

## CHAPTER 1

### INTRODUCTION

#### *Background and Significance of Research Problem*

Health promotion has been an international public health movement to promote health of people for nearly two decades. The change in societal perspectives for the need to strengthen health promotion has been enhanced since the World Health Organization (WHO) held the international conference in Ottawa, Canada in 1986 and in the following five conferences in Adelaide, Australia; Sunsvall, Sweden; Jakarta, Indonesia; Mexico city, Mexico; and Bangkok, Thailand respectively. The focal issues of the sixth conference in Bangkok, Thailand were policy and partnership to achieve the goal of health promotion (Ministry of Public Health & WHO, 2006). The World Health Organization organized these beneficial conferences in order to implement social change and improve the quality of living and working conditions which are conducive to health of population at all ages, risk factors, diseases and settings. The first international conference detailed the development of health promotion as a process of enabling people to have more control over their health and making health a responsibility of the public sector (WHO, 1986). In addition, the Ottawa Charter stated, *“Health is created and lived by people within the settings of their everyday life, where they learn, work, play, and love”* (WHO, 1986, p. 3). This statement strongly addressed the basis of the “setting-based approach”, emphasizing health promotion in different settings where people live and work. The settings that

were described included the hospital, school, workplace, and city (WHO, 2005). The school, an educational setting, has long been acknowledged as an important setting because it helped school age children grow up with an awareness and knowledge of proper health conditions (Mitchell, Palmer, Booth, & Davies, 2000). The period of school age is recognized to establish health promoting behavior according to their growth and development (Cagle, 2002). School children can make correct decisions about their health behavior when they participate in activities that influence their own social, physical, and educational environment (WHO, 1999). Furthermore, because school children are physically active, it is an opportune time to encourage their use of motor skills through regular physical activity and establish healthy eating habits. The advantages for children who have healthy eating habits and perform regular physical activity are two-fold, they are more likely to resist the development of chronic disease (WHO, 1998b) and this routine will contribute to their health status later in life (Nutbeam, Farley, & Smith, 1990). Hence, schools are beneficial places for children to grow up and learn with healthy conditions.

Health Promoting School (HPS) was a setting-based approach introduced by WHO since 1995 (WHO, 1998b). The approach has derived from the philosophical based of health promotion to enable people to improve health of everybody in their community. A "HPS" was characterized as, *"a place where respond to the challenge to improve and support the education and health of students and the health of staff...a health promoting school must be more than a collection of different programs and services. It must be an organism, a living thing in which all of the parts work together."* (WHO, 1996, p. 5). The definition was given by WHO in 1998 as *"a school constantly strengthening its capacity as a healthy setting for living, learning*

*and working*". In this study, the term "HPS" was defined as *"a school which all members of school and community work together to set policies; provide school health education, school health services and programs; encourage community participation; and create healthy environment to promote health of school children, school personnel, and community members"*. The concept of HPS based on a holistic view of health comprising of physical, emotional, social, mental and spiritual health and education, (Tetaga, 1997). Based on this concept, the HPS would provide a health program which encompasses the skill development of school children, the creation of healthy physical and social environments, the integration health services, and the encouragement of community (St. Leger, 1999).

The benefit of HPS was not only to promote health but also to solve health problems of school age children in current society that affected by socioeconomic changes and technology advances. There are various health problems that occur due to unhealthy eating habits, decreased physical activity, health-related behaviors such as tooth brushing behavior, and an increased exposure to television and computer games (WHO, 1999). Malnutrition, anemia, and goiter may occur due to food insufficiency, iron deficiency, and iodine deficiency respectively, and all of these conditions affect the learning ability of school children (Taras, 2005). Obesity is also a problem associated with unhealthy eating habits, and decreased physical activity (WHO, 1999). Dental problems are commonly found due to improper teeth brushing and poor eating behaviors. The ideal time for screening school children's hearing and vision is between the ages of six and seven (Cagle, 2002). In addition, the increase of violence and decrease in physical activity in school children may be associated with increased exposure to television and computer games (WHO, 1999). The successful

of health promotion in school children depended upon the partnership of education, health, and many sectors to help children to grow up and learn in healthy environment. Hence, schools should make an attempt to solve the problems of school children by encouraging the participation among teachers, school children, parents, health personnel, and community members and creating healthy environment based on the idea of the "Health Promoting School".

