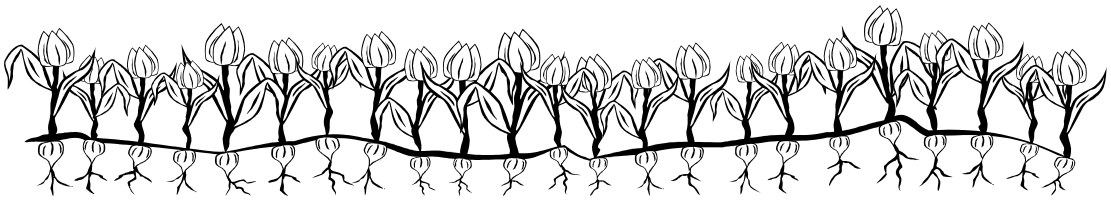

Passion and Policy: A Selected Review of Delivery Systems for Comprehensive School Health

Prepared for the
EVER ACTIVE SCHOOLS PROGRAM,
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Policy and Passion: A Selected Review of Delivery Systems for Comprehensive School Health

1. INTRODUCTION

This paper was commissioned by the Ever Active Schools program in Alberta, Canada to discern how comprehensive school health (CSH) is delivered in various jurisdictions across Canada and the world. It is hoped that this information will inform and stimulate discussion and reflection on the Ever Active Schools program.

In Alberta, there are several initiatives that are delivering what the school health promotion field calls CSH approaches. Ever Active Schools (EAS) is the only province wide program and "facilitates the development of healthy children and youth by fostering social and physical environments that support healthy active school communities". [1] The original concept for EAS came from a recommendation within the Alberta Active Living Task Force (June 1997). The result of a provincial consultation with a wide variety of stakeholders was the creation of EAS through a grant from the Alberta Sport, Recreation, Parks and Wildlife Foundation. Part of the development process included an international review of programs and interventions in the school setting, which led to the adoption of a CSH approach.

The provincial government ministries of Alberta Community Development, Health and Wellness, and Education provide annual funding for this program. EAS is supported administratively by the Health and Physical Education Council of the Alberta Teachers' Association and oversight is provided by an inter-sectoral Steering Committee.

EAS is a voluntary membership-based program designed to recognize, reward and assist schools that focus on creating and sustaining a healthy active school community. The program is based upon a model whereby a Provincial Coordinator provides learning events and planning resources to implement and monitor CSH practices, policies and environments.

The EAS program is currently working with 120 schools (out of approximately 2200) in Alberta. Each of these member schools have submitted "Game Plans" of strategies to increase health promoting environments and behaviours in their school community. The program provides a unique framework for school communities to identify strategies in four areas that exemplify the CSH approach. The four "E's" of Ever Active Schools include:

[1] www.everactive.org

Education

Providing ways to increase the quality of program delivery in instructional settings within the school community to encourage students to make healthy choices and achieve the outcomes of the health and physical education programs[2] (e.g., offering quality physical and health education consistent with curricular outcomes).

Everywhere

Encouraging and supporting healthy initiatives in the community and opportunities for increased cooperation between school, home, and community (e.g. encouraging adults within school communities to act as role models and be mentors for students by being physically active, making healthy food choices and supporting mental wellbeing).

Everyone

Providing opportunities to increase healthy behaviours and involvement for all students, including those identified as at-risk (e.g. allowing for socio-economic factors when planning activities, implementing policies or developing projects).

Environment

Building and sustaining physical and social environments supportive of healthy active lifestyles which include active living, mental health, and healthy eating (e.g., developing an alternative play environment, adopting a nutrition policy for the school to eliminate unhealthy food choices in the vending machines, developing an anti-bullying campaign).

2. WHY CONDUCT A REVIEW?

Comprehensive school health (CSH) is essentially a catch all term to describe an approach to school health promotion. CSH is a Canadian term[3] and will be used interchangeably with "health promoting schools" which is used in Europe and Australia[4]. The terms are basically synonymous.

There are excellent guidelines that establish specific elements that describe what such an approach should include. The 4 "E's" that form the foundation of the EAS program, as articulated above, is a good example of how the key elements of CSH are integrated into program guidelines.

[2] http://www.education.gov.ab.ca
[3] http://www.phac-aspc.gc.ca/dca-dea/7-18yrs-ans/comphealth_e.html
[4] http://www.who.int/school_youth_health/en/

There are also documents that take these concepts further and put forward critical elements for success. For example, the IUHPE[5] published protocols and guidelines for health promoting schools and included the following 12 descriptors for sustaining an effective health promoting school (HPS) initiative:

1. *Ensure there is continuous active commitment and demonstrable **support by governments and relevant jurisdictions** to the ongoing implementation, renewal, monitoring, and evaluation of HPS.*

2. *Establish all the elements and actions as **core components to the working of the school.***

3. *Seek and maintain **credibility for HPS programs** and actions both within and outside the school.*

