

SCHOOL HEALTH COORDINATORS AS CHANGE AGENTS

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“In these fragmented times, a school leader’s survival is directly linked to his or her ability to understand strength and draw upon the school system’s connectedness” (Markova & Holland, 2005).

The Comprehensive Approach to School Health (CSH) is celebrated as the model approach in promoting healthy schools (Allensworth & Kolbe, 1987; Kolbe, 2005; Lewallen & Vamos, 2006; McCall, & Roberts, 2006; Stewart-Brown, 2006). Facilitated programs are recognized as effective (Bond, Glover, Godfrey, Butler & Patton, 2001; Warwick, 2004; Winnail, Bartee, & Kaste, 2005; Stewart-Brown, 2006; Austin, Fung, Cohen-Bearak, Wardle, & Cheung, 2006). Provinces, regional health authorities and school boards across Canada are increasingly looking to a model where dedicated staff and infrastructure promote CSH. The nine school boards in Nova Scotia have joined with the regional health authorities in appointing Healthy Living Consultants. The majority of Healthy Living Consultants have backgrounds in physical education or school administration. In the Simcoe-Muskoka area of Ontario, Public Health nurses with a school health liaison have offices in both the district health unit and the district school board buildings. Comprehensive School Health Coordinators and School Health Facilitators assist in delivering the comprehensive school health program in the David Thompson Health Region (DTHR) in Alberta. Many other examples exist across Canada, including New Brunswick, where the Healthy Learners program has been underway for several years is also based on the assignment of public health staff within school board offices. The name applied to this position varies, but these individuals are frequently referred to as “coordinators” or “consultants”. This article looks at the findings of a recent study in Newfoundland and Labrador that evaluated the role of school health coordinators known as School Health Promotion Liaison Consultants (SHPLCs). The aim of this study was to assess the effects of introducing SHPLCs as facilitators of education-health cooperation. The SHPLCs work in promoting the health and learning of children at the school board/health authority/community level.

Background and Newfoundland and Labrador Context

Newfoundland has the highest rates of childhood onset diabetes and cardiac disease in the country. This reality provided impetus for a corresponding investment in Wellness initiatives (Provincial Wellness Plan for Newfoundland and Labrador, 2006). The 2006 Provincial Wellness plan outlined a two-phase strategic plan. This study took place during Phase 1 (2006-2009) of the

plan which introduced the Healthy Students, Healthy Schools (HSHS) initiative. This comprehensive school health approach is focused on healthy eating, physical activity, tobacco control and injury prevention. When the Wellness Council (which includes representation from the Department of Education and the Department of Health and Community Services) met to discuss changes in schools based on the provincial wellness plan; the need for the creation of the School Health Promotion Liaison Consultant position was identified.

At around the same time, the Provincial Healthy Schools Summit was held. The Healthy Schools Student Summit was an important opportunity to hear directly from students the priorities and concerns they had in making schools healthier places. The summit was a spark that put Healthy Students, Healthy Schools on the radar screen of the districts. Soon after the summit, the Healthy Students, Healthy Schools (HSHS) Web site was established and the SHPLCs were hired. The breakdown of funding for this position is illustrated in Figure 1.

