

My mission is instruction, education is only complementary (2-EL1 French teacher).

No, it’s not my job. And I think it’s a family matter (4-A6 Maintenance staff).

1. It’s part of my mission.

The large majority of participants perceived HE to be part of their mission even if, for some of them, their current contribution was very small. Ten categories of this were identified in the content analysis and were brought together in three groups. Group A: contribution linked to their everyday activity as educators in the school (72% of the participants perceiving HE as part of their mission); Group B: individual support and listening of students (14%) and Group C: involvement in collective projects focused on HE (14%).

**Group A: a contribution linked to their everyday activity as educators in the school**

*HE is perceived as a general ethos.*

We are adults so we are the role models (4-E5 French teacher).

I insist on the security rules related to the use of the materials, machines we use in class (3-ES7 Technology teacher).

I’m working a lot on the idea they have of themselves. If you don’t respect yourself, it’s hard to take part in the social game (4-CDE3 Special education teacher).

That’s our duty to show we are responsible adults (5-E7 French teacher).

*HE is linked to their professional activity.*

Depending on participant status, this educational contribution was described in different ways. Three groups of professionals were defined. Those for whom having a role in HE was core to their job (principals, school counsellor, nurse, social worker and doctor), the teachers for whom HE was linked to their teaching activity (even if HE is defined part of the curriculum or not) and administrative, cleaning, canteen and maintenance staff for whom this educational contribution was linked to a specific and often small part of their professional activity.

For school nurses, social workers and doctors, HE is central to their job description:

It’s our duty, in addition to our mission of listening, and caring, we have to take part in prevention, and information on everything linked to health matters (5-IDE1 School Nurse).

For teachers, of different subjects, there were two subgroups. Those for whom HE in its own right is
a part of the curriculum (biology and physical education teachers) and those for whom it is not the case:

In the biology curriculum, there is a specific topic about HE. In 9th grade, we speak about diet and sex education (3-ES2 Biology teacher).

An education in the field of health, doing sport, they are good things. Even if we only have 3h a week, it gives them some ideas on how to live with sport and improve their own health (1-ES4 Physical education teacher).

In my teaching, it can be very simple, I make links. I ask for what they are doing in the other subjects and I offer my small contribution (to the project AIDS), my personal touch. […] I had a song written by a school in Nanterre, they wrote lyrics and music. Each paragraph describes a mode of contamination (4-E4 Music teacher).

As a class tutor in 9th grade, the last day in June, when I say goodbye, I give them two pieces of advice. Be careful with AIDS and drugs … and we talk together about these issues. It’s all the easier since these issues have been tackled in the school (4-E5 Physical education teacher).

Two years ago, the nurse did something about tobacco, I had some texts in English, then we worked on these documents in my class (4-E3 English teacher).

In French for example, I’m working, in 7th grade, on accidents, accidents linked to the behaviour of reckless drivers […] there’s some texts on that (4-E2 French teacher).

For administrative staff and kitchen staff, it depends on their specific work:

It’s a common concern with the cook, to make well balanced meals (5-G5 Financial administrator).

Group B: a contribution based on individual support and listening

When interviewed about their role in HE, 14% of the participants perceiving HE as part of their mission put the emphasis on individual relationship with students.

This is central to the function of counsellors, school nurses, social workers and doctors:

When I have to deal with a student who’s not well, I won’t … at this level … because there is probably not a regular use [of cannabis] … I’ll be focused on his unease (5-AS2 Social worker).

Teachers also thought they had similar role:

If you are a class tutor, you have to act as an educator and a psychologist because you are in charge of the class. If a student is in trouble, we have to manage (5-E7 French teacher).

We are listing the youth speaking about their problems between them … […] they trust me and then I talk with them (5-E5 Physical education teacher).

Cleaning and canteen staff also felt similar:

Oh, yes, they confide in us. The girl … who had some difficulties [suicide] … I knew her very well. I went to the school trip with them and since that time she told me her little worries at the canteen (5-A1 Cook).

Group C: a contribution based on taking part in collective projects at the school level

When interviewed about their role in HE, 14% of the participants who perceive HE as part of their mission said they view their role as contributing to collective projects in HE:

About health and citizenship education, what I did personally, this year, is to take part to the program launched by the municipality on AIDS prevention and the creation of a sculpture with a dozen of partners (4-AS1 Social worker).

Everything depends on the time I have. I make choices […] if it’s only informational lectures,
I’m not interested, I only put a lot of myself in real projects (3-PS3 Specialized teacher).

That’s something we have to live in continuity, we have to build programs, we have the kids during 4 years in the school, we have to create things that will last for four years, I think that’s what we have to do instead of single actions to say we are doing something in health and citizenship education (5-CPE4 School Counsellor).

As I said, in collaboration with a team, with the nurse, the school staff, the other teachers, for me, its no problem being involved […] I think we need to communicate among all teachers, there is a need to build a collective project (3-PS2 Specialized teacher).