4. *Communities need to have **an active expectation** that their schools will promote the health of their children.*

5. *Ensure there is **time and resources** for appropriate staff development.*

6. *Review and refresh after each 3-4 years.*

7. *Continue to **ensure adequate resources.***

8. *Maintain a **coordinating group** to oversee and drive the HPS with continuity of some personnel and the addition of new personnel.*

9. *Ensure that most of the new and ongoing initiatives **involve most of the staff, students, and families** in consultation and implementation.*

10. *Ensure monitoring services in the education sector view health promotion as an **integral part of the life of the school** and it is reflected in the monitoring indicators.*

11. *Designate a **trained lead person** with adequate release time.*

12. *Publicise success and progress with students, staff, parents and the community.*

This list from IUHPE is valuable as to key elements for effectiveness and sustainability, however, one still is left with wondering what #7 "Continue to

[5] http://www.iuhpe.org

ensure adequate resources" and #11 "Designate a trained lead person with adequate release time" actually looks like in practice.
How CSH is organized or delivered appears to be extremely variable and there are no known studies to the author that compare and contrast the actual way in which effective CSH is delivered and the logic behind particular systems. Some studies come close to addressing this and point to important directions. For example, Stewart–Brown (2006) reports the following:

> *… interventions that promoted healthy eating and physical activity were effective. These programmes were among the most sophisticated, and the ones that were effective were more likely to involve changes to the environment of the school and involvement of parents. In this area, as well as in mental health programmes, a range of different types of programmes proved effective.*

These statements bring into focus evidence that advocates for CSH programs that promote healthy eating, physical activity and mental well-being and attend to elements such as environmental considerations and parent involvement. Stewart–Brown reports on further evidence:

> *The school health promotion programmes that were effective in changing young people's health or health-related behaviour were more likely to be complex, multifactorial and involve activity in more than one domain (curriculum, school environment and community). These are features of the health promoting schools approach, and to this extent these finding endorse such approaches. The findings of the synthesis also support intensive interventions of long duration. These were shown to be more likely to be effective than interventions of short duration and low intensity. This again reflects the health promoting schools approach, which is intensive and needs to be implemented over a long period of time.*

What this particular article tells us is that the delivery of effective school health promotion programs is characterized by a) complexity and sophistication; b) multiple strategies addressing curriculum, school environment and parent/community participation; c) intensive interventions; and d) long duration. The quest to identify effective elements of a delivery system for CSH is like pealing the layers of an onion. Each layer hints at what effectiveness looks like. But one is left wondering – how long is "long duration"? What do "intensive" and "complex" interventions look like? When one combines the IUHPE list of success factors and Stewart-Brown's statements it appears that some school health promotion initiatives may be under resourced and under supported for effectiveness.

Another example that builds upon what we have learned from the information above is the Annapolis Valley Health Promoting Schools Project (AVHPSP) in Nova Scotia, Canada. Veugelers and Fitzgerald (2005) report that

Students from schools that are part of the AVHPSP exhibited lower rates of overweight and obesity and had better dietary habits in terms of higher consumption of fruit and vegetables, less caloric intake from fat and higher dietary quality index scores. Also, these students reported greater participation in physical activities and less participation in sedentary activities.

Needless to say this is strong evidence as to the effectiveness of the AVHPSP and validates some of Stewart-Brown's assertions. The AVHPSP also published documents that summarize process outcomes and relates key lessons learned.[6] They identified, among many other lessons, the following:

- *Designated coordinators at a school make a difference to reach goals.*
- *Need to sustain the project activities so that schools have the support to continue promoting healthy eating and physical activities.*
- *Sustainability equals paid people and partnerships.*
- *Fund schools adequately given an adequate infrastructure.*

These lessons from the AVHPSP also validate IUHPE's guidelines that emphasize the need for adequate time (e.g., trained people, release time) and resources (e.g., funds to implement action).

From this very brief review of relevant documents in the school health promotion literature, we have keen insights into effective school health promotion initiatives. However, what do they look like in existing policy and practice? Are delivery systems in other jurisdictions addressing the characteristics for effectiveness as described above? Are there examples of delivery systems that reflect the protocols and lessons learned for sustaining effective health promoting schools? Who is providing the leadership – the health and/or the education sectors? Who is providing financial and human resources to plan, implement and evaluate the delivery system? These are questions we posed for this paper.

3. METHODS

A review of websites listed on the Alberta Coalition of Healthy School Communities website[7] was conducted to access relevant information for this paper. References were reviewed for relevance as to specific program characteristics or delivery systems for CSH.

[6] http://www.hpclearinghouse.ca/features/AVHPSP.pdf
[7] http://www.achsc.org

From this search there was little found in the way of detailed information to answer the questions posed. Therefore, it was determined to conduct telephone interviews with key informants. Because of the limited time and budget, a maximum number of 15 interviews was established and a one month time period for completing all correspondence and interviews was agreed upon for data collection.