Figure 1: Funding for the SHPLC Position

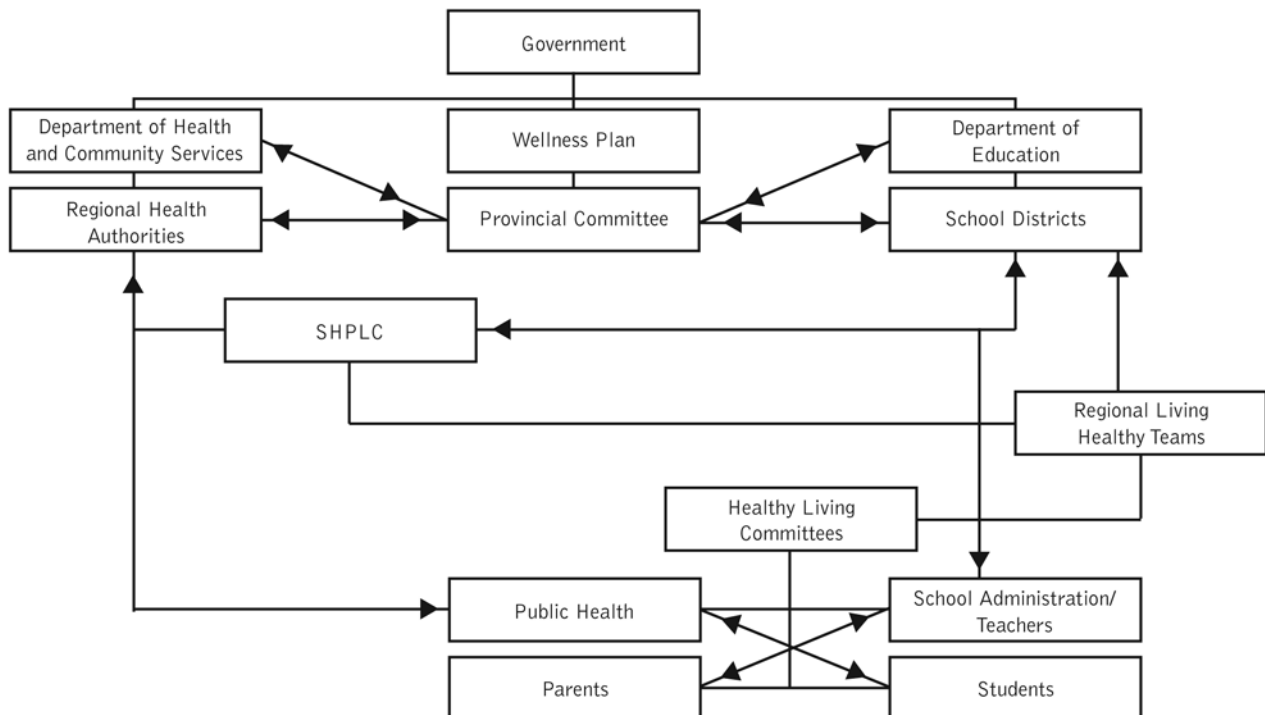
Funding for the SHPLC Position
Salary: Regional Health Authority Travel & Provincial Meetings: Department of Education Office Space: School Board

There is one consultant (SHPLC) located in each school district (Eastern-Avalon, Eastern-Rural, Nova Central, Western and Labrador). The consultants began their positions at different times, with the first position being filled in November of 2005. These individuals are responsible for moving forward the policies and plans set by the government and school boards regarding school health. Since the beginning in 2005, the focus has been on the implementation of the School Food Guidelines and on changes to schools based on these guidelines. In the future, the coordinators will spend time focusing on physical activity, the anti-tobacco campaign, mental health issues, and other related health concerns. Figure 2 is a description of the roles of the SHPLC and Figure 3 traces the organizational relationships of the School Health Promotion Liaison Consultants.

Figure 2: Roles of the SHPLC

- Encourage schools to become healthy schools
- Assist with the creation and support of Living Healthy teams; Develop an action plan
- Provide information on Healthy Students Healthy Schools to school groups, school councils, etc.
- Support the implementation of school food guidelines, physical activity policy initiatives and smoke free school grounds
- Assist with the interpretation of the School Food Guidelines with key stakeholders (i.e. administration, catering, etc.)
- Strengthen capacity for local district, RHA and community agencies to work together in areas such as policy coordination
- Assist schools with accessing relevant health promotion resources
- Provide in-services on Living Healthy topics to teachers, principals, parents, catering staff, etc.
- Support schools focusing on student and staff wellness
- Provide schools with support for Living Healthy events
- Assist schools with applications for funding opportunities
- Developing and maintaining linkages between school district, RHA and community agencies necessary for coordinated responses
- Reach out to the community to strengthen partnerships
- Undertake a baseline evaluation of their students’ health and their current policies and programs

