Int. J. School. Health. 2023; 10(3)

Published online 2023 July.

Discussion

Sustainability in School Health: Leadership is the Key

Robert F. Valois[1, 2, 3*], PhD

[1]University of South Carolina, Arnold School of Public Health, Department of Health Promotion, Education & Behavior, USA
[2]University of South Carolina, School of Medicine, Department of Family & Preventive Medicine, USA
[3]Valois, Kammermann & Associates, Columbia, South Carolina, USA

Corresponding author:* Robert F. Valois, PhD; Department of Health Promotion, Education & Behavior, Arnold School of Public Health, University of South Carolina, USA. **Tel: +1-803-917-5844, **Email:** rfvalois@gmail.com

Received: June 01, 2023; **Revised:** June 05, 2023; **Accepted:** June 11, 2023

Keywords: School Health Leadership, Sustainability, School Improvement, Healthy School Communities

How to Cite: Valois RF. Sustainability in School Health: Leadership is the Key. Int. J. School. Health. 2023;10(3):171-177. doi: 10.30476/INTJSH.2023.99159.1319.

1. Introduction

School health goals in the USA and other countries, have become increasingly aligned with the goals of educational reform, over the past two decades (1). Much of this goal alignment has focused on the association between health and academic achievement (2). Despite research suggesting that academic achievement and student health status are "inextricably intertwined (3)," many school administrators and governmental agency leaders are not convinced that improving student health status can translate into improved academic success, or these leaders perceive multiple challenges hindering successful health promotion implementation (4). Diminishing financial and human resources and an increased focus on school academic accountability have challenged many administrators into reducing current curricula and restricting faculty, staff and student services. Subsequently, changing the culture of a school to become more health-promoting has been perceived as a complex, time- and labor-intensive endeavor (5) and as a consequence, Coordinated School Health Programs (CSHPs) with the greatest potential to improve academic performance and outcomes are still relatively non-existent in most schools in the USA (4, 6) and more than likely Canada and Europe.

2. Arguments

2.1. Health Promoting Schools Efforts in the USA and Europe

Health-promoting schools, in concept, process and impact, appear to have more interest and utilization outside the USA. Buijs (7) notes that Schools for Health in Europe (SHE) is one of the most effective and sustainable school networks in Europe and worldwide. The SHE network has direct links with schools, practioners, researchers and law/policy makers. The SHE network was established in 1992, and previously known as the European Network for Health-Promoting Schools. It is an established network of national education and health coordinators in 43 countries in the European region. The SHE network is focused on making school health promotion an integral component of policy development in the European Education and Health sectors. SHE is providing the blueprint for European professionals, with an interest in school health promotion and is supported by three European organizations including WHO Regional Office for Europe, the Council of Europe and the European Commission. The SHE network contributes to making schools in Europe a better place for learning, health, and living. SHE utilizes a positive concept of health and wellbeing and acknowledges the UN Convention of the Rights of the Child (8).

In Germany, the health-promoting school movement has been connected to the school core tasks associated with learning, through "the good and healthy school" concept (9). In countries such as Portugal, Poland, and Scotland (10), health-promoting schools are in what has been described as an establishment phase (11) characterized by policy statements at the national level, in the health sector feeding into the education sector. In England, Denman (12) suggested that health-promoting schools provide a vehicle for advancement in health promotion, especially for state-maintained schools. School health researchers in the Netherlands developed a collaborative model

Copyright© 2023, International Journal of School Health. This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 International License (http://creativecommons.org/licenses/by-nc/4.0/) which permits copy and redistribute the material just in noncommercial usages, provided the original work is properly cited.

called "SchoolBeat" designed for whole-school health (13) while in Hong Kong, Lee and colleagues (14) implemented a healthy schools award program supported by a system to monitor, access and promote staff development, parental education, community involvement, and linkages with school stakeholders. Changing the culture of a school or school district to be more health promoting, and the sustainability of such efforts, is a major time-consuming challenge to education, social service and school health professionals.