Right from the start, it was agreed that this study was not going to meet scientific rigor in terms of sampling techniques. The sample would be based upon inviting people in decision-making roles with respect to school health promotion in Canada, Australia and England. It was basically "first come, first interviewed" sampling.

The focus was on key informants in jurisdictions other than Alberta. The list of key informants began with the provincial School Health Coordinators affiliated with the Pan-Canadian Joint Consortium for School Health[8]. Eleven School Health Coordinators were invited to participate and six were interviewed. Quebec is not part of the Consortium (and neither is Alberta) therefore no one from Quebec was invited to participate due to time constraints. Two contact people in 2 health regions in Alberta were contacted and interviewed because of their known participation in formal CSH initiatives.

From there the list of potential key informants grew from contacts in Australia and England through web searches and past correspondence with the author. Key informants were asked for names and contact information of others they thought would be interested in participating in the study. There were many more potential contact people than time allowed and it was unfortunate to not interview more people for this study.

Fifteen interviews of approximately 30 minutes each were conducted between August 24, 2006 and September 15, 2006. Eight key informants were working in school health promotion in Canada, 5 in Australia and 2 in England. The following table indicates the province, state or city of key informants.

Country and province or state and/or city of key informants	**# of interviews**
Canada: Alberta (Calgary and Red Deer), Saskatchewan, Prince Edward Island, Yukon, Manitoba, New Brunswick,	8

[8] http://www.jcsh-cces.ca/

British Columbia	
Australia: Victoria, New South Wales, South Australia, Australian Capital Territory, Western Australia	5
England: London, Manchester	2
Total	**15**

A semi-structured interview guide was developed and included the following questions:

- What does comprehensive school health (CSH) look like from a provincial/state perspective?
- How is CSH delivered in your province/state?
- What does CSH look like at the school board and/or health region level?
- What does CSH look like at the local school community level?
- Who funds CSH positions and to what extent?
- What are the key influencers to the design of the delivery systems?
- What have been the greatest challenges?

4. FINDINGS

The interviews generated two themes. Firstly, CSH initiatives need to nurture the passion that exists at the "grass roots" level, often championed by teachers, nurses, social workers and other professionals. Secondly, having a coordinated "top down" policy platform can pave the way for collaborative action to occur.

4.1 Passion for CSH

One key theme that ran throughout all the interviews was the incredible passion of key informants -- representing many sectors, positions and disciplines -- for promoting the health of school-aged children and youth. It was an extremely uplifting exercise to conduct these interviews and all informants were very forthcoming in talking about their jurisdiction.

This passion was revealed as informants talked about how important the "bottom up" grass roots support for CSH is to any delivery system. It was teachers, nurses and social workers who are champions at the school and regional levels that make CSH happen. People spoke about how a jurisdiction could have all the policies, frameworks, and documents for CSH but without the commitment and support of decision makers and practitioners at the local and regional levels it would not be as successful. One person suggested that Health Promoting Schools "doesn't come from the top". There is a definite desire among informants to work with a CSH approach!

However, this was tempered with a consistent message -- the need to constantly advocate and lobby for the necessary infrastructure for CSH. The passion was expressed when just about everyone interviewed stated that the single largest challenge to CSH is inadequate resources. One person asked: "Who's going to do it?" It was made abundantly clear in the interviews that overall teachers do not have time and Public Health Nurses are not are regularly allocated time for health promotion in schools. This became even more impassioned when one looks at CSH from a regional and provincial perspective where the goal is for every school to have adequate resources for CSH.

Some informants conveyed that the success of CSH in their jurisdiction could be strongly attributed to the passion and commitment of key people in senior decision-making positions. Examples cited were writing policy papers and personal involvement in seeing that policies and programs were developed.

When informants were asked what CSH looks like at the local school community level -- just about everyone stated emphatically that there is no one model. It did not seem to matter if the jurisdiction had a well articulated policy platform or not -- everyone explained in one way or another that each school was a unique and distinct community with its own priorities for action and varying levels of desire, understanding, and passion for CSH. For example:

- "*the curriculum is based on CSH however practice is extremely varied*"
- "*it is extremely varied at the local school level in terms of partnerships and programs*"
- "*some coordinators are better able to establish partnerships with community resources and obtain other grants*"

4.2 Policies for CSH

While informants talked about the passion and the drive from grass roots as key to CSH, most of the time in interviews was spent discussing the policy platforms that are in place to support CSH. "Policy" was used to express a broad definition of things such as documents that propose CSH as promising practice through to formal programs with articulated goals, outcomes and resources. All informants discussed the level of political will and commitment present in their jurisdiction and how this influenced the development "top down" policy platforms or frameworks for CSH, or more generally for promoting the health of school-aged children and youth.