Figure 3: Organizational Relationships of the SHPLC



The Need for School Health Coordinators

Interventions that have aimed for health promotion in schools in the past have frequently been “piecemeal, short term packages” (Bond, Glover, Godfrey, Butler & Patton, 2001). Dedicating an individual to help guide the comprehensive school health program and to help develop capacity is related to the success of the implementation (Ebbesen, Heath, Naylor & Anderson, 2004; Warwick, 2004; Winnail, Bartee, & Kaste, 2005; Stewart-Brown, 2006; Austin, Fung, Cohen-Bearak, Wardle, & Cheung, 2006). The coordinator sustains the health promotion program by helping schools to access support in accordance with their unique needs and priorities. Outside facilitators have helped schools to carry out school health assessments, thus alleviating problems of limited staff and resources (Staten et al, 2005; Austin, Fung, Cohen-Bearak, Wardle, & Cheung, 2006). The process of assessing the strengths, weaknesses, opportunities and threats inside the school has been reported to “give rise to a creative tension between the school’s present situation and its preferred future, leading to a strategic plan” (Tuohy & Coghlan, 1997). The coordinator, a critical friend, helps the school to build capacity for sustained comprehensive school health. This includes, but is not limited to, helping to evaluate comprehensive school efforts, helping to promote mental health and encouraging professional development (Stewart-Brown, 2006, Stewart Brown, Warwick, 2004; Hausman, & Ruzek, 1995).

Methodology

As governments consider an extension of their investments in this coordinator based approach, this study described the potential impacts, effective roles and benefits of this position based on expectations derived from school health literature. This study was an in depth evaluation of SHPLC position in Newfoundland and Labrador. The evaluation of the SHPLC involved an analysis of documents pertaining to the role of the SHPLCs, it involved a process of semi-structured interviews and focus groups with forty key informants from the Department of Health and Community Services and the Department of Education. The goal of the research was to identify key activities of the SHPLCs program, successful aspects of the program and primary barriers to success. Ethics approval for the study was given by the Interdisciplinary Committee on Ethics in Human Research at Memorial University (2006/07-053-HKR). All interviewees were encouraged to engage in the process of respondent validation to verify that transcripts were accurate. Transcript data from interviews with 40 participants were analyzed using NVivo software. The analysis of themes involved an iterative process that helped to identify central themes that arose during interviews.

Findings and Discussion

Much of the feedback on the new SHPLCs positions was positive. People responded that in a short amount of time the SHPLC have helped to implement the school food guidelines,

increase physical activity in the school and to implement smoke free school grounds. The SHPLC have enhanced communication between health and education and also between schools and districts. People viewed the SHPLC as critical in helping students to become healthier.

The interdepartmental collaboration involved in the creation of these positions was identified as a model which could be used by the government in other areas (Official from the Department of Education). This partnership presented opportunities and complexities. Partnerships between Health and Education present a challenge to traditional roles and require time, commitment and persistence as mutual understanding and trust are established (Young, 2008). Although informants reported some initial jurisdictional confusion over the process of hiring, this deliberate and transparent partnership was viewed “...as a great success story...” (Official from the Department of Education).

Present and Future Role of the SHPLC

The comprehensive school approach adopted by the province of Newfoundland and Labrador includes a number of components integral to the Comprehensive School Health model found in the Healthy School Report Card and promoted by Lewallen & Vamos (2006). Responses about the present and future roles of the SHPLC are categorized into these different components of a healthy school.

Figure 4: Components of a Healthy School

Environment	Response to the SHPLC role and areas of future involvement
Emotional and social environment	Initiatives were geared mostly at younger children. There was a reported use of drugs among the school age population. There is a “...challenge of undoing things that have developed over a number of years...” (SHPLC). Areas to address include: social behaviors, vulnerable populations, drug use, body image, violence in schools, bullying.
Family and community involvement	More work could be done with parents.
Physical environment	The smoke free school grounds policy was highlighted as being successful. Future projects will include a hand washing pilot study and injury prevention initiatives.

Physical activity	There were very positive responses to all active schools initiatives including but not limited to: i. the school led “Commotions” (a celebratory day focused on activity), ii. the pedometer challenge. Physical activity will be targeted with increased focus.
Nutrition services	The SHPLC was considered integral in implementing the School Food Guidelines. There was very positive feedback, although in some cases people were reluctant to change. High school children were leaving school grounds to purchase junk food outside. The SHPLCs were integral in procuring new cafeteria equipment and helping to bring the message of the new guidelines into the schools. Consideration is being given to after school food guidelines as a project for the future. There was a proposal to put in place a subsidized fruit and vegetable program similar to the current subsidized milk program.
Counseling, Psychological and Social Work Services	Issues regarding mental health will be addressed in the future by the Healthy Students, Healthy Schools initiative.
School Health Promotion for Staff	The in-services training sessions for caterers were highlighted as a very effective incorporation of staff into the initiative. Professional development days for teachers are ongoing, but there were some reports of teachers not complying with the initiatives. The meetings of principals were viewed very positively. In the future there will be training for preschool staff and more professional development days.

changes in the schools are a result of a number of events and the actions of a number of people; the School Health Promotion Liaison Consultants are viewed as effective change agents who can transfer on the ground knowledge from other programs directly to the schools.

