

HEALTHY SCHOOLS PROJECT
NORTH EASTERN HEALTH BOARD

EVALUATION REPORT

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November, 1997

TABLE OF CONTENTS

	<i>Page</i>
Table of Contents	(i)
List of Tables	(iii)
Acknowledgements	(iv)
Preface	(v)
1. Introduction and Background	1
1.1 Approaches to Social and Health Education	2
1.2 The Healthy Schools Project	5
1.3 Implementation of the Healthy Schools Project by the NEHB	7
1.4 Scope of the project	8
2. Evaluation Strategy	9
2.1 Teachers' Questionnaire	10
2.2 Pupils' Questionnaire	11
2.3 Evaluation Design for Pupils' Outcomes	14
3. Results	15
3.1 Results 1: Results from Teachers Survey	15
3.1.1 Effectiveness of Training Programme	15
3.1.2 Implementation of Programme and Perceived Effects	17
3.1.3 Content of Programme and Suitability for both Boys and Girls	19
3.1.4 Factors in implementation of the Programme	21
3.1.5 Contribution of the Health Board	23
3.2 Results 2: Outcome Measures: Comparison of Pilot and Control Students	25
3.2.1 Acceptance of Responsibility	25
3.2.2 Self-Esteem	28
3.2.3 Positive Outcomes in Adulthood	30
3.2.4 Assertiveness vs Aggression	32
3.2.5 Attitude to Substance Abuse	34
3.2.6 Acceptance of Feelings	36
3.2.7 Student Reaction to Programme	38
3.3 Results 3: Qualitative Research Outcomes	39

Conclusions		41
Recommendations		43
Appendices:		
Appendix A:	Pupils' Questionnaire	45
Appendix B:	Teachers' Questionnaire	51
Appendix C:	Steering Group Members	57
Appendix D:	Schools In the Project	58

LIST OF TABLES

		<i>Page</i>
Table 1	Evaluation of Teachers of Training and Preparation for the programme	16
Table 2	Implementation of Programme and Perceived Effects	18
Table 3	Overall Suitability and Suitability for Boys and Girls	20
Table 4	Factors Considered Helpful in Implementation of the Programme	22
Table 5	Ratings of NEHB Support Service	24
Table 6	Items relating to Acceptance of Responsibility	27
Table 7	Self Esteem Items	29
Table 8	Plans for the Future	31
Table 9	Assertiveness vs Aggression	33
Table 10	Attitudes to Substance Use	35
Table 11	Acceptance of Feelings	37
Table 12	Opinions of Students on Programme and Activities	38

ACKNOWLEDGEMENTS

The following individuals and organisations contributed their time, advice and support in the compilation of this report. This is gratefully acknowledged.

The schools in the Healthy Schools project - principals, teachers and students, who participated in the different elements of the evaluation.

A special thanks to schools outside of the project whose students participated in the questionnaire survey.

The members of the Healthy Schools Steering Group (Appendix C) whose suggestions and advice helped shape the evaluation strategy.

The Health Promotion Service, North Western Health Board, and especially Ms. Janet Gaynor, Schools' Programme Manager, who acted as consultant to the project.

The Department of Health and the Department of Education and Science.

The staff of the Health Promotion Department, North Eastern Health Board, especially Mr. Bernard Mc Donald, Health Education Officer and Mr. Billy White, Health Education Officer.

PREFACE

On behalf of the North Eastern Health Board Steering Group on The Healthy Schools Project, I am delighted to welcome this evaluation of our programme. The initial terms of reference for the Steering Group were to:

“consider and report on the value and effectiveness of the second level schools pilot programme and advise, based on the observation of the programme, how the North Eastern Health Board might best meet the social and personal health education needs of second level students, throughout the North East, in partnership with parents, schools and education authorities”.

From the outset the emphasis has been on the need to involve all the partners equally so as to ensure a multi-agency and multi-disciplinary approach to the task in hand.

The Healthy Schools Project initially started in ten second level schools in the region and has been expanded to include twenty-nine schools involving 56% of the students in the region.

The Steering Group were acutely aware of the need, not only to extend the project to reach as many students as possible, but to carry out a serious evaluation of the project so that we could be assured that we were using the resources available to us wisely. With this in mind, the Steering Group felt it appropriate to commission an evaluation report on the Healthy Schools Project from an expert external evaluator. The importance of this evaluation report can not be under- estimated. The Steering Group are anxious that those who have participated in the programme read this report and provide feedback to the Group as to their analysis of the report. This applies to all participants, be they students, teachers or parents. Indeed we would invite all interested parties to comment on the report. The Steering Group is anxious that in moving the project forward, that there is unanimity amongst all of the partners on the need for such a project in second level schools and on the programme content.

Finally, on behalf of the Steering Group, we wish to express our appreciation to the Principals and Teachers in the project who have given a lot of their own time in making this Healthy Schools Project a feasible option for the benefit of the students they teach.

Dr Fenton Howell
Chairperson
Healthy Schools Steering Group

1. INTRODUCTION AND BACKGROUND

There has been considerable activity in schools in the area of Social and Health Education over the last 20 years. The initiatives that gave rise to this activity have had either local, regional or national origins. At local level individual schools have put together programmes, sometimes drawing on pastoral care or related features. At regional level, the Health Boards have been especially active in trying to develop and implement comprehensive programmes in the schools in their areas. Efforts at national level have been more recent and are likely to be more important in the future.

There are several reasons for the development of this aspect of the curriculum including educational, social and economic reasons. Many teachers have been concerned with a system that placed undue emphasis on examinations to the neglect of the other features of development. Recent years have witnessed the growth of an array of problems including drug use and family breakdown which require schools to consider their roles in relation to such issues. Finally, given the evidence that traditional school subjects do not completely prepare young people for work, the development of social skills and competencies can be expected to improve the preparation of young people for such roles.

1.1 Approaches to Social and Health Education

There have been dramatic changes in the development of the methodology in health education over the last 20 years. The first efforts to shape healthy behaviour were based largely on scare tactics. For example, in relation to prevention of substance use, pupils were told of various consequences (frequently exaggerated) that were very likely to occur if they experimented with illicit substances. The problem with such an approach is that young people's own experience often contradicted this 'misinformation', resulting not only in a rejection of the specific message but also in the undermining of the credibility of the educational source from which the message derived.

Later developments in health education focused more carefully on presenting factual information. Within such an approach, care was taken to ensure that exaggerations were eliminated but that students were made aware of the potential hazards of particular behaviours and practices. Thus, scientific information about consequences replaced the scare tactics of the earlier approach.