4.2.1 CSH Policy at the National Level

Some key informants discussed the Canadian Joint Consortium for School Health as an example of a national initiative that provides a forum for promoting and

exchanging information about CSH approaches among partners. It was not discussed in terms of national policy however.
In England, a national partnership between the health and education sectors for a health promoting schools initiative was the clearest demonstration of support from a national policy perspective. The Public Health White Paper (2004) introduced the idea of the National Healthy School Status (NHS). The NHS is funded by the Departments of Health and Education, and includes a national infrastructure and networks at the regional and local levels. There is a national coordinating office as well as regional Coordinators who support staff in schools to implement NHS actions.

Funding is provided to all school jurisdictions in England and is based upon funding of 2000 pounds (around $4200 Canadian) plus a formula that takes into account the total number of schools and the number of "deprived" schools. No other jurisdictions represented by key informants related a national policy platform such as described in England.

The goal is for all schools in England to meet certain criteria and be recognized as a healthy school by 2009.[9] To meet the standards of NHS status, schools are required to demonstrate evidence in the following four interrelated and interdependent theme areas using "a whole-school approach involving the whole school community":

- *Personal, social, and health education*
- *Healthy eating*
- *Physical activity*
- *Emotional health and well-being*

In England, OFSTED (Office of Standards for Education) plays a key role in ensuring that schools are working towards standards through inspections. The notion of having standards from which to guide and monitor CSH was certainly echoed by many other informants as an important ideal to achieve.

4.2.2 CSH Policy at the Provincial or State Level

There are four jurisdictions in Canada and two from Australia that exemplify policy platforms at the provincial or state level. Canadian examples include the provinces of New Brunswick, Manitoba, British Columbia, and Prince Edward Island. The Australian examples are from Southern Australia and Western Australia.

[9] http://www.wiredforhealth.gov.uk/PDF/NHSS_A_Guide_for_Schools_10_05.pdf

New Brunswick's Healthy Learners in School Program was introduced province-wide in 2000 and appears to be a very integrated and solid policy platform for CSH. It is a program of the Department of Health, which is managed and delivered through the province's eight Regional Health Authorities. The Program provides 1-2 Public Health Nurse (PHN) FTEs for each of the 14 school districts, who essentially act as School Health Coordinators. These personnel are assigned full time to work in the School District office.

Furthermore, there are 10 PHN FTEs in high schools in 4 districts. Their function is similar to their counterparts at the school district and this component of the program will be expanded as resources permit.

Health Learners in School program staff promote a comprehensive school health approach to support health and wellness, in collaboration with school-community partners and other partners such as agencies, businesses, community leaders, community organizations, service providers, etc. PHN roles include advocacy, community development, collaboration (each district has a District Health Committee), health education support, consultation and needs assessment. The PHNs working in high schools also provide counseling and referral. A comprehensive evaluation of the program has not been conducted to date.

New Brunswick's Wellness Strategy, targeting health eating, physical activity, mental fitness/resilience and tobacco free living, was introduced in January 2006. It is focuses on children and youth and includes schools as a key setting for wellness promotion. As part of the Strategy, a number of programs are provided to enhance support to schools to take action on wellness, including two grant programs: a high school Tobacco Free schools Grant program and a middle school Healthy Eating Grant program.

As a result of New Brunswick joining the Joint Consortium for School Health, a provincial school health coordinator was assigned. This position, in Department of Wellness, Culture and Sport, supports alignment and coordination between the Wellness Strategy, Dept of Education and the Regional Health Authority's Healthy Learners in School Program.

The second example is from the province of **Manitoba**. The Healthy Kids, Healthy Futures document produced in June 2005 provides umbrella policy support for CSH. However, the Healthy Schools initiative is based upon a provincial framework developed in consultation with health and education stakeholders in 2002. The initiatives receives funding from Health and Education in order to support a Provincial Coordinator and provide funding for regional initiatives.

Regional funding is provided to 37 school boards to implement CSH. In the past, the funding went to 11 Regional Health Authorities. School Boards receive a set base funding of $5000 plus additional dollars based upon a formula for per capita students. Guidelines for practice were developed based upon CSH. It was mentioned that there are differences in the way in which CSH is implemented and this can be attributed largely to the capacity to school boards to partner and leverage other funding.

In **Manitoba**, $100 grants are also available to local schools through an application process and are targeted toward provincially determined health topics (e.g., nutrition, injury prevention).

The third example is the province of **British Columbia** (BC). There has been a demonstrated political commitment to strengthening healthy school policy environments. Health and education ministry staff have developed a strong working relationship and share leadership and accountability for school health promotion. This was seen as key to success to any delivery system and much like New Brunswick, seems to pave the way for partnerships at the regional and local levels. Furthermore, the government of BC has initiated a government-wide goal to make the residents of BC the healthiest ever to host an Olympic Games (Winter 2010) through ActNow BC. This too provides a fertile environment for CSH.

BC has a rich history in school health promotion with the Action Schools! BC initiative. Action Schools! BC is an initiative to assist elementary schools in creating action plans to promote physical activity and healthy living. The initiative provides resources and recommendations for the creation of individualized Action Plans that integrate physical activity and healthy eating into the school environment – much like the Ever Active Schools program in Alberta.

