Summary report 2016

Healthy Schools BC evaluation

Introduction

Healthy Schools BC (HSBC) is a key initiative of Healthy Families BC, the provincial health promotion strategy launched by the Ministry of Health in May 2011. It aims to strengthen relationships across the health and education sectors, and foster more coordinated action to improve the educational and health outcomes of BC students. This initiative supports schools and their health partners in implementing the Comprehensive School Health (CSH) approach, and it involves a partnership between the ministries of Health and Education, the Directorate of Agencies for School Health BC (DASH), health authorities, and education partners.

The HSBC initiative has focused action in four key areas:

Cross-sector partnerships, which supports planning opportunities between health authorities, school districts and community partners.

Coordination and consolidation, which supports collaboration among provincial healthy living programs in schools and creates "one stop" access for healthy schools related information at www.healthyschoolsbc.ca.

Capacity building, which includes the provision of CSH learning sessions, and the creation and dissemination of tools and resources to support and showcase strong healthy schools practice in BC.

Student engagement, which focuses on supporting youth to become meaningfully involved in healthy schools initiatives, and to take greater ownership over their health and learning.

This report demonstrates impacts of the HSBC initiative across the four key action areas, and towards the outcomes of increased CSH capacity across stakeholders and improved implementation of the CSH approach in schools between 2013 and 2015. The results presented in this report come from a combination of the sources described in Table 1, and reflect evaluation activities taking place between December 2013 and January 2016. In this report, "cycle 1" refers to evaluation activities taking place between October 2013 and March 2014, "cycle 2" refers to evaluation activities taking place between April 2014 and March 2015, and "cycle 3" refers to evaluation activities taking place between April 2015 and March 2016.

Table 1. Stakeholder groups, select evaluation methods, and number of responses across the 3-year evaluation period.

Method	Cycle 1	Cycle 2	Cycle 3
Online survey with health authority staff (December 2013, January 2015, December 2015)	78 respondents	124 respondents	118 respondents
Online survey with school district representatives (December 2013, January 2015, December 2015)	27 respondents	33 respondents	31 respondents
Online survey with educators and school administrators (December 2013, January 2015, December 2015)	439 respondents	1233 respondents	638 respondents
Online survey with students in the Student Healthy Living Network and working on inquiry projects (June 2015)	n/a	n/a	58 respondents
Online survey for teachers active on Healthy Schools Network Inquiry and Activity Grant projects (June 2014, June 2015)	n/a	57 respondents	146 respondents
Paper survey post-training at DASH-led HSBC learning sessions (ongoing)	62 respondents	44 respondents	57 respondents
HSBC website analytics review (ongoing)	n/a		

Cross-sector partnerships

The advancement of partnerships across the health and education sectors is at the heart of the Healthy Schools BC initiative.

School districts increasingly communicated with their health authorities. 90% of school district respondents reported that they communicated with their health authority in cycle 3, up from 88% in cycle 2 and 74% in cycle 1.

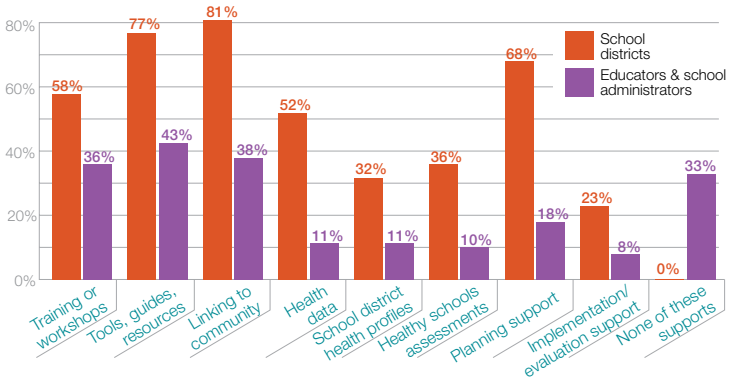
Over the evaluation years, health authorities supported school districts and schools with healthy schools tools and resources, and linked them to community resources. Key to the partnerships between education and health are the supports health authority staff provide to school districts and schools for healthy schools planning, assessment and initiative implementation. Health authority HSBC supports include:

- Providing tools, guides and resources
- Linking to community partners, programs or services
- Training or educational workshops / in-services
- Providing and interpreting health data
- Providing school district health profiles
- Supporting healthy schools assessments
- Providing planning support
- Providing implementation or evaluation support

Of the available supports, health authority staff most often indicated that they provided tools, guides and resources (64-75%), and helped school districts and schools link with the community (67-69%) in each year. These were the supports school districts and schools were most aware of and using most often. For most supports, awareness was approximately two times greater for school districts than schools (see Figure 1).

> "We have a Health Promoting Working Group in [our school district] that has bonded the various sectors so that we can understand each other's language and identify issues and barriers to health. This multi-sector group meets 3 times per year, … [and] values working together as a community using the CSH framework."
>
> – School District Representative

Figure 1. School district representatives' and educators and school administrators' awareness of HSBC supports provided by the health authority, cycle 3.

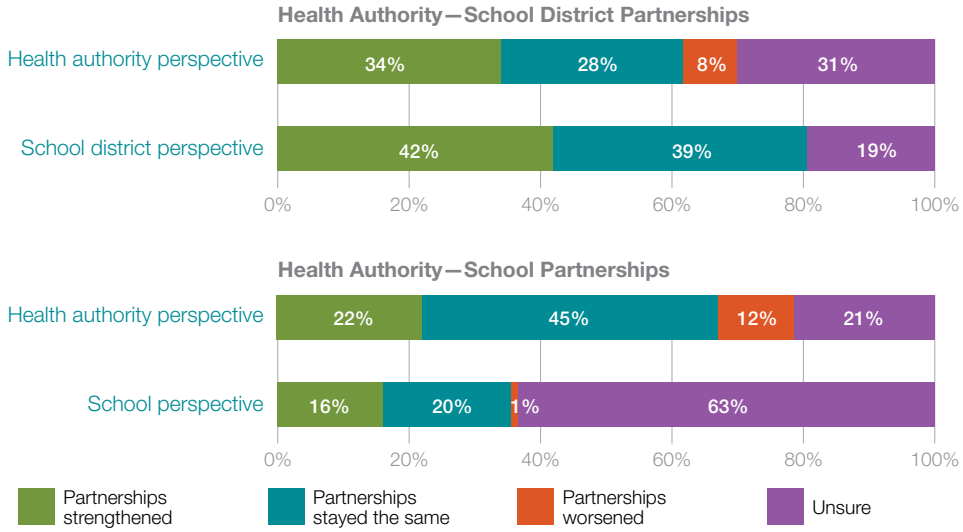


Educators reported that the support from health authorities made them stronger. In cycle 3, over half of educators and school administrators reported that health authority support made their schools stronger in assessing, planning, implementing and evaluating healthy schools initiatives. There was a slight increase between cycle 2 and cycle 3 in the proportion of educators and school administrators agreeing that healthy authority support made them stronger in their healthy schools approach.

Time availability was a key limiting factor for health authority staff in providing meaningful support. Most health authority staff felt that they had the knowledge (89%), skills (88%), and tools (77%) to support the education sector in healthy schools initiatives, but less felt they had the time (46%). These data did not change over the evaluation years.

In the most recent evaluation cycle, a greater proportion of all stakeholders felt that the health-education partnerships had strengthened in the past year. In both cycle 2 and cycle 3, there was a higher proportion of school district representatives, compared to health authority staff or educators, who felt that the health-education partnership had strengthened (see Figure 2). Often, stakeholders indicated that partnerships had stayed the same. Many educators were unsure about the strength of partnerships. These results are in line with the emphasis of the initiative, where much of the HSBC partnering activity focused on building the relationships between health authority staff and school districts.