It is fair to say that informational approaches have had and still have an important role to play in health education. The real question is whether they can be regarded as being adequate in themselves. The evidence on this point is that they are not a complete answer. Numerous evaluations have shown that informational approaches do not of themselves change attitudes, beliefs or indeed behaviour.

An early illustration of this point (in relation to illegal drug use), is found in the work by Stuart (1974) who examined the effects of a fact-oriented drug programme and found that relative to a control group, young people receiving drug information did indeed increase their knowledge about drugs. However, their anxiety about drugs also decreased and, more significantly, their use of alcohol, marijuana and LSD was greater than that of the control group.

Since the middle of the 1980s the social skills/competency approach has become especially influential. This method is based on the assumption that individuals develop problems with substances because they lack particular social skills that would enable them to withstand pressure to experiment with these substances. In line with this, young people are taught how to identify the various kinds of influences that are brought to bear on them in interpersonal situations and in the media and to acquire a repertoire of skills to cope with these influences. In addition, this approach stresses the self-understanding and self-esteem that underpin the capacity to make effective use of such skills. Many of these programmes have sought to equip young people with a range of assertiveness skills.

In general, social skills techniques require active involvement by the participants. Thus, rather than learning about such strategies, students actually enact these in role playing and modelling situations. In addition, many approaches involve peer-leadership as a component of presentation of the programmes. In other words, the input and direction is given by one of the learners rather than by the teacher.

One of the best indications of the effectiveness of social skills programmes is the review by Tobler (1986) who examined evaluations of all prevention programmes, published up to and including 1985. Her results (involving 127 separate studies) showed that programmes designed to equip adolescents to resist peer pressure were much superior to the others. She demonstrated that the social skills approach was better on all measures but especially on measures relating to actual drug use. Interestingly, the more recent review by Hansen (1992) also concludes that social skills approaches are relatively more effective than are other ways of preventing the onset of substance use.

In recent approaches to health education there has also been an emphasis on decision-making skills. This approach attempts to increase self-awareness of a range of values and the way in which healthy behaviours can serve to promote or prevent the fulfilment of those values. Young people are required to ask themselves whether certain behaviour is consistent with a variety of beliefs and values, which they themselves regard as important. This approach has been used in a variety of other contexts, including moral education, and interpersonal problem-solving.

In summary, the most successful approaches to health education are those that embrace a wide range of approaches. Information- giving is essential but is not of itself sufficient. There is also a need for the development of social skills to help students understand and resist influences. In addition, the enhancement of self-esteem and the development of decision making capacity are also of great importance. Above all, the active involvement of pupils in the learning process provides the most likely avenue for the development of attitudes and values that will change behaviour in the longer term.

1.2 The Healthy Schools Programme

In 1994 the North Eastern Health Board (NEHB) decided to support health education/promotion in second level schools in a structured way by establishing the Healthy Schools project. Many of the features of the project have been adopted from the North-Western Health Board Health Education programme. This programme is designed for secondary schools and places a strong emphasis on 'life-skills'. A central feature of the philosophy of the programme is that many aspects of health are inherently related to behaviour and that there is a need for young people to acquire a range of skills to enable them to take responsibility for their own behaviour. The programme also recognises that while the provision of factual information plays a part in enabling young people to take such responsibilities, such knowledge will not of itself be adequate to ensure appropriate taking of responsibility for their own health.

In describing the programme it is convenient to draw a distinction between the areas that are covered and the skills that are targeted. Among the topics covered are: (i) Personal hygiene, (ii) nutrition, (iii) relationships, (iv) legal and illegal drugs, (v) growth and development, (vi) environmental health, and (vii) safety and first aid.

Among the skills that are targeted in the programme are the following: (i) communication skills, (ii) maintaining physical well-being, (iii) building self-esteem, (iv) assertiveness, (v) decision making skills, (vi) skills involved in relationships, (vii) study skills. Great emphasis is placed on the process of learning as well as the content. In this regard experiential learning is crucial together with active participation. In turn, this emphasis is reflected in the inservice which involves active participation.

There was a significant involvement by the North Western Health Board in the planning of the project, in the initial recruitment of schools at the pilot phase in the provision of materials, and in the design and delivery of inservice training. To ensure continuity with the experiences of the NWHB, Ms. Janet Gaynor was appointed consultant to the programme.

1.3 Implementation of the Healthy Schools Project by the NEHB

In implementing the project in the schools in their area, the NEHB were especially conscious of how teachers might be encouraged to develop the programme to suit the particular needs of the students under their care. They were also concerned to ensure that the primacy of the objective of students taking responsibility for their own health and behaviour. In addition, they took the view that by providing a broadly based support structure they could enhance the effective implementation of the programme.

In line with these views the NEHB took the following actions: Firstly, great emphasis was placed on training which involved not only the teachers who delivered the programme but also the whole school staff. The rationale for this approach was that changes in the behaviour of school pupils are more likely to be brought about as a result of a change in whole school ethos. Another feature was the provision of a support structure that enabled teachers to discuss and resolve issues of implementation of the programme, throughout the school year. This involved the employment of two experienced teachers with particular expertise in the area of health education who provided the following services to schools: (i) ongoing inservice training, (ii) appropriate resource materials, and (iii) advisory support through school visits.

A very important feature of the implementation of the project was the development of an organisational support structure which effectively supported the team at school level. This included the appointment of a co-ordinator within each school.

Another aspect of the NEHB approach was to provide as broad a base as possible for the management of the programme. Thus, the Steering Group included not only Health Board personnel but school and parent representatives as well as representatives from the Depts. of Education and Health, the Church and School management. This broadening of the base of the project allowed for consultation with a wide range of interests and drawing on expertise of a great many professionals from complementary disciplines.

1.4 Scope of the Project

The Healthy Schools Project was begun in 10 schools in the North Eastern Health Board in 1994. In subsequent years, an additional 19 schools were added so that by September 1997 29 schools are participating. In terms of the numbers, the schools currently operating the programme serve 16,500 pupils. It is envisaged that when the programme is fully operational, the target group will be 30,500 pupils.

The development of the programme within each school follows a gradual pattern beginning in first year and increasing yearly until all years are involved. This approach ensures that the accumulated experience can benefit the project.

2. EVALUATION STRATEGY

Modern approaches to evaluation tend not to rely on any single strategy but to take an eclectic approach that draws on both quantitative and qualitative methodology. In line with this philosophy, the present evaluation drew on the following sources: (i) site visits by the evaluator, (ii) records of judgements by participants on training days and staff development, (iii) records of meeting of co-ordinators, (iv) records of meetings of school principals, (v) formal questionnaire to teachers, and (vi) questionnaire to pupils in intervention and control schools.