Currently, there is effort to broaden the program: [10]

> *Pilot research showed that Action Schools! BC was an effective and feasible model. The provincial dissemination of Action Schools! BC has been launched and partners from across many sectors are involved to enhance the sharing of knowledge and increase the implementation of the Action Schools! BC model across British Columbia.*

The Healthy School Network is a new initiative lead by BC's Ministry of Education. The network is based upon the voluntary participation of schools to undertake a Healthy School planning process that includes such things as the

[10] http://www.actionschoolsbc.ca/content/home.asp

formation of a team and the use of a school health assessment tool. Schools will receive $1000 at the end of the first year upon completion of the planning process and are established as part of the network. In subsequent years, schools will receive $500 per year to maintain a healthy school designation, which is under development.

What is particularly noteworthy about BC initiatives is that much of the school health agenda is now shared between the Ministry of Health and the Ministry of Education. Integration was not happening to the extent that people expected and by sharing the roles and responsibilities, there is more opportunity to promote health in the school setting. The goal in BC is to have a healthy school standard for the school setting.

The fourth example is from the province of Prince Edward Island (P.E.I.). P.E.I. has a program that shares many similar characteristics as the EAS and it is called Active Healthy School Communities (AHSC). This program was established following a national roundtable hosted by P.E.I. in October 2001.

Initially, the program offered schools a basic planning process: school assessment, selection of priorities, developing plans, and reassessment. It appears that the initiative was hard to get off the ground. One of the main objectives of the program is to increase the number of partnerships between schools and communities and it was hard to engage schools and communities in this work. AHSC continues to supports schools in identifying and addressing issues related to healthy eating, physical activity, tobacco reduction, emotional well-being, and youth engagement - in partnership with their surrounding communities.

P.E.I. also has a Strategy for Healthy Living that provides a policy platform for strategies targeting healthy eating, physical activity, and tobacco reduction.

A steering committee of representatives from government and non-government organizations oversees the planning and implementation of strategies. There is a desire to improve the P.E.I. Active Healthy School Communities program, and much like the EAS initiative, questions are being asked about "what else could it look like" to improve participation and make a lasting difference in the health of school-aged children. One direction that is being explored is to build Active Health School Communities into school improvement initiatives. The idea of linking CSH with school improvement was mentioned by others as well.

In **South Australia**, a deliberate policy for CSH is now coming together because of the efforts of several stakeholders coordinating their collective efforts. An

important impetus was the Department of Education's initiative called the Child Health Education Support Services (CHESS). CHESS brought together health, social services and education stakeholders to develop plans for services in schools. All ministries signed off on this initiative and thus, paved the way for bureaucrats to work more closely together.

From CHESS, a health promotion charter was developed to support Health Promoting Schools. Leadership for the Charter came from the health sector and the goal was to illuminate promising practice in school health promotion. The charter is still in development, however, considerable effort went into bringing all health regions, non-government organizations, government agencies, and schools to agree in principle on the charter ideals – and "the Charter then went up the ladder". The charter development is considered a good example of harnessing the passion from the ground up and influencing policy from the top down.

One other policy platform is the Well-being Framework and it is scheduled to be launched November 2006. This is a state-wide framework that focuses attention on physical activity and health eating and it is anticipated that synergy will be created when all these initiatives are brought together. The buzz words in Southern Australia are "whole school approaches" and "healthy weights".

In **Western Australia**, school health is typically delivered by community and population health staff (mostly nurses) in partnership with allied health promotion professionals of the 3 area health services (much like the Canadian RHAs). With a growing interest in the Health Promoting schools framework, a Memorandum of Understanding (MOU) was developed between the state departments of health and education. There is no formal accountability associated with the MOU and no additional resources. The MOU, however, provides a broad policy backdrop for the development of local service agreements for Health Promoting Schools. The service agreements include such things as assessing resources and gaining a shared understanding of strategies.

4.2.3 CSH Policy at the Regional Level

Two Canadian (Calgary Health Region and David Thompson Health Region in Alberta) and two Australian (Canberra, Australian Capital Territory and South Eastern Sydney Illawarra, New South Wales) jurisdictions provide examples of policy platforms at a regional level.

The **Calgary** Health Region (Calgary, Alberta) has an impressive history in school health promotion. Much of the work can be traced back to a demonstration phase of the Alberta Heart Health Project in the mid to late 1990's. The current model has been guided by the Calgary and Rockyview

Comprehensive School Health Partnership -- where regional health and education authorities have established the CSH program.

The Calgary model is based upon the health region allocating community health nursing time to schools to facilitate CSH actions. Over the past ten years it is estimated that half of the schools have participated in CSH. However, it is thought that this model does not readily allow expansion to all schools nor does it have adequate sustainability. Changing school demographics combined with staff turnover has presented a challenge to sustaining comprehensive school health momentum beyond the three-year implementation period. This reality has resulted in agreement of the partners to incorporate a Health Promoting Schools approach at the systems level.