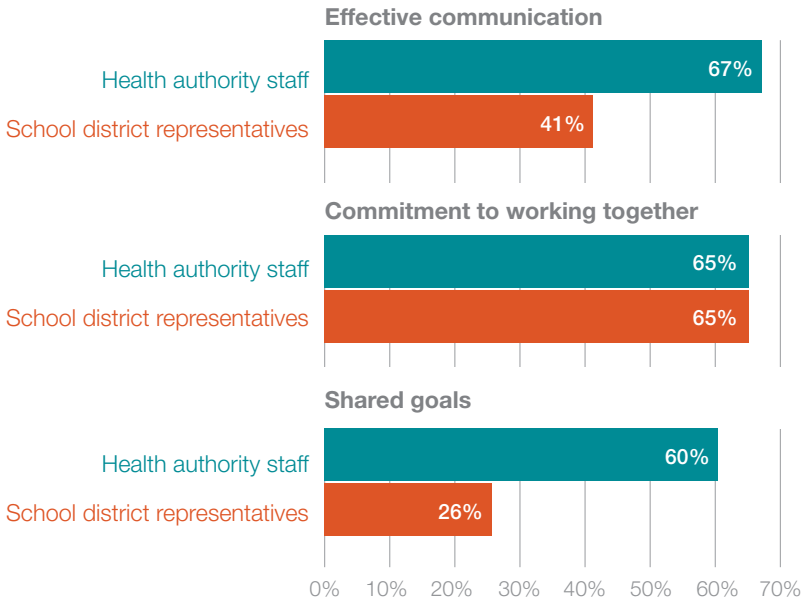
Figure 2. HSBC stakeholder perspectives on whether partnerships had strengthened in the past year, cycle 3.



Health authority staff reported on the change in their partnerships generally, for all schools or school districts in their region. Schools and school districts reported on the partnership with the one health authority with which they work. As such, some caution is a warranted in comparing health and education perspectives.

Health authorities and school districts agreed that there was a high level of commitment to working together. This commitment did not necessarily translate to working together towards shared goals, for which there was a large discrepancy between health authority and school district perspectives. Although the majority of health authority staff (60%) indicated that they were frequently working towards shared goals with the education sector, only about a quarter of the school district representatives (26%) saw that this was occurring. Health authority staff also thought that communication with their education partners was effective (67%); again, school district representatives were less sure about this, with less than half indicating that communication with their health partners was effective (see Figure 3).

Figure 3. HSBC stakeholders reporting effective or highly effective cross-sector communication, moderate to high commitment to working together, and frequently or very frequently working towards shared goals, cycle 3.



Future considerations

- Strengthen and align strategies to increase school districts' and schools' awareness of the support that health authorities, the Ministry of Health, DASH and other NGOs can provide to implement a CSH approach.
- Given the lack of time to work on healthy schools approaches, explore strategies to increase the collective healthy schools capacity of partners and sectors within and beyond health and education (e.g., private sector, other NGOs, post-secondary education, local community partners).
- Increase the opportunities to define and work together towards healthy schools goals for school districts and health authority staff.
- First Nations health and education partners had little involvement in HSBC to date. Initial engagement should be expanded to identify opportunities to strengthen relationships, and align HSBC activities with traditional understandings to support education and wellness in First Nations students.

Coordination and consolidation

Awareness of provincial, school-based healthy living programs is low among educators in BC. Beyond the BC School Fruit and Vegetable Nutritional Program, educators are mostly unaware of school-based healthy living programs. As such, efforts towards coordination and consolidation of these programs may not have been noticed by educators, given their low familiarity with the programs in general.

There was a correspondingly low awareness of the extent to which programs could be (or were) coordinated or consolidated. Less than half of the educators surveyed felt that the school-based healthy living programs were coordinated. When asked how they could be better coordinated, educators suggested the need for increased awareness and promotion of programs, greater linking of the programs to the curriculum, more support for teachers to take a lead role in coordinating programs, more training for volunteers and teachers, and a coordinator to work with schools.