The teacher questionnaire was sent to 97 teachers in 10 schools giving a response rate of 79%. These teachers were in ten randomly selected schools within those participating, of which six schools had begun in Phase 1 of the project and four had begun in the second phase of the project.

The student questionnaire (Appendix A) was given to 15 classes from various pilot schools. Of these seven were first year classes, four were second year and four were third year classes. The 10 classes in the control group were in schools that were similar in terms of social background, gender balance and ability group. There was 100% return of questionnaires from the participating classes.

While it is the case that particular attention is being given to the formal questionnaires in the report, due recognition will also be given to the other sources outlined, above.

2.1 Teachers' Questionnaire

The full questionnaire given to participating teachers is shown in Appendix B. The main focus of this questionnaire was on the following areas: (i) Extent to which teachers felt that the training prepared them to teach the programme, including views on how the inservice preparation might have changed their views on Social, Personal and Health Education, (ii) implementation of the programme and possible consequences of this implementation including effects on teaching behaviour and attitudes, (iii) The suitability of the programme for boys and girls, (iv) Factors that may have helped in the effective implementation of the programme, (v) support services of the Health Board and (vi) extent to which the programme contributed to awareness of how the whole school can contribute to the health of young people.

The questionnaire was an objective, multiple choice instrument but for every item teachers were given an opportunity to make comments as they wished. Great care was taken to ensure balance in the response choices, that is, to ensure that respondents had equal opportunities to make negative as well as positive comments.

In the administration of the questionnaires, care was taken to ensure that confidentiality and anonymity were guaranteed. The instructions asked respondents to be as frank as possible and the respondents placed the questionnaire individually in a sealed envelope.

2.2 Pupils' Questionnaire

The themes in the pupils' questionnaire were largely those that would be expected to reflect the outcomes of a successful health education programme, viz., acceptance of responsibility for own health, self-esteem, plans for the future, communication skills with others, attitudes to alcohol, cigarette smoking and use of illegal drugs. A part of the questionnaire was specifically concerned with pupils' reactions to the health education classes.

With regard to acceptance of responsibility for their own life and health, pupils were given a list of 13 statements which focused on the reasons why certain things might happen to them and they were asked to indicate their agreement/disagreement with each one. These included 'having a healthy life', 'doing well in exams' and 'getting into trouble'. The central point in this series of questions was to see whether pupils were of the view that what happened in their lives was due to their own behaviour and thus within their own control or whether it was due to luck or factors outside the pupil's control like teachers, other people and parents.

The self-esteem measure consisted of 10 items each of which required the respondent to agree/disagree, on a five point scale. These statements are of two kinds: the first kind was global in nature ('I have a number of good qualities') while others were highly specific in nature ('I am quite good at games'). Most of the items were phrased in a positive direction while others were phrased -negatively ('At times I think I am no good at all').

The third scale in the pupils questions was concerned with 'plans for the future'. Students were asked to indicate how likely it was that each of 10 outcomes would come when they were adults. Of these outcomes, four were concerned directly with health (e.g. taking exercise regularly) while the others were broadly in the area of social and personal development ('Feel able to cope with the ups and downs of life', and 'have many friends'). For each of these outcomes, the respondents were asked to indicate on a five point scale (ranging from 'very likely' to 'very unlikely') how likely it was that each would be true of them as adults.

The fourth scale focused on assertive behaviour/coping with anger and the extent to which aggressive behaviour was endorsed. The major emphasis in these items was to examine the different ways of coping with anger including 'flying off the handle', fighting, explaining things calmly or letting people know you are angry with them.

Attitudes to legal and illegal drugs were, the focus of the fifth scale in the pupils' questionnaire. Of the seven statements which presented for agreement/disagreement, four expressed permissive views about drugs (e.g. People who smoke make friends more easily', 'Occasional use of drugs is part of growing up for nearly everyone'). Other statements expressed negative attitudes ('Smoking is usually a sign of immaturity').

There were eight items related to expression of feelings. The focus was on both expression of feelings of others as well as on own feelings. An important feature of these items was the extent to which pupils accepted the various feelings that are an intrinsic part of daily life e.g. 'It's OK not to feel good all the time'. These items were on a five point scale ranging from 'strongly agree' to 'strongly disagree'.

Pupils in the pilot schools were asked directly about the Health Education Programme. Of the three questions that focused on this matter, the first was concerned with their overall reaction to the programme with options ranging from 'very enjoyable' to 'disliking these classes'. They were also asked in the same format about the activities in these classes like giving their opinions, role playing and writing. Finally they were asked whether they thought the activities were more suitable for boys or girls or equally suitable to both.

2.3 Evaluation Design for Pupils' Outcomes

An ideal evaluation design is truly experimental with subjects being randomly assigned to either the experimental or control group. For a variety of reasons such a design is impossible in the evaluation of school interventions. Firstly, the experimental group is decided on in advance of identification of the control group. Secondly, it is necessary in school evaluations to deal with intact classes rather than individuals. This imposes major constraints on assignment of individual pupils.

For these reasons, the most appropriate design is a quasi-experimental design in which some of the features of experiments are retained while accommodating to the necessities of the 'real world'. In the present study the comparison group selected were classes which are not currently in the project (some of which will join in September 1997). Then classes were selected from these schools, matched with the pilot schools on as many relevant variables as possible. While it is impossible to match schools on every variable, the control schools were similar in terms of social background of students, gender balance, as well as age and year in school.

3. RESULTS

3.1 Results 1

The results presented in this section are divided under a number of headings. In the first section the results of the training programme are examined. The second part describes various aspects of the implementation of the programme and its suitability. In setting many aspects of these results the teachers' questionnaire will be drawn on. The third part of the chapter considers some organisational dimensions of the project, school factors and the role of the NEHB. A later section will examine the outcomes of the project.

3.1.1. Effectiveness of Training Programme

In a preliminary report on this project, the results relating to evaluations of the inservice component of the project were set out. These earlier responses were obtained in the immediate aftermath of the training and were favourable.

Below are set out the responses of participating teachers to the Teachers' Questionnaire in which three questions were of particular significance, viz., extent to which inservice days prepared them for teaching the programme, extent to which the inservice changed their views about health education and their perceived competence with the informal methodologies that are an inherent part of the programme.