2.2. Leadership is Imperative for Sustainability in Health Promoting Schools

In regard to the lack of well-designed and implemented CSHPs, Health Promoting School and Healthy School Community interventions, are the lack of corresponding well-designed and implemented evaluations for these school health efforts (4, 5, 14-16). Healthy School Community and Coordinated School Health Program evaluation results and a review of school health promotion literature, (5, 7-14, 15, 16) strongly suggested that enthusiastic, supportive and consistent leadership is the key to successful design, initiation, implementation and subsequent sustainability for any whole child, or coordinated school health or school improvement effort.

2.3. The Mariner Project: South Carolina USA

The Mariner Project's eight-component model was implemented in three middle schools and their four feeder elementary schools in three South Carolina, USA communities (5). This study determined the extent to which a coordinated school health program (CSHP) infrastructure was in place and functioning adequately within a two- to three-year developmental period (5). Valois and Hoyle developed eleven critical performance elements for the Mariner Project evaluation (5), and a modified indexing technique from previous evaluation efforts was utilized (17, 18). This well-designed, theory-based intervention, that was well-implemented and evaluated, determined that four of the eleven critical evaluation elements contributed significantly to program success. In essence, if the: 1) Principal "bought into" the project; 2) the Program Champion was an effective Liaison / Facilitator; 3) the School-Based Health Promotion Team (SBHPT) was well coordinated, and 4) the Staff Wellness Coordinator had a good performance, that particular school had a solid foundation for success as a health promoting school (5). These four performance elements are all anchored to effective leadership. In particular, if the principal: 1) was either visible at SBHPT meetings and trainings or had clearly delineated responsibility to an assistant principal; 2) was visible at school and community health promotion events; 3) designated a staff person as liaison and provided ample flex time for carrying out responsibilities assigned by principal and project staff; 4) demonstrated high expectations for a health promoting school through supportive policies, procedures, and practices; 5) approved and encouraged a staff wellness program by designating a staff wellness coordinator, providing flex time for coordination and participation of staff, and allocating time during faculty meetings for announcements and incentive presentations; and 6) empowered the SBHPT to design and implement plans for health promotion initiatives with minimal oversight and communicated good faith in the decisions and actions of the liaison, wellness coordinator, and team members (5). Mariner evaluation results evidenced schools that began with strong and supportive leadership in year one, lost that leader the following year and subsequently secured engaged leadership in the final year and regained their school health promotion momentum toward sustainability. The Mariner Model (19) and Mariner Project (5) delivered insight into the design, development, implementation and evaluation of a coordinated school health program prior to the evolution in efforts for health promoting schools, healthy school communities and the whole school, whole child and whole community interventions. However, the most important lesson learned from the Mariner Project was the need for consistent, enthusiastic and engaged leadership from the school principal, over the entire scope and sequence of the intervention.

2.4. Pueblo Colorado USA: School District 60 School Community Health Promotion

Hoyle and colleagues (16), conducted a case study to examine Pueblo, Colorado School District 60, and its efforts to develop, continuously improve and sustain health promotion in the school community. In this study, capacity building strategies and a program-planning model for continuous improvement for health-promoting schools were utilized that included: 1) visionary/