Principals, counsellors, school nurses, social workers and doctors also play a role of facilitators in such projects:

My role is to encourage, make things possible and coherent (4-CDE8 Principal).

**Emergent themes**

Professionals defined their role, contribution or priorities in reference to themes. The analysis showed that these themes can be classified in two groups: health centred (nutrition, tobacco, alcohol, cannabis, STD, AIDS, etc.) and citizenship centred (social skills and values, respect, inclusiveness and school climate).

Ninety-one percent of them were able to give at least one theme on which the school has a project (14% gave one theme, 14% gave two and 63% three or more).

**Group A: health**

Alcohol and tobacco emerged frequently:

Firstly tobacco, I think it’s important because some students begin to smoke in the 7th or 8th grade, earlier and earlier […] About alcohol it also begins during the 9th grade, the parties, the disco on Saturday evening (2-VS6 School supervisor).

For me when it is question of health, I mainly think about addictive behaviours, alcohol, tobacco and drugs in a wide sense. I think about the workplace risks. I think these are the priorities (3-DIR2 Deputy principal).

Alcohol, for middle school students, […] that’s what I say because last year we had an event with 8th grade students (3-VS1 School supervisor).

Also nutrition, sex education and AIDS/STI prevention emerged as important:

I attended a specific training and I’m now accredited to teach in sex education. We also have speakers for the association, the league against cancer (2-S1 School Nurse).

I’m trying to deal with the main theme of the year. In grade 6, I work on tobacco and we talk about alcohol […] and I’m doing something in depth about diet. In grades 8 and 9, I do AIDS/STI and contraception, I spend a lot of time on that. In 8th and 9th grade, with small groups of 12 students […] we are working on alcohol, tobacco and cannabis (5-E1 Biology teacher).

The nurse and the social worker are teaching sex education […]. There is also nutrition and a breakfast at school (once a year) for the students of the 6th grade (5-CPE4 School Counsellor).

Every year, the nurse organizes group work on tobacco and AIDS (2-EL2 English teacher).

**Group B: citizenship**

These themes referred to more general values and social skills such as respect, difference and solidarity:

I’m taking part in the activities of the committee [the health and civic education committee] more for the citizenship side than for the health side. A workshop on citizenship happens, for two classes of 7th grade, a one hour a week (2-VS1 School Counsellor).

In fact, they [students] live in a context where they are constantly in the view of the others. There is
an emphasis on the body, the clothes. Students are very hard on each other about these things. For me it’s a priority to let them to understand we are all different and that’s not a problem. For me the priority is to soften the school climate, to establish peace. There is a lot of tension between the students (1-DIR1 Deputy principal).

There is a commission ‘respect’, we call that respect, I think, in this school, it’s an important focus to develop (1-ES2 Math teacher).

The nurse and the social worker have created a club whose activity is focused on people suffering with AIDS. It means taking the problem from another point of view, understanding the consequences mainly in Africa. Then the idea to sponsor children suffering AIDS in Rwanda (1-DIR1 Deputy principal).

I think about sexual violence. Sometimes they don’t think touching a girl’s rear end is normal (2VS2 School counsellor).

We organize training for the ‘elected captains of the classes’ focused on citizenship at the beginning of the year (3-DIR2 Deputy principal).

Discussion

This study examined the views of staff (principals; teachers; school nurses and doctors; counsellors and administrative, maintenance, canteen and cleaning staff) with regard to the nature of their role and contribution to HE. Strengths of the study were the deductive approach which led to eliciting staff’s views without the need to define categories a priori and the large number of interviews. Given the range of school personnel involved, the collected data are rare and at times unusual, for example data were collected on the views of cleaning staff about their educative role, the contribution of canteen staff to individual support of students, the emphasis placed on respect and references to solidarity. The results show that staff members have quite different perceptions of their role. For those who think they have a contribution to HE, three main roles were identified: as an educator in everyday life issues, individual support and listening and taking part in collective projects and facilitation. Very few people (three) consider they have more than one role. They defined their role in reference to health-related issues such as addiction, alcohol and/or tobacco, social skills and values, school climate or partnership.

A potential weakness of the study was the potential for response bias. Even if the interviews were performed before any intervention, a selection bias could exist (selection of the schools having the strongest HE policy). This was not the case here since inclusion of schools in the study was not based on the willingness of staff but on sociological data. None of the principals of the five selected schools refused to take part in the study. The representativeness of the sample could be considered a second possible bias. The interviewed population cannot be considered to be representative of the overall staff. People who perceive that they have a contribution to HE are potentially more open to interview participation than staff not sharing this view. This lack of representativeness does not impact on the aims of the study but it is interesting to take into account the percentage of staff having a contribution since ‘percentage of staff actively involved’ is one of the key indicators of evaluation defined by the European Network of Health Promoting Schools [18]. It could be argued that participants who had taken part in the interviews were generally those who thought they had a contribution to HE. We cannot assume that all of those who did not participate did not have any interest as some may have been absent from work for various reasons. However, 42% of the overall population could be considered as being involved in HE (as 170 said they had a contribution to HE of a total population of 402).