It can be seen from Table 1 that that the vast majority of the teachers (more than three quarters of them) thought that they were prepared ‘thoroughly’ or ‘quite well’ prepared for teaching the programme. It was especially interesting that even more of the teachers expressed the view that the preparation has changed their views. The satisfaction with the level of perceived competence in teaching th6 programme. Is also very satisfactory with over three fifths saying that they were either ‘very competent’ or ‘quite competent’.

Table 1

Evaluation by Teachers of Training and Preparation for the Programme

Adequacy of Preparation	Thorough or Quite Well 77.8	Moderate or Inadequate 22.2
Preparation change views	A lot or Somewhat 82.2	A little or No Change 17.8
Feeling of competence in teaching	Very or quite Competent 61.2	Fairly or Not Competent 38.8

When given an opportunity to make open-ended comments, the teachers' comments were largely in line with the results of the table. One teacher said..... 'The inservice work provided background information, and classroom materials informationand did that very well'. Another commented that while he/she was already familiar with teaching life-skills, 'I found great affirmation from the inservice programme'. Many of the comments were of the kind.... 'If it were possible I would have liked much more training'.

3.1.2. Implementation of Programme and Perceived. Effect1s

Below are presented the results regarding the extent to which the methodology of the programme was implemented and the extent to which there were effects on teachers' relationship with pupils, as well as effects on teachers' views on health matters, especially as these affected their own lives.

It can be seen from Table 2 that the vast majority of the teachers implemented the programme as it was intended. It is Interesting to note that the majority of teachers (or close to majority) perceived effects on important outcomes in their own and children's views and behaviour. These perceived effects seemed to be somewhat greater in the case of teachers own relationships with pupils and on their views on health matters. The perceived effect on how pupils relate with each other was somewhat weaker.

Table 2

Implementation of Programme and Perceived Effects

	Large or Some extent	Minor extent Or not at all
Extent of Implementation	70.0	30.0
Effects on teaching 'own' subject	51.1	48.9
Effects on relationships with pupils	71.3	28.7
Effects on relationships with pupils in other classes	43.4	56.6
Effects on how pupils relate with each other	48.9	51.1
Effects of teachers' awareness on health matters	64.4	35.6
Effects on teachers' thinking on issues in the programme	58.9	41.1

The comments of the teachers are in line with the impression from the table. One teacher summed up the views of quite a few: 'The informal methodologies allow for better communication with students. I find I listen more carefully particularly to the hidden agenda of each student.'

I find many students come to discuss their concerns on personal issues as a result of the Health Education class'. In the same vein another teacher commented that he/she 'had developed the art of listening'.

It was especially interesting that a number of teachers commented on the way in which students relate to each other, while recognising how difficult it is to bring about changes in students' behaviour. As one teacher stated..... 'They have shown increased responsibility for their behaviour among themselves..... but don't actually change their behaviour'. Another made the point that..... 'from my experience, students are more willing to share ideas and listen to each other attentively', and another took the view that 'students were understanding of each others shortfalls and problems'

3.1.3. Content of the Programme and Suitability for Both Boys and Girls

Teachers were asked about the appropriateness of the overall content of the programme, its suitability for both boys and girls, the extent to which boys and girls participated equally and what factors might have accounted for any gender differences in participation.

From Table 3 it is evident that in the opinion of the teachers, the vast majority took the view that the topics in the programme were indeed very appropriate, and it can be seen that this was also the case in relation to suitability for boys and girls.

At first sight it might be thought that there was some small gender bias in relation to participation but in fact this was not the case. As can be seen just over 62% of the teachers (for whom this question was relevant) thought that boys and girls participated equally. However, of those who did not think that this was the case, exactly half of these thought that boys participated more and half thought that girls participated more.

Table 3

Overall Suitability and Suitability for Boys and Girls

	Most or all topics Appropriate	Some or most topics Not Appropriate
Overall Content	92.1	7.9
Suitability for both girls and boys	Equally suitable boys and girl 87.7	More suitable for either boys or girls 12.3
Participation of boys and girls in the classes	Boys and girls Participated equally 62.1	Either boys or girls participated more 38.9

The comments of teachers were generally supportive of these findings. With regard, to the overall suitability of the topics in the programme, one teacher commented that ‘.....all students will face some or all of the problems dealt with’. To the extent that criticisms were made they had to do with the difficulty of finding time to do everything. One comment was that ‘....all topics were appropriate but it was impossible to fit them all in’.

There was considerable variation between the comments in relation to suitability for boys and girls. What seems to come across is that it depended greatly on the experiences of Individual teachers. One teacher made the point that ‘.....Boys were definitely more vocal, usually with questions... .but the girls seemed to know more’. On the other hand, a comment was that ‘.....Boys tend to be shy in discussing their problems’. Another interesting view was that ‘....boys participate more vocally, but I feel that the girls actually gain more due to their maturity’.

3.1.4. Factors in Implementation of the Programme

Teachers were asked about the extent to which five factors influenced the implementation of the programme in their school. These factors included the attitude of the principal, school ethos and planning.

The resulting outcomes are shown in Table 4, which indicates the extent to which these factors were considered to be helpful or not. It is striking that three factors were considered to be important by about four-fifths of the teachers. In this regard. These were the attitude of the principal, school ethos and planning. It could of course be said that these factors are in many senses closely related to each other. It is also noteworthy that in some cases the timetabling was a problem. This was especially the case where the tutors were allocated the last period on Friday evening.

Table 4

Factors Considered Helpful in Implementation of the Programme

	Helped a lot or somewhat	Helped a little or did not help	Hard to say
Attitude of the Principal	87.0	6.7	6.3
School ethos	80.0	11.1	8.9
Suitable time-table	64.4	24.4	11.1
Good planning and co-ordination	77.8	17.8	4.4

Rather than comment on these particular factors, the open-ended part of this item asked for teachers to say whether any other factors were important. Relatively few actually added any 'new' factors. One teacher indicated that the '...excellent work of school co-ordinator and regular meetings together with the inservice contributed greatly to the effective implementation of the programme'. Another said that '...the programme was very well presented and the enriching sharing of ideas with other participants was very worthwhile'.

3.1.5. Contribution of the Health Board

The teachers were asked about the extent to which they found the contribution of the support service of the NEHB to be helpful. This question was on a five-point scale and the full results are presented below. It seems clear that the contribution of the Health Board was regarded as very significant, with over four-fifths of the teachers saying that the contribution was either very helpful or quite helpful. Conversely only an insignificant number took the view the Health Board support was not especially helpful.