effective leadership and management structures, 2) extensive internal and external supports, 3) development and allocation of adequate resources, 4) supportive policies and procedures, and 5) ongoing, embedded professional development. Effective leadership is necessary at multiple levels of the school system—district, building, and community. Designated leaders need to be able to articulate a project vision, mobilize people of good will who share that vision, empower others, and enable collaborative action toward common goals (16). School health professionals suggested that the primary leadership structure for enabling capacity for health-promoting schools should be a designated school health coordinator at the district level (5, 16, 19). In Pueblo 60, the Director of the Office of CSHP served in that role. This 12-month position, integrated into Pueblo 60's administration and fully funded by the district, provided leadership and coordination for multiple health and social service programs. Pueblo 60's superintendents were visionary leaders who took risks on behalf of students' well-being and academic achievement, and advocated for the same among faculty, staff, School Board, and the broader community. Leadership from the Pueblo community was represented on a Health Advisory Council comprised of approximately 60 members from among business, clergy, medical professionals, health and social service agencies, nonprofits, students, parents, and others, with a majority being parents of Pueblo 60 students. Strong leadership was also necessary at the school level (5, 16, 19). Building-level leadership included a principal or assistant principal who was committed to the innovation and cofacilitators who served as leaders of the Health-Promotion Team, empowering team members as leaders of the change effort. Interdisciplinary Health-Promotion Teams provided leadership for health programming at the school level. These teams administered the program-planning model (19), developed and implemented School Health Improvement Plans, and documented and monitored program efforts. In this regard, Maeroff (20) stated that the success of this approach rests on the endorsement and participation of the school principal who ensures that those taking the risks are bolstered in the uncertain pursuit of change. Also, Maeroff stressed that a team who asks the right questions, begins to discover some answers through exposure to cutting edge ideas, and takes the lead in modeling change initiatives, in visible ways can be instrumental in the success of the innovation (20). In Pueblo 60, school health, social service and education professionals, among others, strategically developed an infrastructure through which they successfully delivered a wide array of health programs and services. Through visionary and effective leadership, internal and external administrative support and capacity building, especially at the school district and school levels, additional school health programming was designed, implemented and sustained (16). Strong and enthusiastic leadership at multiple levels and in numerous schools and agencies, enhanced the success and the sustainability of the school-community health promotion efforts in Pueblo 60.

2.5. Association for Supervision and Curriculum Development (ASCD) Healthy School Communities Project: Canada and USA

The two-year, Association for Supervision and Curriculum Development (ASCD) Healthy School Communities (HSC) project, (15) utilized eleven pilot sites in Canada (three sites), and the USA (eight sites). For this health promoting schools innovation, the overall evaluation question was "What are the levers of change in a school community that allow for the initiation and implementation of best practice and policy for improving school health?" For the HSC pilot project, a "lever" was considered an aspect of the project, alone or in combination, that caused a positive change to occur in the school community. The HSC evaluation team identified fifteen levers characteristic of significant positive change in the health promotion culture of participating school communities. Evaluation of each school-community site, suggested that these levers work synergistically, and in concert to support the sustainability of positive school health promotion change. Two of the HSC levers focused on leadership. The first was the *Role of Leadership Within the School* - Having a long-range perspective on the depth and breadth of the Healthy School Community purpose and philosophy along with a whole child perspective. Evaluation questions included: 1) Was a distributive leadership model in place that empowered stakeholders? 2) What mechanisms were in place for effective communication? 3) Did the leadership demonstrate an ongoing and focused role in team functions and effective leadership traits? 4) Was the leadership

active and engaged in the HSC process? The second was the *Effectiveness of the School-Community Team Leadership* - The ability to bring a team together and mentor or coach team members. Evaluation questions included: 1) Was the team leadership effective in facilitating the process of reaching team goals and objectives? 2) Did the leadership establish an atmosphere of results and accountability? 3) Was team leadership a shared process? 4) Did team leadership build and manage the consensus process? Evaluation results for Principal as the Leader of the HSC innovation found that effective principal leadership was extremely important for both effective implementation of the HSC process and successful involvement of the school community, as well as for increasing the probability for long-term sustainability. When the principal led the HSC team, and was actively engaged in the HSC process, priorities identified through the Healthy School Report Card (HSRC) process were more quickly and fully embedded in the school improvement process. At the most successful HSC sites, the principal was absolutely the key individual in leading and organizing the team through the HSC process. Effective principal leadership not only provided an automatic "educational acceptance" of the continuous improvement initiative within the entire school body, but also enabled a more systemic method of engaging and aligning stakeholders in the planning and school improvement process (15).