Since WHO has introduced the idea of HPS worldwide and many countries adopted the concept to implement in their countries. Results of HPS programs in Australia and Hong Kong showed the classic examples of successful action to promote health (Booth & Samdal, 1997; Lee, Tsang, Lee, & To, 2003; Lynagh, Knight, Schofield, & Paras, 1999; McLellana, Rissel, Donnellya, & Baumanb, 1999). These results indicated the significance of HPS where there is the mandate and the responsibility for enhancing a healthy setting for school children (WHO, 1998a).

Thailand was one of the countries that adopted the HPS as a strategy to promote children's health and solve common health problems in school children. Health problems commonly found among Thai school children are malnutrition, dental caries, anemia, goiter, impaired vision, and hearing problems. A survey by the Department of Health, conducted from 1995-2000, showed an increase in malnutrition in rural school age children (10.5% in 1995 to 11.45% in 2000). The effect on children's learning ability because of malnutrition made the alleviation of this problem a national concern and a major goal in the Human Resource Development Plan of Thailand. Obesity was also prevalent among urban school children (15.4% in 1998 to 13.6% in 2000). Although the data showed a decline in this problem, the percentages remain higher than the national target. In addition, a dental survey in 1994 and again

in 2001 reported that 85.1 percent and 87.5 percent respectively, of six year old children; and 53.9 percent and 57.5 percent respectively, of 12 year old children had dental caries (Bureau of Health Promotion, Ministry of Public Health, 2000). The increase of dental caries has made it the number one health problem in this age group. Iron deficiency anemia has decreased but still remains a problem (14.6% in 1995 to 6% in 2000). Goiter, which is caused by the lack of iodine, also decreased during the past five years but remains a concern as well (3.3% in 1997 to 2.2% in 2000). Vision problems (4.3%), and hearing problems (5.8% in urban area and 3.9% in rural area) were also included in the national policy (Bureau of Health Promotion, Ministry of Public Health, 2000). Furthermore, a recent study revealed that only 42 percent of Thai children exercised for more than half an hour to one hour each day. In addition, they spent more time watching television or playing video games (Chooprapawan, 2000). The data showed a decrease in children's physical activities because of their social environment. As such, the government has targeted to decrease these problems through their Ninth Health Development Plan (2002-2006). The national goals include 10 percent or less of children with malnutrition; 10 percent or less of children with obesity; 1.5 or fewer teeth with dental caries in 12 years old children; 5 percent or less children with anemia from iron deficiency; 5 percent or less of children with goiter; 5 percent or less of children with vision problems, and 5 percent or less of children with impaired hearing. The common health problems of school age children in Thailand were similar to the global situation. Thai school children were also faced with health problems caused by unhealthy eating habits, lack of physical activity, and exposure to television and video games. Hence, strategy once used for health promotion in school children may no longer meet the current health situation.

Consequently, Thailand was one of the countries that pursued the idea that HPSs could be used as a strategy to promote the health of their children.

After WHO conducted Intercountry Consultation on HPSs in Bangkok, Thailand in 1997, Thailand has initiated the HPS program since 1998 (Jiaskul & Kannakhum, 1999). The Ministry of Public Health became the key sector, which collaborated with the Ministry of Education to set target, develop the guidelines for implementing and evaluating the HPSs. The National HPS Committee was established and a policy created to involve the schools at provincial, district, and sub district level in HPS program respectively. The Ministry of Public Health has set target to encourage 60 percent of all schools eventually became HPSs, which was included as one health promotion indicator to serve the national policy of "Healthy Thailand" in 2006 (Bureau of Health Promotion, Ministry of Public Health, 2006). The guidelines of implementing and evaluating HPS covered ten components that suggested by WHO's experts in the Intercountry Consultation on HPSs (Jiaskul & Kannakhum, 1999). They are as follows: (1) school policies; (2) management in school; (3) school and community collaborative projects; (4) healthy school environment; (5) school health services; (6) school health education; (7) nutrition and safety foods; (8) exercise, sport, and recreation; (9) counseling and social support; and (10) health promotion of school staff. In 2000, the Ministry of Public Health developed initial assessment criteria to evaluate the HPS. The initial assessment criteria evaluated the process of implementing HPS in five components: (1) school policies (policies and management in school); (2) healthy school environment (environment, nutrition, and sanitation); (3) developing personal skill (school health education, life skill, and recreation); (4) school health services (school health