Table 5

Rating's of NEHB Support Service

	Percent
Very helpful	54.8
Quite helpful	27.1
Moderately helpful	13.7
Not especially helpful	2.2
Hard to say	2.2

The additional comments of teachers were largely in line with what might be expected from the table. They ranged from 'most welcome' to 'the back-up was very welcome'.

Results 2: Outcome Measures: Comparison of Pilot and Control Students

Below are presented the findings of the comparison of the pilot and control groups. As noted above a comparison is presented in terms of both individual scales and individual items. Given that with this number of comparisons, a number of differences will emerge by chance. It is the overall pattern of the findings that merits most attention.

3.2.1. Acceptance of Responsibility

In the students' questionnaire acceptance of responsibility for their own lives and health was measured by giving a list of 13 statements which focused on the reasons why certain things might happen to them and they were asked to indicate their agreement/disagreement with each one. The focus of these questions was to see if pupils were of the view that what happened in their lives was due to their own behaviour and within their control or was due to luck or factors outside their own control.

The results of this was analysed in two ways. Firstly, the statements for each individual were coded 1 to 5, depending on their level of agreement with each statement so that a composite Acceptance of Responsibility Score was created first for each individual and secondly for the pilot and the control group. An analysis of the internal consistency of the items showed that they form an acceptable scale. The relevant statistic is Cronback alpha which emerged as .91 - indicating that the thirteen items can legitimately be added to make a scale.

Pages 26 and 27 are missing.

3.2.2. Self-Esteem

As noted above, the self-esteem measure consisted, of 10 items each of which required the respondent to agree/disagree, on a five point scale. These statements are of two kinds: the first kind was global in nature while others were highly specific in nature.

As in the case of the Acceptance of Responsibility Scale a composite scale was calculated firstly for each individual and then for the total pilot and control groups. An analysis of the Internal consistency of the items showed that they form an acceptable scale. On the Cronback alpha, the relevant statistic was .89 - indicating that the items can be added to make a scale. This yielded a mean score of 3.64 for the pilot group and 3.53 for the control group. Thus, the mean score for the pilot group was higher (higher self-esteem) than the control, however, the difference fell short of statistical significance on the analysis of variance test.

Table 7 shows the scores on three individual items for both the pilot and groups. From this table it can be seen that a statistically significant difference emerged between the pilot and control groups in relation to one of the items, having to do with feeling embarrassed when speaking in class. A significantly greater number of the pilot group disagreed with this statement while a significantly greater number of the pilot group agreed with this statement. It is also of interest that while the differences in relation to the other two items were not significant, the trend of the results tended to favour the pilot group, that is, they responded in ways that would be considered to indicate higher self-esteem.

Table 7

Self-Esteem Items

	Agree	Hard to Say	Disagree
		PILOT	
I feel I have a number of good qualities	71.6	18.1	10.3
I feel very embarrassed when I have to say something in front of the class	24.1	14.9	61.0**
I have plenty of interests and hobbies.	87.9	6.0	6.1
		CONTROL	
I feel I have a number of good qualities	71.7	18.0	10.3
I feel very embarrassed when I have to say something in front of the class	33.4	15.2	51.4**
I have plenty of interests and hobbies.	86.1	7.3	6.6

3.2.3. Positive Outcomes in Adulthood

The respondents were asked to indicate how likely it was that each of 10 outcomes would happen to them when they were adults. Four were concerned directly with health and the others were broadly in the area of social and personal development. When the internal consistency of the scale was examined. It emerged that Cronbach alpha was .53. This is a borderline coefficient for considering the items as a single scale. It is understandable that this is the case given that the outcomes are very different in kind from each other. The mean scale value was 3.61 for the pilot group and 3.23 for the control group. This difference is statistically significant ($p < .01$) indicating that the pilot group who had experienced the programme were more Inclined to believe that positive things would occur to them as adults than was the case with those who did not have the programme.

The analysis of four single items are shown in Table 8. Two of these items are directly relevant to substance use; specifically drinking alcohol and smoking, while two other items are relevant to the area of emotional control. It can be seen from this table that there were significant differences between the pilot and control group on two items, viz., being a smoker and losing one's temper. In each case, students in the programme were more likely to disagree with the idea that they would be smokers when they were adults and also to disagree with the statement that they would frequently lose their temper.

Table 8

Plans for the Future

	Agree	Hard to Say	Disagree
		PILOT	
Drink alcohol regularly	25.0	28.5	46.5
Be a smoker	13.8	21.6	64.6**
Lose my temper a lot	24.1	33.5	42.4**
Be able to cope with ‘ups and downs’	58.6	39.7	1.7
		CONTROL	
Drink alcohol regularly	26.5	30.0	43.5
Be a smoker	17.2	25.6	57.2**
Lose my temper a lot	29.6	37.1	33.3**
Be able to cope with ‘ups and downs’	57.8	40.0	2.2

3.2.4. Assertiveness vs. Aggression

Five items focused on assertive behaviour and in particular the extent to which an aggressive response was regarded as appropriate. The different ways of coping with anger included 'flying off the handle', fighting, explaining things calmly or letting people know you are angry with them.

An examination of the extent to which the items formed a scale showed that the Cronback alpha was .83 indicating that these Items can appropriately be treated as a single scale. When the Items were added for each individual the mean for the pilot group was 2.75, while the corresponding mean for the control group was 2.74 - a difference which was not statistically significant.

The results for three individual items is shown in Table 9. The pattern in this table indicates that the results for the control and pilot group is almost identical so that no significant differences emerged between the groups. For each of the items, the vast majority of the students endorse what is reasonable in the circumstances.

Table 9

Assertiveness vs. Aggression

	Agree	Hard to Say	Disagree
		PILOT	
The only way to deal with a bully is to let them know who is in charge	57.8	18.3	23.9
There are always ways of dealing with problem without having to fight about	81.0	10.0	8.0
It is much better to 'fly off the handle' than to explain things calmly	18.1	18.1	63.8
		CONTROL	
The only way to deal with a bully is to let them know who is in charge	59.3	17.9	22.8
There are always ways of dealing with problem without having to fight about	80.0	11.1	8.9
It is much better to 'fly off the handle' than to explain things calmly	16.9	21.3	61.8

3.2.5. Attitude to Substance Use

Attitudes to legal and illegal drugs were the focus of one of the scales in the questionnaire. Of the seven statements which presented, four expressed 'positive' views about drugs (e.g. People who smoke make friends more easily' while other statements expressed negative attitudes ('Smoking is usually a sign of immaturity').