Several organizations that deliver provincial, school-based healthy eating programs were brought together for a series of meetings, to develop a framework for operating in a more collaborative and coordinated manner. While the group developed a collective framework for action, the focus was largely limited to coordination of communications (e.g., cross-promotion of programs, amalgamating newsletter content, integrating consistent language around CSH in promotional materials), and did not address a deeper level of operational coordination and consolidation (e.g., coordination of actual program delivery, consolidation of program components). Differing mandates and funding sources for these programs were identified as barriers to more intensive coordination and consolidation efforts. Overall, the original goals for program coordination under the HSBC initiative were not achieved.

Information on school-based healthy living programs and resources was successfully consolidated within the HSBC website. Website analytics indicated that the HSBC site was a key tool for connecting the health and education stakeholders to HSBC resources and information, and assisted with consolidation by serving as the “one-stop shop” for school-based healthy living programs. However, it is unclear to what extent, if any, this consolidation contributed to the coordination of school-based healthy living programs.

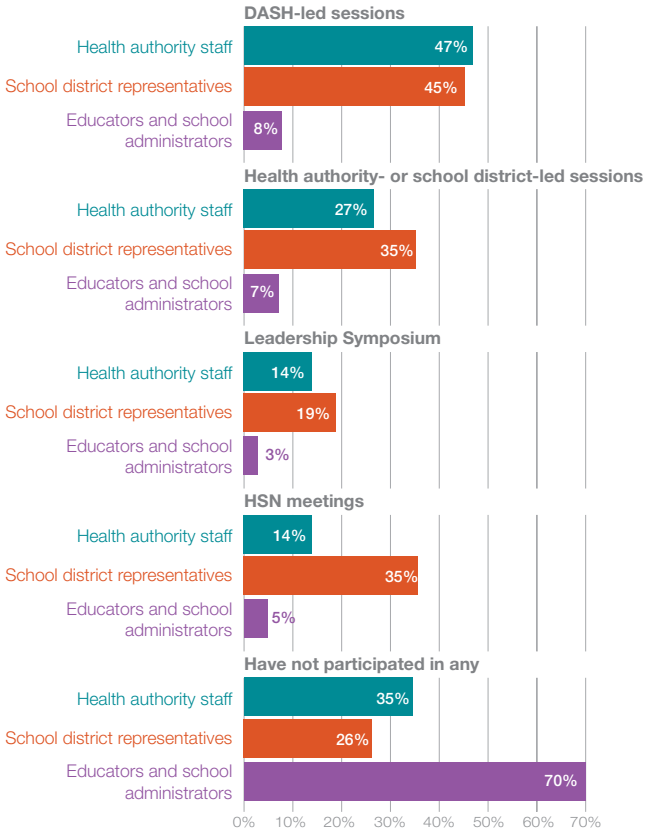
Future consideration

- Consider the advantages of an umbrella approach for coordinating and consolidating the school-based healthy living programs: to increase awareness of and access to the programs, share resources, improve implementation of the CSH approach, and deliver a greater impact on student health.

Capacity building - knowledge exchange and skill development

DASH-led HSBC workshops reached almost half of health authority staff and school district representatives surveyed. Over the evaluation years, HSBC and the CSH approach were promoted through various knowledge exchange and skill development opportunities, which were offered mostly to health authority and school district staff. In cycle 3, both health authority staff and school district representatives most frequently reported participation in HSBC learning sessions with DASH. Both groups also participated in HSBC learning sessions through their health authority or school district (see Figure 4). Some school district representatives also indicated that they participated in the DASH Healthy Schools Leadership Symposium and Healthy Schools Network (HSN) meetings. Given that the HSBC learning sessions were targeted towards health authority and school district staff (not educators), and the HSN meetings and the Leadership Symposium included a relatively small number of the roughly 35,000 teachers in BC, it is not surprising that the majority of educators and school administrators responding to the survey (70%) reported that they had not participated in these opportunities.