services, counseling, and health promotion of school personnel); and (5) school and community participation. Schools were announced to be a “Health Promoting School” upon completion of the above criteria. During the last eighth National Socioeconomic Development Plan (1997-2001) the results revealed that among 32 percent of schools in Thailand which were enrolled in the program; only 9.6 percent passed the criteria to become a HPS (Bureau of Health Promotion, Ministry of Public Health, 2002). In 2003, the Ministry of Public Health and the Ministry of Education revised the assessment criteria to be a national standard for HPSs. The new assessment criteria was composed of ten components of HPS and detailed sub-categories in each component. According to self-development guidelines and assessment tools each component would receive scoring. In addition, to encourage school participation, the Ministry of Public Health presented a certificate to each school that passed the minimum standards of the HPS. The certificate was divided into three levels. The gold level was awarded when a school passed at least 75 percent of the eight components and at least 55 percent of the remaining two components. A silver level was awarded when a school passed at least 75 percent of six components and at least 55 percent of the other four components. Lastly, the bronze certificate was given when a school passed at least 75 percent of four components and at least 55 percent of the other six components. The results of the entire country showed, of the schools (30,687) involved in the HPS project 40.1 percent (12,572) passed the three levels of assessment in 2003; 24.4 percent gold level (3,068), 37.3 percent silver level (4,690), and 38.3 percent bronze level (4,814) (Bureau of health Promotion, Department of Health, 2003). Even though the results showed that at least 30 percent of the schools reached the national target and passed the three levels of assessment

certifying them as HPSs, over half of the remaining schools were challenged to continue implementing the HPSs.

Chiang Mai, a province in the northern part of Thailand, had followed the national policy in implementing the HPS program. Chiang Mai Provincial Health Office reported that 46 percent of government primary schools were enrolled in the project with 41.6 percent having passed the criteria to become HPSs (Chiang Mai Provincial Health Office, 2001). However, after the Ministry of Public Health and the Ministry of Education developed the standard assessment criteria in 2003, there were 84.3 percent (907) of total 1,076 schools participated in the HPS project. Unfortunately, there were only 253 schools (27.9%) that passed the standard criteria for the gold, silver, and bronze level (Bureau of Health Promotion, Ministry of Public Health, 2003). The results were lower than the national target to establish the HPSs by at least 30 percent in 2003. The percentage of schools that passed the standard criteria at gold, silver, and bronze level were 17.0, 37.2, and 45.8 respectively. The results indicated that over half of the schools (72.1%) did not pass the minimum standard criteria (Bureau of Health Promotion, Ministry of Public Health, 2003) and fewer schools (17.0%) achieved the ultimate goal of HPS. Since the policy of HPS in Thailand has been strengthen and the standard assessment criteria were developed. The information about the implementation of HPS and the factors that influence the success are still needed to be good example for schools. Then, the researcher intended to conduct this study in schools that passed the standard criteria at gold level and schools that did not pass the minimum standard to compare how similar and difference of the implementation and what made them success. The lesson learned



will especially influence the future success of HPSs and can be documented so that all schools can initiate and sustain a policy through appropriate action.

### *Objective of the Study*

The objective of this study is to explore the factors influencing the success in implementing HPSs.

### *Research Questions*

The research questions of this study are:

1. What are the similarities and differences of factors in implementing HPSs between the schools that passed the standard criteria at gold level and schools that did not pass the standard criteria, ?
2. What are the factors influencing the success in implementing HPSs?

### *Scope of the Study*

This study was conducted in the government schools involved in the HPS project in Chiang Mai province, in the northern part of Thailand from May 2004 to December 2004.

### *Definition of Terms*

*Health Promoting School* was a school that all members of school and community work together to set policies; provide school health education, school health services and programs; encourage community participation; and create healthy

environment to promote health of school children, school personnel, and community members. It was the school that involved in health promoting school project and passed the national standard criteria at gold level.

*Comparative school* was the school that involved in health promoting school project and did not pass the minimum national standard criteria.

*Stakeholders* were the people who involved in the health promoting school project such as a principal or director in school, teachers, school children, parents or guardians, janitor, food seller or school cook, health personnel, and community members in that school community.

*Factors influencing the similarities in implementing health promoting school* were the situation, person, and the things that cause the similarity in implementing the ten components of HPS between gold level HPSs and schools that did not pass the minimum standard criteria of HPS.

*Factors influencing the difference in implementing health promoting school* were the situation, person, and the things that cause the difference in implementing the ten components of HPS between gold level HPSs and schools that did not pass the minimum standard criteria of HPS.

*Factors influencing the success in implementing health promoting school* were the situation, person, and the things that cause the achievement of schools in implementing the ten components of health promoting school at gold level.