When a Cronback alpha statistic was calculated. It was found that $\alpha = .79$. This indicates that the seven items can be considered to be a scale. When scale scores were calculated for each individual, it was found that the mean for the pilot group was 2.73 while for the control group the corresponding mean was 2.39. This difference was found to be statistically significant ($p < .01$) indicating that the pilot group had less favourable attitudes to substance use than was the case with the control group.

The results for three of the individual items are shown in Table 10. From this it can be seen that there were statistically significant differences ($p < .01$) between the pilot and control groups on two of the three items, dealing respectively with smoking and alcohol. For each it was found that pilot groups had attitudes and beliefs that were less favourable to the substance in question.

Table 10

Attitudes to Substance Use

	Agree	Hard to Say	Disagree
		PILOT	
People who smoke make friends more easily	24.1	16.4	59.5**
People who drink usually relax more than those who don't	32.8	22.5	44.7**
Occasional drug use is part of growing up	9.5	13.8	76.7
		CONTROL	
People who smoke make friends more easily	31.7	18.0	51.3**
People who drink usually relax more than those who don't	37.8	24.1	38.1**
Occasional drug use is part, of growing up	9.9	14.2	75.9

3.2.6. Acceptance of Feelings

In the pupils' questionnaire, there were eight items concerning expression/acceptance of feelings. These focused on both expression of feelings of others as well as on own feelings. A common feature of these items was on the extent to which pupils accepted, that various feelings are an inherent part of dally life e.g. 'It's OK not to feel good all the time'. These items were on a five point scale ranging from 'strongly agree' to 'strongly disagree'.

When the Cronbach alpha was carried out on these items to ensure that they conformed to a scale, the result was $\alpha = .90$, Indicating that it was appropriate to scale the items. On the total scale, the pilot group were found to have a mean score of 4.46 on this scale while the corresponding mean for the controls was 4.61. This difference between the pilot and control groups was not statistically significant (In fact in this case, the control group had a more 'better' mean score-It should be noted however that as seen in Table 11, the scores on all of the items are skewed toward the positive end of the scale).

The scores for three individual items are shown in Table 11. From this it can be seen that the scores of both the pilot and control groups were uniformly on the positive end of the scale. Thus, as might be expected no significant difference emerged between the groups.

Table 11

Acceptance of Feelings

	Agree	Hard to Say	Disagree
		PILOT	
It's OK not to feel good all the time	70.7	26.7	2.6
When I'm upset I usually keep it to myself	61.2	27.6	11.2
I am usually sensitive to the feelings of others	93.1	3.4	3.5
		CONTROL	
It's OK not to feel good all the time	71.7	26.3	2.0
When I'm upset I usually keep it to myself	63.1	24.3	12.6
I am usually sensitive to the feelings of others	93.9	4.1	2.0

3.2.7. Student Reaction to Programme

Students were asked about their overall reaction to the programme, which was identified by the topics which were Included in the programme (hygiene, feelings, smoking, alcohol and drugs). They were also asked about active participation in the programme (role-playing, giving opinions, artwork). In each case they rated their enjoyment from ‘Very enjoyable’ to ‘Disliked these classes/activities’.

The results are shown in Table 12. From this it can be see that the students in the programme had extremely positive feelings about the overall programme and also in relation to their active participation in this. Well over two-thirds of the students expressed the view the classes were very enjoyable/enjoyable. Slightly less than this percentage expressed this same view in relation to the activities on the programme.

Table 12

Opinions of Students on Programme and Activities

	Very Enjoyable/ Enjoyable	Hard to Say	Not Enjoyable/ Disliked
Overall opinion on classes	69.8	20.8	9.4
Reaction to active participation	66.8	19.8	13.6

3.3. Results 3: Qualitative Research Outcomes

Here we summarise a number of points emerging from site-visits, meetings of advisory group, meeting of co-ordinators and meetings of school principals. Rather than summarise the outcomes of the meetings of these various groups, it seems more appropriate to identify the main themes emerging from these discussions.

Firstly, it was clear that school staff including principals and co-ordinators as well as tutors valued the programme greatly. This was evident in their readiness to devote time to discussion of issues, in the tone of their comments and in the commitment that was evident throughout the various discussions. They seemed very aware of the need for a programme that would cater for the health and personal developmental needs of their students at a time when other curricular developments were in danger of crowding the school timetable.

It became clear at these meetings that the success of the project should be seen against the great number of curricular innovations and programmes of inservice that are currently being piloted and/or launched. These include the new revised subjects in the Leaving Certificate as well as totally new programmes like the Applied Leaving Certificate and the Vocational Leaving Certificate. In addition the new CSPE (Civics, Social and Political Education) programme and the RSE programme are also beginning to make demands on schools.

All of these result in a certain level of disruption to school routines.

A third point to emerge was that there was general satisfaction with the different components of the project including the materials, inservice and support service. Many of the principals and co-ordinators expressed satisfaction with the various feature of the inservice programme, a finding that is in line with the results from the teachers' questionnaire. Satisfaction was also expressed at these meetings with the value of the school visits of the support team in making them feel they could get advice and support when needed.

A. fourth point to emerge in these sessions was that organisational factors within the school had an important Influence on the success of the project. This was not merely the formal organisational factors, but also the level of consensus in the staff regarding the importance of facilitating health education within the school. The effective organisation of the project resulted in some schools in greater acceptance of the need for new organisational structures.

A fifth point to emerge concerned the suitability of the programme for all classes and for students with learning difficulties particularly. Some teachers made the point that the materials were at a level of difficulty that made an adaptation of the programme necessary for such classes. This view was not held by all those who taught the programme nor by all who were teaching classes comprising mainly of students of moderate or low academic ability.

CONCLUSIONS

Overall the results reported, suggested that the Healthy Schools project embodies those essential components of health education that are appropriate to the needs of postprimary school students. The philosophy of the project is in line with approaches that have been found to be most effective. The programme was very well received in the schools and given the pressure on the curriculum, this has to be considered as one of its great successes. Its effective implementation at a time of increasing demands on schools and their resources is of itself a very worthwhile contribution. With so much of the curriculum being mandatory and examination-driven. It is a tribute to the project staff that so much effort was devoted by principals, class teachers, and co-ordinators.

While the success of the project is to be welcomed, the results of the survey show the kind of attitudes and beliefs that need to be targeted in future health promotion programmes. The table above (Table 10) dealing with attitude to substance use is especially revealing. Taking pilot and control groups together it can be seen that a significant minority of young people (over one quarter) endorse the view that people who smoke make friends more easily than those who do not. Even more disconcerting is the finding that over one-third of young people thought that people who drink relax more than those who don't. The item on illegal drug use is also of concern; around one-tenth took the view that occasional drug use was part of growing up.