Figure 4. Participation in HSBC knowledge exchange and skill development opportunities, cycle 3.



Knowledge exchange and skill development opportunities improved CSH knowledge. Of stakeholders who participated in knowledge exchange and skill development opportunities, a high majority (82%-100%, depending on opportunity) agreed that their knowledge of CSH was improved through their participation (cycle 3). The Leadership Symposium was especially effective in improving CSH knowledge for health authority staff and school district representatives, with 100% of both groups indicating that their knowledge increased. Further, the majority of stakeholders (60-88%, depending on stakeholder group and opportunity) indicated that their ability to partner with the other sector improved because of their participation in knowledge exchange and skill development opportunities.

Future considerations

- Continue to provide HSBC knowledge exchange and skill development opportunities with appropriate linkages (e.g., to the redesigned Physical and Health Education curriculum, and provincial school-based healthy living programs) for all stakeholder groups. Engage in widespread promotion of these opportunities to key target groups, including stakeholders who haven't previously been involved.
- Increase the reach of DASH-led HSBC learning sessions to educators and school administrators in particular, as this learning opportunity demonstrated a great impact on increasing CSH knowledge in this stakeholder group.

Capacity building - assessment, planning, implementation tools and resources

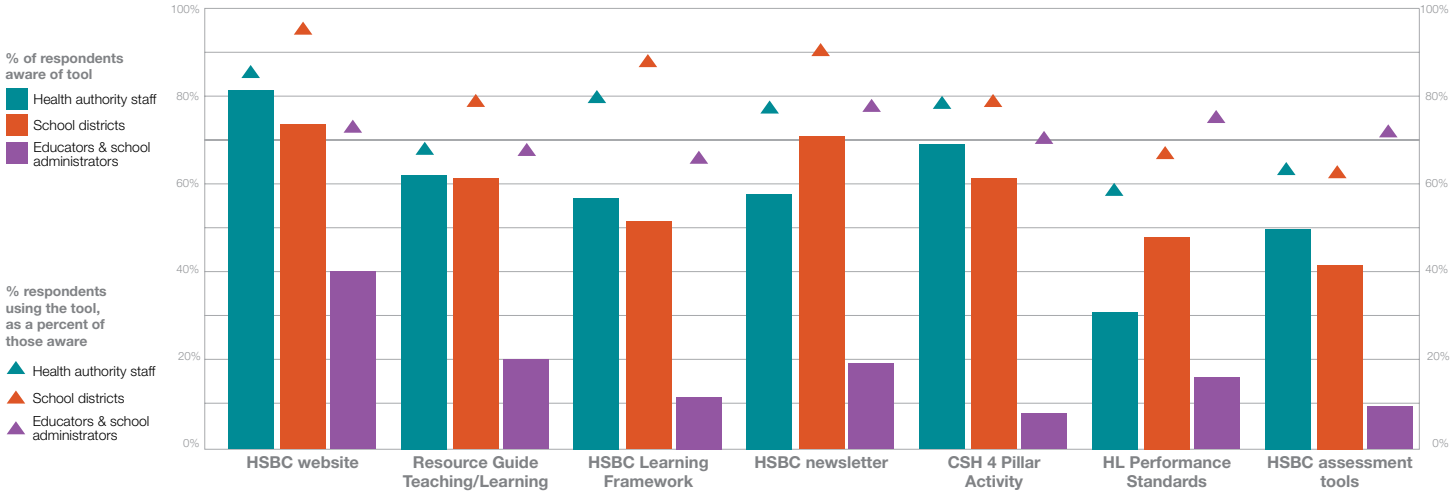
Many health authority staff and school district representatives were aware of the HSBC website, the Resource Guide for Teaching and Learning, the HSBC newsletter, and the CSH 4 Pillar Activity, and were using these tools with great satisfaction. Awareness of HSBC tools and resources was low across educators and administrators at schools, and this was constant across the evaluation years. However, those educators that were aware of the various tools tended to use them (see Figure 5). Among all stakeholders who used HSBC tools and resources, the vast majority were satisfied with them. Over 85% of all stakeholders were satisfied with the tools shown in Figure 5.