Evaluation findings suggested, that it is insufficient for a principal to merely give permission for HSC work, and a school community initiative cannot expect a high level of success, if the principal delegates the lead role to another individual. The principal must lead or co-lead the HSC effort for the change process to be systematic and subsequently sustainable. Additionally, when the principal delegated team leadership and authority to another staff member, the HSC team was less likely to use a systems approach and more likely to be programmatic or event focused and were less effective in their work. The levers of change for HSC success are synergistic and interrelated. However, the principal as leader of the HSC initiative is imperative for HSC success. In essence, Valois and colleagues determined that enthusiastic, engaged and distributive principal leadership in the HSC pilot sites became the "*piece de resistance*" of the HSC process from which other elements of HSC success could effectively be designed, implemented, evaluated and sustained (15).

As for distributive team leadership, successful HSC teams had leaders who demonstrated team building skills and facilitation skills for the HSC process to effectively foster leadership at all levels of the school improvement process. These effective leaders held team members accountable for meeting HSC benchmarks and had a positive influence on their team's ability to define and focus and complete its work in a timely fashion. Most important, the leader engaged and encouraged others in leadership roles throughout the HSC process, distributing tasks, responsibilities, and the unquestionable authority to carry out the HSC action plan within an agreed-upon systems approach (15).

3. Conclusions

In the Mariner, Pueblo 60 and ASCD HSC sites evaluated, the school principal was the keystone to school health promotion/continuous improvement success. Principal-led teams with active, engaged leadership developed teams and committees with diverse membership, involved more stakeholders, and initiated more systemic change to school policy and improvement processes. This finding is consistent with school health promotion (3-16, 19, 26) and school improvement literature (20-22, 24, 25).

In addition, principal-led school-based teams, more readily integrated the results of their needs assessments and planning process results into their overall school improvement plans. Principal leadership in these school health promotion project processes, took what may have been perceived as merely a health system responsibility, somewhat separate from education, and positioned it directly under the responsibility of the principal and within the overall school improvement plan and process (5, 15, 16).

Most effective principals demonstrate the major characteristics of effective change agents (21). They provide resources for their school, communicate effectively, embrace resistance, maintain a visible presence, and build and sustain relationships inside the school and with community stakeholders. The manner in which the principal develops relationships can in fact fundamentally determine

the success or failure of the school improvement/change process (21). Fullan suggested that the improvement of relationships is the single factor common to every successful school change initiative (21). Principals for the most successful ASCD HSC schools, fostered good working relationships, had high levels of social and emotional intelligence and developed and mentored future leaders.

Successful principals and other leaders from these evaluated school health promotion projects, had an understanding of systems (macro) approaches to school improvement, and they also had a micro perspective on the whole child. Effective leaders in these projects also demonstrated the belief that successful learners are emotionally, socially and physically healthy, knowledgeable, motivated, safe, and engaged, while networking and working toward policy and systems change (5, 15, 16). Effective principals possess the status and often the interpersonal and managerial skills essential to effective communication and relationship building (22).

Diffusion of the HSC innovation will require that future generations of education and school health professionals, especially leaders, incorporate the theory and practice of HSC into their administrative, academic, and practicum training. School health professionals should study school improvement and leadership literature, language and culture, and collaborate with education leadership colleagues to implement a seamless process that focuses on health promotion within school improvement for academic success (5, 15, 16, 23-25).

Findings from these evaluated projects, suggest that a systemically-focused school improvement process, led by the principal, that started with a core understanding of the benefits to learning in a healthy environment and a positive school culture, offers the most effective, and sustainable mechanism for health promotion in schools (5, 15, 16). This conclusion is consistent with school improvement literature (20, 22, 24, 25) underutilized by school health professionals pursuing the creation of a health-promoting environment in schools.