An important feature of the implementation of the project was the back-up provided by the NEHB in relation to inservice, co-ordination of the programme in school, as well as monitoring and advisory back-up. The evidence considered here indicates that this contribution made this effective implementation possible and contributed greatly to the satisfaction with the programme by both teachers and students.

In considering the outcomes and especially the differences between the pilot and control group, it should be stressed that the effects of a programme like this are likely to occur after a long time (perhaps several years). The differences between the pilot and control groups which emerged here are promising, even if account is taken of chance effects (as is appropriate with multiple items). It is of particular interest that significant differences emerged between the control and pilot group on items relating to acceptance of responsibility, self-esteem, positive outcomes in adulthood and attitudes to substance use. While these effects were evident only in single item comparisons, it should be stressed that in almost all outcome measures the results were in the direction that would be expected.

Taking into account the size of effects found in evaluations of other programmes, the effects found here are positive and with appropriate fellow-through it is likely that the project will have important effects on the life-style of the young people who were targeted. The effects that have been observed should, therefore provide a basis for building in future work.

RECOMMENDATIONS

1. The Healthy Schools project should, be continued and expanded along the lines that have already been planned by the Health Board.
2. The inservice programme should continue along the present lines, with the emphasis on the balance of skills development and experiential learning.
3. The support offered to teachers of weak ability students should be developed as far as possible.
4. If possible attention should be given to creating a positive environment for schools introducing the programme into the curriculum. In other words, the elements of health promotion as well as health education should be fostered.
5. The project management has successfully drawn on the skills of the North Eastern Health Board., parents, the Department of Health, the Department of Education and Science, School management and the North Western Health Board. These links should be continued and strengthened.
6. Discussion should take place with the Department of Education and Science to examine how arrangements might be made to cover for teachers involved in the inservice component in this project.

7. There is a need to take into account in the future development of the project, national initiatives undertaken by the Department of Education and Science. The introduction of the Relationships and Sexuality Education programme and the Civics, Social and Political Education programme has important Implications in terms of curriculum overlap and the release of teachers for inservice training.
8. The Healthy Schools project has shown that an important contribution has been made by the North Eastern Health Board In promoting the health of school children. The partnership model of management and implementation employed on this project could be adopted in other regions.

Dr Mark Morgan, November 1997

APPENDIX A

PUPILS' QUESTIONNAIRE

What is Your Opinion

In this survey we are asking you about your opinions on many things in your life, about your opinions and feelings and views on the future. It is very important that you answer as truthfully as you can. Bear in mind that there are no right or wrong answers.

PLEASE DO NOT PUT YOUR NAME ON THE QUESTIONNAIRE. Your answers will not be made known to anyone. We are interested only in the average for groups and not in any single person's opinion.

In answering the questions all you need do is put a tick in the () that is right for you.

Do not leave answers blank.

1. For each of the statement put a tick in the () that is right for you

	<i>Strongly Agree</i>	<i>Agree</i>	<i>Hard to Say</i>	<i>Disagree</i>	<i>Strongly Disagree</i>
(a) It is better to make laws about being healthy than learning about it in school	()	()	()	()	()
(b) I can control many things in my life if I do what is right	()	()	()	()	()
(c) It is nearly impossible to stand up to pressure to drink in Ireland	()	()	()	()	()
(d) If I enjoy a healthy life it is due to luck	()	()	()	()	()
(e) Taking exercise is only a fad and is of little importance for feeling well	()	()	()	()	()

Page 46 is missing

(f) I feel very embarrassed when I have to say something in class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(g) My being happy is important to my parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(h) I worry a lot about silly things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(I) I often feel nervous over nothing at all	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(j) I have plenty of interests and hobbies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. How likely is it that each of these will happen to you when you are an adult?

	<i>Very Likely</i>	<i>Likely</i>	<i>Hard to Say</i>	<i>Unlikely</i>	<i>Very Unlikely</i>
(a) Get a good job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(b) Drink alcohol regularly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(c) Take regular exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(d) Have many friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(e) Lose my temper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(f) Get on well with my parents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(g) I'll be a smoker	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(h) Feel content with life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(I) Feel able to cope with 'ups and downs' of life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(j) I will eat healthy food	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| (d) Smoking is usually a sign of immaturity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Occasional use of drugs is part of growing up for everyone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) The Gardai would be better employed with serious crime instead of being concerned about young people drinking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) People who smoke look 'cool' | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. Here are some statements about feelings. Tick the () that is right for you.

- | | <i>Strongly Agree</i> | <i>Agree</i> | <i>Hard to Say</i> | <i>Disagree</i> | <i>Strongly Disagree</i> |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| (a) I cope well with exams | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) It's OK not to feel good all the time | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) In any one day I have a lot of feelings and that's OK | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) When I'm upset I usually keep it to myself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) I am usually sensitive to the feelings of others | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) How I get on with my friends is very important to me | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) When I have a falling-out with a friend, there is nothing I can do about it. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) I make friends easily with boys and girls | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

The next set of questions are about some classes that you have in school which include topics like study skills, hygiene, your feelings, smoking, alcohol and drugs. You probably call these classes ‘Health Education’ or Civics or Pastoral Care. These questions are about these classes.

7. How did you find these classes (tick one)

- Very Enjoyable
- Enjoyable
- Hard to Say
- Not especially enjoyable
- I disliked these classes

Of the topics that you did please write the name of one that you liked

8. In these classes you were often asked to take an active part either by giving your opinions, role-playing or writing or artwork.

How did you find these activities ?

- Very Enjoyable
- Enjoyable
- Hard to Say
- Not especially enjoyable
- I disliked these activities

In your view were these activities more suitable for boys or girls ?

- More suitable for boys
- More suitable for girls
- Suitable for boys and girls

APPENDIX B

TEACHER QUESTIONNAIRE

In order to evaluate how the programme fared, it is important to establish what you thought of various aspects of the programme.

Most of the questions require only a tick in a (). However, it would be of great help if you make some comments as appropriate.

PLEASE DO NOT PUT YOUR NAME ON THE QUESTIONNAIRE.

