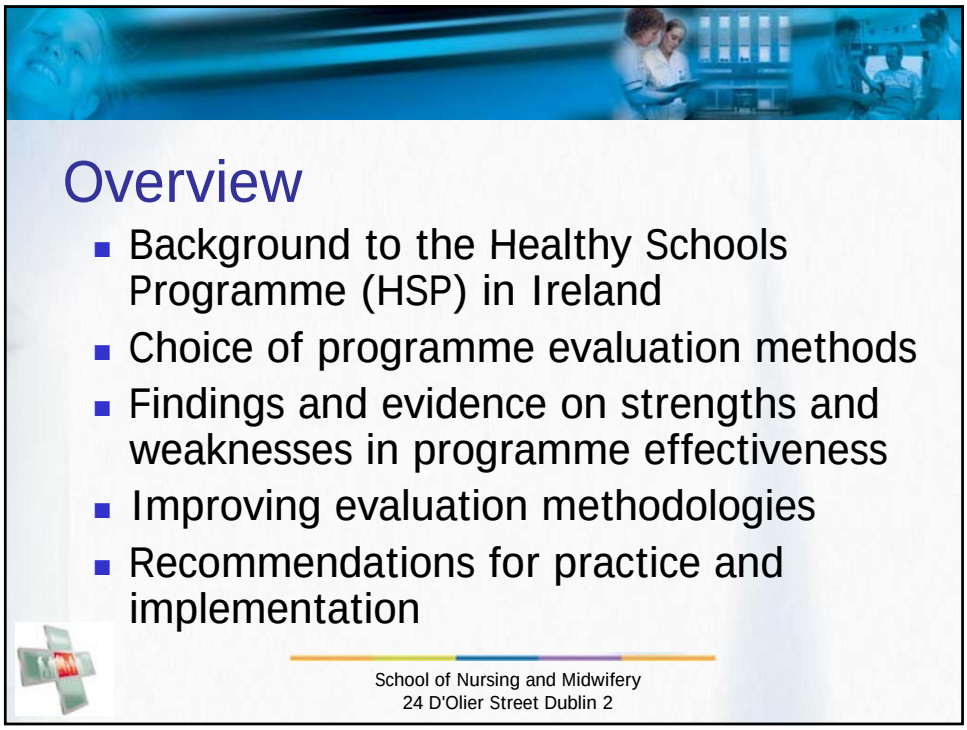
Cette présentation a été effectuée le 28 novembre 2011, au cours de la Rencontre internationale *La prochaine décennie pour les écoles favorisant la santé, le bien-être et la réussite éducative* dans le cadre des 15es Journées annuelles de santé publique (JASP 2011). L'ensemble des présentations est disponible sur le site Web des JASP à la section *Archives* au : http://jasp.inspq.qc.ca/.



Background

Healthy Schools Programme Model

- The broad aims of the Healthy Schools Programme are:
  - Improvements in children's physical and psychological well-being
  - Improvements in access to and uptake of health care services – effective referral systems
  - Greater involvement of parents and families in their children's health
- Manualised programme.
- Informed by a logic model and identified outcomes
- Healthy Schools Co-ordinators in schools

Role of the Healthy Schools Co-ordinator (HSC)

- Initiator, Instigator
- "a preparer of the way"
- Resource person
- Co-ordinating meetings of health/education teams
- Liaison person – partners & community
- Drawing up policy documents with partners.

(Lahiff, 2000)

- HSC facilitates the school/partners in the process of school change towards a more health promoting school environment.

Aims of the Healthy Schools Programme

- Reduce children's health problems early on
- Strengthen children's participation in school
- Help children to feel safe in and happy to belong to their community.

Healthy Schools Manual

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Approach to Evaluation

- The Comparative Effectiveness Research approach is the new 'Gold Standard' in effectiveness research and has been endorsed in the Health Reform Bill in the United States March 2010 (Tunis, Benner, McClellen, 2010)
- At the centre of CER is meaningful engagement and feedback from local policy and service providers and *the incorporation of a wide variety of relevant qualitative and quantitative research methodologies* into policy and service provision decisions.

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Evaluation Aims

- To determine the impact of the HS programme on specific child and parent outcomes
- To contribute to the evidence on best practice in terms of children's services in Ireland.