Unhealthy students are not effective learners. Students with physical, social, mental emotional and family-based problems will struggle academically, and more than likely disrupt the classroom learning process for teachers and fellow students. Health-promoting schools are assimilating health-promotion into the system of schooling, seeing it as a process - "a systemic series of actions directed to some end" – of the way they do business. In this regard, school health promotion is not seen as "one more thing to do" but rather "the way we do our thing (5, 19)." There is a reconceptualization of systems and structures, policies and practices, roles and relationships, attitudes, beliefs and values – a "reculturing" – effecting the way in which administrators lead, faculty and staff function, and students thrive and learn in a health-promoting school community (5, 15, 16, 19). Similar to previous responses to social challenges, now is the time for the health-promoting schools/healthy school communities concepts, theories and processes (5, 15, 16, 19) to be embraced by schools and school districts that have the capacity (16) to change and sustain those positive changes for a culture of health promotion (5, 15, 16, 19, 26, 27), positive youth development (28, 29), life satisfaction (28, 29) and academic success (4, 23-25). Future success in the design, implementation, evaluation and the subsequent sustainability of school health promotion endeavors, will depend significantly on the effectiveness of visionary, engaged and distributive leadership.

Authors' Contribution

RFV: Conception of the study, interpretation of data, drafting and revising. The author read and approved the final manuscript and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflict of Interest: The author of this manuscript declares no relationships with any company whose products or services may be related to the subject matter of the article. Robert F. Valois is a member of the editorial board.

References

1. Riegelman RK, Garr DR. Healthy people 2020 and education for health: What are the objectives? Am J Prev Med. 2011;40(2):203-6. doi: 10.1016/j.amepre.2010.10.017. PubMed PMID: 21238870.
2. Institute of Medicine (US) Committee on Comprehensive School Health Programs in Grades

K-12, Allensworth D, Lawson E, Nicholson L, Wyche J, editors. Schools & Health: Our Nation's Investment. Washington (DC): National Academies Press (US); 1997. doi: 10.17226/5153. PubMed PMID: 25121262.
3. Murray NG, Low BJ, Hollis C, Cross AW, Davis SM. Coordinated school health programs and academic achievement: A systematic review of the literature. J Sch Health. 2007;77(9):589-600. doi: 10.1111/j.1746-1561.2007.00238.x. PubMed PMID: 17970862.
4. Symons CW, Cinelli B, James CJ, Groff P. Bridging student health risks and academic achievement through comprehensive school health programs. J Sch Health. 1997;67(6):220-7. doi: 10.1111/j.1746-1561.1997.tb06309.x. PubMed PMID: 9285867.
5. Valois RF, Hoyle TB. Formative evaluation results from the Mariner Project: A coordinated school health pilot project. J Sch Health. 2000;70(3):95-103. doi: 10.1111/j.1746-1561.2000.tb06453.x. PubMed PMID: 10763477.
6. Rosas S, Case J, Tholstrub L. A retrospective examination of the relationship between implementation quality of the coordinated school health program model and school-level academic indicators over time. J Sch Health. 2009;79(3):108-15. doi: 10.1111/j.1746-1561.2008.00394.x. PubMed PMID: 19207516.
7. Buijs GJ. Better schools through health: Networking for health promoting schools in Europe. Eur J Educ. 2009;44(4):507-520. doi: 10.1111/j.1465-3435.2009.01410.x.
8. Young I, St Leger L, Buijs G. School health promotion: Evidence for effective action. Utrecth: Background Paper SHE Factsheet 2, CBO; 2013. Available from: https://www.schoolsforhealth.org/sites/default/files/editor/fact-sheets/she-factsheet2-background-paper-school-health-promotion-evidence.pdf.
9. Woynarowska B, Sokolowska M. Poland: The national health promoting school certificate. In Vince Whitman C, Aldinger C, editors. Case studies in global school health promotion: From research to practice. New York: Springer; 2009. p. 231-224. doi: 10.1007/978-0-387-92269-0.
10. Inchley J, Guggleberger L, Young I. Germany and Scotland: Partnership and networking. In Samdal O, Rowling L, editors. The implementation of health promoting schools. London: Routledge; 2012. p. 144-176. doi: 10.4324/9780203119792.
11. Desforges C, Abouchaar A. The impact of parental involvement, parental support and family education on pupil achievements and adjustment: A literature review. Research Report No. RR433, London: Department for Education and Skills; 2003. Available from: https://library.bsl.org.au/jspui/bitstream/1/3644/1/Impact%20of%20Parental%20Involvement_Desforges.pdf.
12. Denman S. Health promoting schools in England – a way forward in development. J Public Health Med. 1999;21(2):215-20. doi: 10.1093/pubmed/21.2.215. PubMed PMID: 10432253.
13. Leurs MTW, Schaalma HP, Jansen MWJ, Mur-Veeman IM, St Leger LH, deVries N. Development of a collaborative model to improve school health promotion in the Netherlands. Health Promo Int. 2005;20(3):296-305. doi: 10.1093/heapro/dai004. PubMed PMID: 15797902.
14. Lee A, St Leger L, Moon A. Evaluating health promoting schools: A case study of design, implementation and results from the Hong Kong healthy schools award scheme. Promot Educ. 2005;12(3-4):123-30. doi: 10.1177/10253823050120030105. PubMed PMID: 16739497.
15. Valois RF, Lewallen TL, Slade S, Tasco AN. The ASCD Healthy School Communities Project: Formative evaluation results. Health Educ. 2015;15(3/4):269-284. doi: 10.1108/HE-04-2914-0050.
16. Hoyle TB, Samek BB, Valois RF. Building capacity for the continuous improvement of health-promoting schools. J Sch Health. 2008;78(1):1-8. doi: 10.1111/j.1746-1561.2007.00259.x. PubMed PMID: 18177294.
17. Lowe JB, Windsor RA, Valois RF. Quality assurance methods for managing employee health promotion programs: A case study in smoking cessation. Health Values. 1989;13(2):17-23. PubMed PMID: 10292141.
18. Butterfoss F, Goodman R, Wandersman A, Valois RF, Chinman M. The plan quality index: An empowerment evaluation tool for measuring and improving the quality of plans. In Fettermann B, Kafeterian S, Wandersman A, editors. Empowerment Evaluation. Thousand Oaks, CA: Sage Publications; 1996.
19. Hoyle TB. The Mariner Model: Charting the Course for Health-Promoting School Communities. Kent, Ohio: American School Health Association; 2007.
20. Maeroff GI. Building teams to rebuild schools. Phi Delta Kappan. 1993;74(7):512-519.
21. Fullan M. The six secrets of change: What the best leaders do to help their organizations survive