1. To what extent did the inservice days prepare you for teaching the programme ?

(Tick one)

- I felt thoroughly prepared
- I felt quite well prepared
- I felt moderately well prepared
- I felt inadequately prepared

Comment if you wish _____

2. How much did the inservice preparation change your views and understanding of Social, Personal and Health Education ?

- Changed my views a lot
- Changed my views somewhat
- Changed my views a little
- Did not change my views

Comment if you wish _____

3. The 'Healthy Schools' programme involved informal methodologies for teaching including group discussion, artwork,..... How competent do you feel in using these methodologies

- Very competent
- Quite competent
- Fairly competent
- Not Very competent

Comment if you wish _____

The next set of questions are concerned with your perceptions of your teaching the programme and some possible consequence of this.

4. To what extent are you using the informal methodologies that are advocated in the programme?

- Fully, as suggested
- To a large extent
- To some extent
- To a minor extent

Comment if you wish _____

5. To what extent has your experience and training with the programme affected your teaching in your own subject?

- To a large extent
- To some extent
- To a minor extent
- Not at all

If it has affected your teaching, please comment on this _____

6. To what extent has the experience of teaching the programme affected the way you relate with your pupils within the actual classes in Social Health Education?

- To a large extent
- To some extent
- To a minor extent
- Not at all

If it has affected the way you relate with pupils, please comment on this _____

7. To what extent has the experience of teaching the programme affected the way you relate with your pupils in your teaching of other classes?

- To a large extent
- To some extent
- To a minor extent
- Not at all

If it has affected the way you relate with pupils in these classes, please comment on this _____

8. To what extent has the programme affected the way in which students relate with each other?

- To a large extent
- To some extent
- To a minor extent
- Not at all

If it has affected the way pupils related with each other, please comment on this _____

9. To what extent has the programme made you personally more aware of health matters?

- To a large extent
- To some extent
- To a minor extent
- Not at all

If so, in what way did this happen? _____

10. To what extent has teaching the programme made you think about the issues covered in the programme as these relate to your own life?

- To a large extent
- To some extent
- To a minor extent
- Not at all

The next section is about the content of the programme and it's suitability for both boys and girls

11. How do you feel about the overall content of the programme?

- All topics are appropriate
- Most topics are appropriate
- Some appropriate and some are not
- Most topics are not appropriate

Please comment on why you think this is the case _____

12. How suitable did you consider the programme to be for girls and boys?

- Equally suitable for boys and girls
- More suitable for boys
- More suitable for girls

Please comment _____

13. Comment on the participation of boys and girls in the programme in your classes

- Not relevant to me
- Boys participated more
- Girls participated more
- Boys and girls participated equally

Please comment _____

14. If you find differences between the reactions of boys and girls, please say which might have contributed to this (tick one)

- Topics were suitable for one
- Methodology more suited to one
- Inherent differences between boys and girls
- Other factors

Comment _____

This final section concerns the implementation of the programme

15. How has each of the following influenced the effective implementation of the programme in your school? Tick one answer for each

	Helped a Lot	Helped Somewhat	Helped a little	Did not help	Hard to say
a) Attitude of the Principal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Helpful school ethos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Suitable Time-table	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Good planning and co-ordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Involvement of Parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any other factors _____

16. The North-Eastern Health Board have provided a support service for the inservice and implementation of the programme. Please indicated how you found this support service.

- Very helpful
- Quite Helpful
- Moderately helpful
- Not especially helpful
- Hard to say

Any Comments _____

17. To what extent has the programme contributed to the awareness of how the whole school can contribute to the health of young people.

- To a large extent
- To some extent
- To a minor extent
- Not at all

Please comment _____

APPENDIX C

STEERING GROUP MEMBERS

Dr F. Howell (chairperson)	Public Health Specialist, N.E.H.B.
Ms C. Cullen	Training and Education Officer Health Promotion Unit, Dept. of Health
Mr J McKay	Chief Executive Officer, Cavan V.E.C. and N.C.C.A. representative
Ms M Bohan Dr S Breathnach	Psychologist, Department of Education Principal, St Louis Secondary School Carrickmacross, Co Monaghan
Mr C Flynn	Principal, Ashbourne Community School Ashbourne, Co Meath
Ms A Boyle	Association of Secondary Teachers of Ireland representative
Dr P Finnegan Ms D O'Reilly	D.C.C. and M.O.H., Meath Comm. Care Teachers' Union of Ireland representative
Mr H Casey	Diocesan Advisor, Diocese of Meath
Ms B McDonnell	Health Promotion Unit, Dept of Health
Mr N Killian	National Parents Council - Post Primary representative
Ms J Gaynor	Schools' Programme Manager - NWHB
Mr J O'Brien	Director, Youthsills North East
Mr B Me Donald	Health Education Officer, NEHB
Mr B White	Health Education Officer, NEHB
Dr N Eldin	Regional Health Promotion Officer Health Promotion Dept., NEHB
Mr O Metcalfe	Chief Education Officer, Dept. of Health (1994 - 1996)
Mr P O'Cuanagh	Principal, Colalste Ris Dundalk (1994 - 1997)

APPENDIX D

SCHOOLS IN THE PROJECT

PHASE 1

Ardee Community School

Ardee

Co Louth

Ard Scoil Lurgan

Castleblaney

Co Monaghan

Ashbourne Community School

Ashbourne

Co Meath

Bailieboro Community School

Bailieboro

Co Cavan

Eureka Secondary School

Kelts

Co Meath

Loreto College

Cavan

Co Cavan

St Vincent's Secondary School

Dundalk

Co Louth

Our Lady's Secondary School

Castleblaney

Co Monaghan

St Pat's Classical School

Navan

Co Meath

Trim Vocational School

Trim

Co Meath

PHASE 2

Vocational School
Virginia
Co Cavan

St Peter's College
Dunboyne
Co Meath

St Oliver's Community College
Drogheda
Co Louth

Monaghan Collegiate
Corlatt
Co Monaghan

St Louis Secondary School
Carrickmacross
Co Monaghan

Our Lady's College
Drogheda
Co Louth

O'Flalch College
Dundalk
Co Louth

Community College
Dunshaughlin
Co Meath

St Aidan's Comprehensive
Cootehill
Co Cavan

St Macartan's College
Monaghan
Co Monaghan

PHASE 3

St Joseph's Secondary School
Athoy
Co Meath

Scoil Mhuire
Trim
Co Meath

Beaufort College
Navan
Co Meath

St Mogue's College
Bawnboy
Co Cavan

Colaiste Ris
Dundalk
Co Louth

St Joseph's CBS
Drogheda
Co Louth

St Louis Secondary School
Monaghan
Co Monaghan

Dundalk Grammar School
Dundalk
Co Louth

Patrician High School
Carrickmacross
Co Monaghan