The task of reaching geographically dispersed schools in rural areas also constrains the work of the SHPLCs. A number of school principals suggested that they would like to see more of the consultants and many respondents equated rural places with fewer resources. Geography plays an interesting role in this study because each region of the province has unique characteristics. This posed a specific problem in implementing the School Food Guidelines; it can be difficult to access healthy foods at a reasonable price in rural locations. One official from the Department of Education described how vast his district was, noting that eight schools could only be accessed by ferry. HSHS initiatives can look very different in the different regions of the province as school boards also have their own health promoting schools policies and are challenged by geographical distances in different ways. The smaller districts were generally able to implement policies more quickly than the larger districts.

“Finding the right person” (School Board Official) is a third issue with sustained coordination. The five SHPLCs had a variety of professional backgrounds. At the time of the study, there were two dietitians, a social worker, a principal and a physical education teacher. Each SHPLC was able to bring a unique set of skills to the SHPLC team and consequently enhance its overall effectiveness. A SHPLC needs to be a multifaceted individual who can relate to students and teachers as well as others. Ideally a consultant is a dynamic person, a driving force with vision, passion, and organizational and communication abilities. One consultant found that “everybody wants a piece of you” (SHPLC) and having a resource group composed of individuals from different backgrounds has facilitated support and the sharing of ideas.

Activities of the School Health Coordinator

The American Cancer Association has described the basic skills of a coordinator and identified seven areas of responsibility. Further, the association would like to have a coordinator in every school, and has been advocating this for over a decade (American Cancer Society, 2008). The impact of the SHPC intervention will now be discussed in relation to the seven areas of responsibilities.

1. Ensure that instruction and services provided are mutually reinforcing and consistent.

The reported high turnover of personnel in the Regional Health Authorities, in School Districts and in the SHPLC position has been remedied with the presence of school health teams and the process of team building. The HSHS teams encouraged networking which resulted in project sharing and communication among the different regions

Coordination of the School Health Program

The Health Promoting Schools approach is intensive and needs to be implemented over long periods of time (Stewart-Brown, 2006). “It’ll take a generation to make the kind of difference that we really need to make” (Official with Department of Education). Many participants reported the importance of making the SHPLC position permanent in order to sustain changes. Although the

and among employees at all levels. The HSHS framework enables support for the Healthy Students, Healthy Schools Provincial Committee, regional committees and Living Healthy teams at the school level. The interview respondents noted that these teams encourage communication and link different stakeholders with the initiative, “We hire about 77 new teachers a year... we have a lot of people who are going to retire who are principals and new people who have to be brought on side”. The hierarchy of teams has helped to sustain healthy living initiatives. The Healthy Students, Healthy Schools web page and newsletter were also seen as effective in bringing forth a consistent message of the initiative in NL. The respondents emphasized a need to bring the HSHS message into junior and senior high schools. High school principals also reported that the curriculum requirements pose a challenge to any significant restructuring of daily activities. The SHPLCs help to support communication between the hierarchy of provincial healthy schools committees and support principals in overcoming challenges to implementing school health initiatives.

2. Facilitate collaboration between health program and schools staff.

The feedback from interview participants was very positive about the development of the relationship between the Department of Health and Community Services on the one hand and the Department of Education on the other. In one district, the consultant was made a part of a Health Promotion consultant team within the Department of Health and Community Services and this helped with the identification of resources for everyone involved. The most noted enhancement in communication was between principals and the Department of Health and Community Services. The SHPLC had established this link by attending a meeting of school principals. Some respondents, however, suggested that a communication barrier can exist because of the incompatibility of organizational cultures in health and education, “you have an incompatibility of systems in terms of work day, in terms of union and collective agreements, and it does create some issues” (School Board Official).