Views of staff were strongly linked to status and three groups of professionals were defined. The first group was teachers (they represent 60% of the staff and 47% of the interviewed population). Reference to the curriculum emerged as the most important for this group before general ethos and the role of counselling (listening and individual support). This is consistent with St Leger’s [11] observations that
‘teachers see their role in school health as emanating from the curriculum and focusing on life skills, rather than health knowledge gain or changes in health practices’. Currently, teachers have different approaches to their role in HP depending on their subject but also their personal epistemologies of education. However, in reality, all teachers are potential role models for students and all teachers contribute to the affective development of students as well as their cognitive development. Reaching the stage where all teachers perceive that they have a role in the affective development of their students requires a paradigm shift in teacher thinking. It also means that more exposure to HE/HP in initial teacher education and in teacher in-service professional development is essential. All teachers need to understand that they potentially contribute to the attitudes and beliefs of their students in terms of health and affective development and not just within their own subject [19].

The second group of professionals included principals, school counsellors, nurses, social workers and doctors. They represented 19% of the population and 29% of the sample. All had in common awareness of their role in HE and defined it in relation to their contribution to collective projects, facilitation, listening and individual support. Contributing to the HE policy was perceived as part of their core business. Their mission was not to implement class-based curriculum but to operate in a number of areas, including developing appropriate school health policies, enhancing the social environment and linking with relevant community agencies [11]. Theses findings are consistent with a French national survey completed in 2002 [27] which showed that the majority of collective projects in HE is driven by principals, counsellors, nurses, social workers and doctors.

The last group included administrative, canteen, maintenance and cleaning staff. They represent 19% of the population and 24% of the sample. They are less involved and their knowledge of the school policy was not as sophisticated as that of the other groups.

The view of staff then is directly linked to their status and more deeply to their professional identity [28]. A whole-school approach to education for student health is desirable; but this requires recognition of the contribution of all staff and not just teachers per se. It also means that professional development and support should be targeted at all school staff not teachers alone. The teaching that happens informally also has an important role to play and often can be quite effective in its own right. In a comprehensive analysis of the effectiveness of the promotion of health in schools, Lister-Sharp et al. [29] found that the most common European intervention was classroom based which aimed at developing student knowledge and skill; however, interventions that combined curriculum with changes to school ethos and environment and with family and/or community involvement were far more likely to be effective.

Taking cognisance of the fact that there is consensus in the literature for the need for a whole-school approach, coherence between school policy and practice that promotes social inclusion and commitment to education is important [6]. These results are considered in reference to the comprehensive framework of the HPS concept which take into account all these different aspects [11]. The HPS is a holistic approach that includes six components: healthy school policies, the school’s physical environment, the school’s social environment, individual health skills and action competencies, home and community links and health services.

In comparison to the social environment, the physical environment was not valued in the same way. Very few staff even mentioned it and when they did they linked to cleanliness and not infrastructure. In fact, while these schools had adequate buildings and furniture, staff did not seem to consider the physical environment as a priority.

Our study confirms the previous observations of St Leger [11] since the development of competencies related to health and citizenship was the domain to which the staff referred more often. Staff valued the social environment as a main objective for HE in schools. The key components were respect, inclusiveness and solidarity. They were concerned with having a violence-free and bullying-free environment. The idea of the environment as
influencing the promotion of student and staff well-being is not present in the interviews; the concern was clearly more related to issues of citizenship. Building the competencies and skills of students was viewed as the main goal of HE in schools. It is important to note that these skills were often related to health topics such as nutrition or AIDS prevention; this is in keeping with Chi-Lan Do and François Alluin [27] who also found that risk prevention was the priority for school staff.

Partnership was rarely evoked by interviewed staff. On the occasions that it did happen, it was done so by principals, counsellors, nurses, social workers and doctors. Frequently, it was linked to accessing external speakers such as doctors, police officers in charge of drug prevention and associations fighting against cancer, drugs or alcoholism. In France, unlike some other countries, nurses, social workers and doctors are available in schools [30]. They are members of school staff and are considered as a point of reference for health-related questions such as screening, counselling or contraception. There was also awareness of external programmes imposed on them or in which they chose to be involved. However, there was no reference to community involvement in programmes managed by the school.

Recommendations for action

This analysis gives the perspectives of school staff in 2006/2007. It also shows the strengths and weaknesses of current French HE policy and offers some potentially useful knowledge for the development of HE in schools. The key recommendation is related to school support. There is a need for schools to build a common culture based on a comprehensive understanding of HE. Schools have to be supported in undertaking their role in HE not only to be able to build policy (need analysis, definition of priorities and partnerships) but also to develop the means by which an inclusive and real sharing of common culture among all staff can happen, one that includes non-teaching staff. This support must include training for all staff. The objective of such education should be to help all school staff to build a professional identity commensurate with the current reality of their job and to integrate HE within their role as a central component.

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Conflict of interest statement

None declared.

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