The Calgary Health Region is implementing a new model whereby Community Health Nurses are receiving intensive training in community development and CSH. The expectation is that they will work with all schools in the region and facilitate school assessments and collaborative processes to identify themes for action. The 13-year partnership has recently changed its focus from an individual school based model to one that addresses comprehensive school health at the systems level. This collaboration is guiding the development and implementation of a Health Promoting Schools model that reaches every student in every school within each of the three districts. Three school health consultants have been recruited to work within the school divisions to facilitate this process. A key role for these staff will be to promote evidence based practice related to health promotion in schools.

The **David Thompson** Health Region (central Alberta) has had an established Health Promoting Schools Initiative since the late 1990s. It began as a small pilot of 3 schools and grew to upwards of 15 schools. This model was based upon having a facilitator in the school to help coordinate collaborative CSH actions. The importance of identifying priority health issues for the schools was emphasized as opposed to a pre-selected agenda (e.g., healthy eating, physical activity).

There was a reorganization of health regions in Alberta in 2004 and another model for CSH (from another health region) was integrated into the initiative. That model included a part time health promotion professional and an educator to share responsibility for supporting schools in one small school division with knowledge, skill and resources for CSH. Annual resource fairs were a key strategy.

Today, the David Thompson Health Region is moving towards a blended model where 10 facilitators continue to work with a limited number of schools however they are increasingly directing their attention to supporting nine school

divisions, much like in Calgary. The health sector is clearly leading this work in this region of Alberta.

In **Canberra,** Australian Capital Territory (ACT), promoting healthy schools has focused on nutrition and physical activity. Of particular note, was the stakeholder consultation process to develop nutrition guidelines for schools. The guidelines were based upon health promoting schools and the work completed in South Australia. The guidelines include such areas as policies, curriculum, marketing of healthy food, safety, environmental awareness, type of foods sold, breakfast programs, etc. The focus began with the canteens, however, the health promoting schools approach was paramount. For example, a whole school approach to accrediting food and nutrition in canteens was developed. The goal is to have all schools accredited by 2009.

The focus of attention has been on the obesity crisis among school-aged children and youth and much like the school nutrition work, mandatory policies for physical activity have been implemented in the last few years. One trend in policy in ACT is that the focus is shifting from the obesity issue to one of well-being. The curriculum is undergoing renewal to address 3 target areas for health and physical activity: 1) promotion of health and well-being, 2) physical skills and activity, and 3) managing relationships.

A key challenge in Canberra – and echoed many other jurisdictions – is the distinct lack of teacher time and funding to implement health promoting schools approaches. Another challenge was the difficulty to embed or integrate this work into the schools agenda and culture.

The state of **New South Wales** produced a document entitled *Health promotion with schools: A policy for the health system* in 2000. This document is considered a "formal statement of direction for the NSW health system" based upon stakeholder consultations. It recommends broad strategies such as "using a combination of health promotion strategies over time to achieve change is more effective that one-off interventions such as education sessions".

In **South Eastern Sydney Illawarra** Health Service (one health service area in New South Wales), the 2000 policy document serves as a focal point for policy decisions. However, the document was disseminated and but there were no additional resources provided at an Area health service level to mobilize partnerships between the health and education sectors or provide training to work more collaboratively. Therefore implementation of health promoting schools varies across NSW and has been "patchy" dependent on local action.

The health promotion office of the **South Eastern Sydney Illawarra** Health Service has established a School Health Incentive Program (SHIP) to further

address some of these challenges of implementation. SHIP is a granting scheme to encourage schools to address any health issues that is considered a priority (e.g., anti-bullying, asthma, safety, nutrition, physical activity, sexual health, etc). Schools must apply for the $1000 grant and must address the three elements of the health promoting school framework: curriculum, school environment/ethos, and school-home-community links. There is a total of $40,000 for grants. Health promotion staff are available to help schools write their grant applications and it is predicted that over 70% of the requested funding will be for teacher release time.

4.2.4 No formal CSH policy: Integration

One example of a jurisdiction where CSH is not guided by a formal policy is in **Victoria,** Australia. There is no formal health promoting schools framework, policies or initiatives and it is described as more of an idea, or a concept that is integrated into various programs (see for example the Gatehouse project [11]). However, three policy platforms or programs were described that integrate concepts of CSH.

Firstly, the Victorian Essential Learning Standards articulate curriculum standards for knowledge, skills and behaviors in physical, personal, and social learning.[12] The "learning domains" include health and physical education (maintaining good health and living a healthy lifestyle), personal learning (recognize and enact appropriate values within and beyond school), interpersonal development (building positive social relationships) and civic and citizenship (having the knowledge, skills and behaviors to participate in society). Interesting that no other people interviewed discussed curriculum policy.