3. Assist principal and other administrators with integration and management.

The majority of respondents reported that the SHPLC had an effective working relationship with school administration. The SHPLCs communicated with the principals regularly and outside of the regular principals’ meetings with, “...health as the main agenda for the day” (Official with the Department of Health and Community Services).

4. Provide or arrange technical assistance.

The implementation of the school food guidelines was the first priority item of the HSHS initiative and SHPLCs were reported as fundamental in helping schools and caterers to procure the necessary equipment to provide healthy food choices in schools. The SHPLC also helped schools to access equipment to encourage increased physical activity, “...because having one set [of snowshoes] per school is not going to cut it in Labrador...when you need to take advantage of that sort of activity” (Health and Community Services Official).

5. Identify resources.

The appointment of the SHPLCs was reported to be important in helping schools to obtain Provincial wellness grants. These grants were made available to individual schools to help them engage in healthy activities. Schools were found to take advantage of these small incentives and felt supported in their initiatives. One SHPLC helped to lobby the school board for the appointment of a dedicated physical education consultant. While the respondents commented on the considerable investment by Government in Comprehensive School Health, it was noted that further funds will be required as CSH requires a significant investment of financial and human resources.

6. Facilitate collaboration between district and other community agencies.

While many positive connections were reported in schools and within the Healthy Students, Healthy Schools working groups, a lack in communication of the initiative to the surrounding community was reported. There was a reported lack of communication materials and a need to communicate more with parents. In response to this concern, campaigns such as “Drop the Pop” were developed and targeted at students and parents beyond the school environment.

7. Conduct evaluation activity.

A number of informants reported that they would like to be able to measure a change in students’ health, such as determining the amount of fruit and vegetables they consume. Research involving the use of pedometers to measure physical activity levels was being undertaken, but it was felt that further research findings would help to support their work.

Conclusion

The SHPLC initiative has provided a different and effective approach to health promotion in schools. This model is based on a conceptual shift from a disease prevention focus in health promotion to a focus that addresses the broader

social and environmental determinants of health (Rowling & Jeffreys, 2006; Bond, Glover, Godfrey, Butler & Patton, 2001). The Comprehensive School Health approach is a complex solution to a complex problem (Goldspink, 2007). This study has shown that researching the effectiveness of the School Health Promotion Liaison Consultant appears to have had an impact in helping to coordinate actions associated with the provincial HSHS initiative. School principals in particular were found to be very positive about their work in linking schools with health authorities and outside organizations such as catering suppliers. This model of health promotion encourages communication and enhances the implementation of school health policies.

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prior to implementing a reverse lunch hour. This principal added that the smoothness of implementation could be attributed in part to the prior discussions with the staff and careful planning through each phase.

Another principal described how a letter explaining the concept was sent home on the first (half) day of school so that parents would be aware of the change occurring the following full school day. This communication gave parents the opportunity to let the school know of any particular student needs. For example, one principal remarked that once informed by parents of a student's needs resulting from diabetes, the school was able to make any required adaptations to ensure the student's well-being.

One piece of advice shared by a principal was the need to consider the community (human) traffic patterns around the school. For example, if the school is located in proximity to another school, changing the time children were on the playground could bring students in contact with those from the other school. If the students from the other school are older and are allowed to leave their property for a cigarette, supervisors need to prompt the visiting students to return to their own school.

Finally, one principal suggested that having a good research and evidence base to share with staff and community helped with the implementation of the reverse lunch hour. This could be done at a

professional development day to help set the stage. Stressing the health effects of the approach was considered very important to its successful adoption.

In closing, it is important to note that there are few more traditional institutions in our society than the public school. The structure of the school day and the design of classrooms has largely remained unchanged for over 100 years. Perhaps we have come to a point where we've done the same thing for so long, and are so rooted in tradition that we lose touch of the fact that there are perhaps better ways of approaching our most fundamental of processes – even something as simple as how our students eat lunch.

About the Author

Simon Blakesley is the Northern Coordinator for the Canadian Council on Learning's Health and Learning Knowledge Centre at the University of Victoria. Simon has been a teacher and school administrator for the past 18 years and resides in Whitehorse, Yukon. Prior to this he served as a jet engine technician with the Canadian Air Force. He is completing the research phase of the Ph.D. (Educational Studies) program at UBC, examining education in northern Canadian and rural contexts.

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