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Evaluation Design

Impact Evaluation

- Five schools with over 1000 urban disadvantaged children form the sample frame for the intervention
- Two schools with 250 children form the sample frame for the comparison group. tm2
- Outcomes measured at baseline, 12 and 24 months
- **Process Evaluation (Qualitative, Quantitative)**
- Semi-structured interviews/focus groups - key stakeholders (e.g. school staff, families, funders, services); questionnaires; programme activity; meeting minutes; observation

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Impact Evaluation Data

- Children (6 to12 years) and Parents (of children aged 4 to 7 years)
- Standardised assessment tools:
- Kidscreen 27
- Health Related Behaviour Checklist (HRBQ)
- The Child Depression Inventory (CDI)
- Body Mass Index (B.M.I)

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Impact Data Rationale

Assessment tools allow us to measure changes in

- Age-appropriate physical development
- Children's awareness of basic safety, fitness and health care needs
- Children's physical fitness
- Children eating habits
- Children feelings about themselves
- Parents involvement in their child's health

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Process Data

	2008/2009 (n)	*2009/2010 (n)*	*2010/2011 (n)*
Semi-structured Interviews and Focus groups			
Healthy School's Co-ordinators Interviews	2	2	3
Principal Interviews	4	5	7
CDI Interviews	2	2	3
Services Interviews	1	3	0
Parent focus groups	n/a	n/a	2
Teacher focus groups	n/a	n/a	2
Documentary Analysis			
Steering Committee Meeting Minutes			
HS manual			
HSC work plans			
HSC progress reports			
Structured Observation			
Steering Committee Meeting	1	4	4
Service Provider questionnaires	0	0	13

Impact Evaluation Null Hypotheses

Children in the intervention group will not differ from the comparison group in their physical and psychological development if they and their families receive a healthy schools intervention within the school

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Impact Results

- A total of 604 signed consent forms were returned by children from intervention (N=467) and comparison (N=137) schools at the beginning of the evaluation, representing 49% and 54% respectively of the sample frames.
- Follow-up rates at year 2 were high with 99.8% followed up within the older cohort of children (aged from 6 to 12 years) and 85.6% followed-up amongst the younger cohort (aged from 4 to 7 years) where parents provided responses.

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Findings: Intervention vs. Comparison

- There were no significant differences found over the three time points between the intervention and comparison schools.
- The HSP had no significant <u>short term</u> impact on
  - improving HRQoL measured with the Kidscreen 27
  - reducing depressive symptoms measured with the Children's Depression Inventory,
  - reducing rates of children who were obese
  - rates of school absenteeism over time

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Findings: Within intervention schools

- Kidscreen 27 revealed that at baseline children were on average within the international average range and remained within these levels at both the year 1 and 2.
- Improvements were observed for children of all ages between baseline and year 1 within the autonomy and parent relations domain of the Kidscreen 27 and this improvement was sustained within the older cohort in year 2.
- CDI revealed that at baseline children were on average within the international normal range and remained within these levels
- Children in the 6 to 12 years cohort demonstrated significant improvements in mean depression scores between baseline and year 2.

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Process Findings

- The evaluation revealed that the planning and implementation of the HSP was a challenging endeavour but that as the programme progressed some green shoots were evident.
- The findings also suggested that when planning was informed more by the programme promoters / manual (top-down) rather than the schools themselves (bottom-up) this led to complications in programme implementation.
- It was found that HSP intervention activities were targeting the school children/parents, rather than supporting the generating of sustainable whole-school change processes.

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Conclusion

- At the end of year 2 of the evaluation, the evidence suggests that whilst there were a number of challenges in implementing this model of health promotion, the schools have begun the process of change that is required to become a WHO defined 'health promoting school'.
- However, further and more refined or focused development at the individual school level is required to ensure that specific health and wellbeing needs within each school are identified and policy and procedural developments initiated are sustained and progressed.

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Recommendations: Impact Evaluation Improvements

- Specific intervention schools may wish to target certain aspects of health and wellbeing given their children's and school's needs, and for that reason it is recommended that individual school health reports be commissioned for the intervention and comparison schools.
- This will aid the school led and evidence informed approach
- In addition short term outcome objectives were too ambitious and these outcomes need to be monitored in the medium to longer term

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