The second identified policy is the Framework for Student Support Services in Victorian Government Schools. [13] This framework is a "whole school approach for creating safe and supportive school communities". It incorporates primary prevention by promoting resilience through strategies such as implementing comprehensive curriculum to engage all students in having a sense of belonging. The framework goes further to describe early intervention, intervention and restoring well-being.

A third policy platform in Victoria that integrates the concepts of CSH is the Go for Your Life program.[14]

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[11] http://www.rch.org.au/gatehouseproject/
[12] http://vels.vcaa.vic.edu.au/essential/personal/index.html
[13] http://www.education.vic.gov.au/studentsupport/welfareinitiatives.htm
[14] http://www.goforyourlife.vic.giv.au/

> *The Government recognises that action needs to occur at all levels of our community if the range of benefits available through increased levels of physical activity and healthy eating are captured. Similarly, multi-sectorial and multi-intervention approaches, which are responsive to the broad physical, social, economic and cultural environments, are required*

Go for your life extends the concept of health promoting schools to health promoting communities. These three initiatives focus on building health into the role of educators and others versus having a focus on health promoting schools per se.

The following two jurisdictions are Canadian provinces that depict a perspective of integration of CSH concepts versus a formal policy and they are Yukon, and Saskatchewan.

In the **Yukon**, CSH is being lead by a Health Promotion Coordinator in the Department of Health and it could be argued that a formal policy exists. For example, there is an agreement between the Departments of Education and Health to work together on school health promotion. However, for the purposes of this paper it is thought to highlight the integration efforts that are happening.

In 2006, a School Health Advisory Committee, comprising of representatives from the Departments of Health and Education and various non-governmental organizations was established. Objectives have been created and they include:

- *Linking health and wellness priorities with the school planning process so that it becomes a built-in priority for school communities (rather than being perceived as an "add-on").*
- *Planning and hosting a Yukon School Health conference that would reflect a global, holistic approach towards building healthy school communities.*
- *Creating and sustaining a Yukon school health advisory committee drawing on interested members of the conference delegation and other identified key individuals*
- *Investigate possibility of establishing a school health coordinator in each Yukon school.*

An excellent, short backgrounder titled "Why do we need health promoting schools in the Yukon?" has been written and the next steps are to get the paper out to schools and work with schools that want to move forward with this approach.

Facilitating factors for this work in the Yukon are: a) there are 30 schools in total, and b) there are no school boards nor regional health authorities. The small number of schools and the few layers of bureaucracy are seen as strengths for integrating health promoting schools into existing structures. One of the biggest

challenges is finding new ways for the Department of Health and Education to work together.

Active Yukon Schools is run by the Recreation and Parks Association , a non-governmental organization and is based upon Alberta's Ever Active Schools Program and also incorporates elements of the Action Schools! BC program. One teacher in every elementary school acts as a champion and "classroom action kits" are provided.

In Saskatchewan, CSH is coordinated by two people: a Health Education Curriculum specialist (Education department) and a Public Health Nursing lead (Health department). This formal partnership has "interministerial sign on" and lays out a shared role and responsibility for school health in Saskatchewan. It is a new collaborative this year and the rich context for moving forward has already been realized.

There are no plans to create a CSH policy or program and the thrust for CSH is to build upon two existing policy platforms that have strong political support. One is the Population Health Promotion Plan and other is Schools Plus. The Population Health Promotion Plan targets all residents in the following areas: nutrition, active communities, substance abuse, and mental health. Schools Plus focuses on enhancements to the education system and providing appropriate and adequate support services for children and families. The two Coordinators are working towards supporting these two polices with a school health promotion lens. There are no additional resources to support this work.

In Motion is a notable program in Saskatchewan. It is a community-based approach to increasing physical activity and the thought is to strengthen the schools role.

5. SUMMARY AND CONCLUSIONS

It appears that in an ideal world, CSH would be supported by "top down" policies that coordinate and integrate CSH at a national level (e.g., England), at the provincial or state level (e.g., New Brunswick, Manitoba, BC, PEI, South Australia, Western Australia) and at the regional level (e.g., Calgary Health Region, David Thompson Health Region, Australian Capital Territory, and South Eastern Sydney Illawarra Health Service).

It also appears that the presence of provincial or state-wide health promotion initiatives that articulate broad goals and strategies for improving the health of the population can create a synergy when coupled with explicit CSH policies. For example, South Australia's Well-being Framework, ActNow BC, Manitoba's

Healthy Kids Healthy Futures, Victoria's Go for your Life and PEI's Strategy for Healthy Living.

Strong and vital partnerships at all levels appear to be the corner stone for effective and sustainable CSH. British Columbia, Yukon, South Australia and Western Australia are examples of jurisdictions that emphasize coordination and collaboration among health and education partners at provincial or state levels. The Calgary Rockyview Comprehensive School Health Partnership is an example of a coordinating group that oversees CSH at a regional level.