and thrive. San Francisco, CA: Jossey-Bass; 2008.
22. Rose M. Reform: to what end? Educ Leadersh. 2010;67(7):6-11.
23. Valois RF. Evaluating whole school, whole community, whole child programs. In Birch, DA, Videto DM, editors. Promoting health and academic success: The whole school, whole community, whole child approach. Champaign, Il: Human Kinetics; 2015.
24. Henderson AT, Mapp KL. A new wave of evidence: The impact of school, family and community connections on student achievement. Austin, TX: Southwest Educational Development Laboratory; 2002.
25. DesLandes R. School success: Determinants and family-school relationships impact. In Deblois L, Lamonthe D, editors. La reussite scholaire. Comprendre et mieux intervener. Quebec: Presses de I'Universite Laval; 2005. p. 223-236.
26. World Health Organization (WHO). Health promoting schools, regional guidelines: Development of health promoting schools - a framework for action, Series 5. World Health Organization – Manila: Regional Office for the Western Pacific (WHO/WPRO); 1996. Available from: https://apps.who.int/iris/handle/10665/206847
27. Valois RF, Slade S, Ashford E. The healthy school communities model: Aligning health & education in the school setting. Alexandria, VA: ASCD; 2011.
28. Valois RF, Zullig KJ, Huebner ES, Drane JW. Youth developmental assets and life satisfaction: Is there a relationship? Appl Res Qual Life. 2009;4(4):315-331. doi: 10.1007/s11482-009-9083-9.
29. Valois RF, Kammermann SK, Valois AA. Life satisfaction and youth developmental assets. In Maggino, F. editor. Encyclopedia of quality of life and well-being research. Switzerland: Springer, Cham; 2021. doi: 10.1007/978-3-319-69909-7_3797-2.