In England, the Healthy School Standards are the most visible and tangible evidence that CSH is an important priority and therefore, to be monitored. In Canberra, Australian Capital Territory, the accreditation standards for school nutrition and canteens is also an example of this. In British Columbia, the Ministry of Education led Healthy Schools Network is moving towards the establishment of accreditation standards and monitoring of progress towards these standards. To a lesser extent, Prince Edward Island is considering moving toward the integration of CSH into school improvement and this may lead to monitoring of standards.

Few people talked explicitly about professional development initiatives for CSH however the Calgary Health Region has focused on training of Public Health Nurses in community development and CSH in order to transform the model to a more systems-level approach to CSH planning and implementation. It appears that training was implicit in many policies and programs and that creating learning opportunities are part of the program. This could be an important area for further study.

As most of the key informants were in regional or provincial/state level coordination positions, the findings did not reveal much information about what CSH looks like at the school level. However, as articulated previously, it was clear that it is impossible to describe a typical model for CSH as each school community is unique in its circumstances, priorities and capacities for implementing CSH.

Many jurisdictions are focusing CSH efforts on healthy eating and physical activity. Certainly the Ever Active Schools program is doing so. Other examples from the findings are as follows:

- Active Healthy School Communities in P.E.I.
- Action Schools! BC
- Canberra, Australian Capital Territory's school nutrition and canteen accreditation
- New Brunswick's grants to middle schools for increasing fruit and vegetable consumption

- Manitoba's grants to schools have focused on nutrition and physical activity campaigns
- South Australia's focus on healthy weights
- South Eastern Sydney Illawarra Health Service's School Health Incentive Program.

Few examples were cited about a focus on mental health promotion, however, questions were not posed to key informants as to specific health topics. The interview questions focused on delivery systems for CSH.

The question remains: Are these programs complex, sophisticated, intensive and of long enough duration to be effective?

The characteristic of effective CSH initiatives includes having a designated trained lead person with adequate release time to work on CSH. Even more specifically, it has been reported that having a designated coordinator or facilitator at the school level makes a difference to reach goals.

Therefore, it appears that in an ideal world a model for CSH would look something like this:

- National School Health Coordinator
- Provincial or State-level School Health Coordinator
- Regional or School District-level School Health Coordinator
- School-level Health Facilitators

In Canada, at the national level the Pan Canadian Joint Consortium for School Health was established in 2005 with all provinces except Alberta and Quebec participating. At the time of this study, the entire structure and process of the Consortium was under review, however, several informants referred to the Consortium as an opportunity for collaboration across provincial jurisdictions.

All informants were in coordinating positions in one of the levels indicated above with the exception of Victoria, Australia where CSH is integrated into other key policies with the aim to promote the health of children and youth. This is an interesting model and may support the actions and elements of CSH as core components to the working of schools. In Yukon, this appears to be the preferred model.

Few jurisdictions have policies in place for coordinators or facilitators at the school level. Calgary Health Region (Alberta, Canada) has Public Health Nurses assigned to schools with the expectation that they work within a CSH approach to health promotion. The David Thompson Health Region (Alberta, Canada) has facilitators assigned to schools, however, like the Calgary Health Region the trend in policy is to allocate human resources at the regional or school division

level to influence policy system a change at the level. New Brunswick's model of having designated people in coordinating positions at the provincial, regional and school levels is the closest to the ideal presented above.

The need for adequate human resources and funding was discussed by just about everyone interviewed. This is the biggest challenge to planning, implementing and evaluating CSH program and it is seen as the biggest barrier to improving the health of school-aged children and youth. However, there are promising models to reflect upon.

For example:

- Jurisdictions that are providing funding to school boards are as follows:
  - England provides funding starting at about $4200 plus further funding that depends of number of students and number of socio-economically disadvantaged schools in the district.
  - Manitoba provides base funding of $5000 to each school division plus further funding based upon number of students.

- Jurisdictions that are providing funding to support schools in undertaking health promotion are as follows:
  - New Brunswick grants to schools to support implementation of comprehensive school health action plans to support tobacco reduction and health eating.
  - BC's Healthy Schools Network will provide $1000 per school after completing a planning process and then will receive $500 in subsequent years.
  - Manitoba provides $100 grants upon application for specific health campaigns.
  - In New South Wales, Australia the South Eastern Sydney Illawarra Health Service's School Health Incentive Program provides $1000 to schools in order to address a priority health issue of their choice.

It would be interesting to further study how these grants to schools increase the capacity of the school community to improve health. Where are grant dollars being allocated? To teacher release time? Are initiatives funded through these granting schemes multi-strategy (addressing curriculum, school environment and parent/community participation) with the necessary intensity and duration for effectiveness?

It appears from these interviews and findings that effective CSH is all about having strongly supported "top down" policies that are supported with the "bottom up" knowledge, experience and passion of health and education professionals. As one key informant stated "There are strong frameworks but it's all in the execution."

6. REFERENCES

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