Future considerations

- Explore mechanisms to promote the HSBC website to reach a wider audience of educators, school administrators, and community partners, while improving the website to ensure that it is dynamic, user-friendly, and responsive to user needs.
- Support and increase the use of existing tools (e.g., for assessing, planning, facilitating and monitoring of healthy school activities) within individual schools and school districts, in alignment with their healthy schools goals.
- Review the HSBC capacity-building tools and resources that stakeholders were consistently least aware of (e.g., HSBC Assessment Tools, CSH Knowledge Guide, BC Community Health Atlas), and:
  - increase promotion of the resources to increase uptake if the tools are still needed;
  - update content so that they are more relevant to the current interests, the new curriculum, and needs within HSBC; or
  - retire them and create new resources that better meet the current needs and interests within HSBC.

Figure 5. Stakeholders' awareness and use of select HSBC tools, cycle 3.

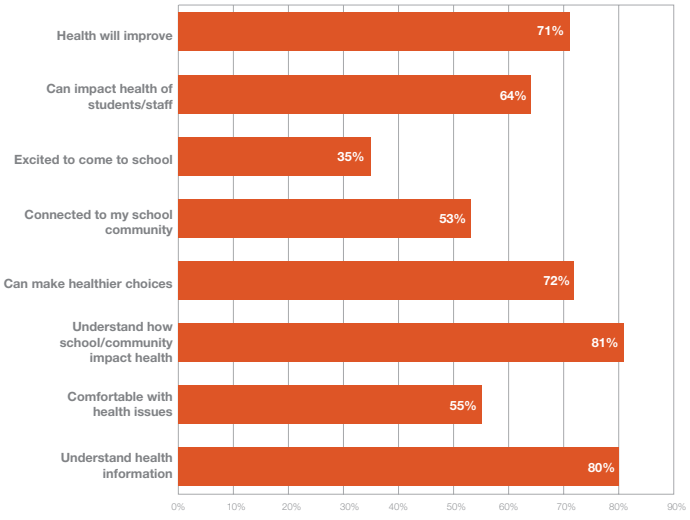
Note: Use reported as a percent of those who were aware of the tool.



Student engagement and leadership

Students participating in the Student Healthy Living Network and Healthy Schools Network Inquiry Projects in the 2014-15 school year (cycle 3) improved their health literacy. Students in the Student Healthy Living Network and other students who had teachers involved in the Healthy Schools Network carried out healthy school inquiry initiatives with support from HSBC grants, teachers, DASH, and their peers. The inquiry process was used to engage students in their learning about healthy schools. Their involvement helped them to understand health information and make healthier choices (see Figure 6). Overall, teachers indicated that student projects conducted through the Healthy Schools Network and supported by HSBC grants provided an important starting point for students to be more involved in their learning. Participation in the Student Healthy Living Network, although low due to a lack of connection to an adult champion infrastructure, still resulted in further benefits: the majority of those students indicated that they developed leadership skills (66%), and had greater involvement in their learning (77%).

Figure 6. Student-reported benefits of participating in a Healthy Schools Network Inquiry Project, cycle 3.



What makes a school a healthy place?

Student Responses:

"In order to make a healthy school you must have active students who can be considered as positive role models for other students in the school, as well as an activity counsel or group that can plan active events and other various projects that will make the students move. You can also start serving healthier foods in your cafeterias like vegetables, fruits and whole-wheat things instead of popsicles, cookies, tacos and pizza pops."

"If it is a fun place to be in, if the food that they provide is good and healthy, and the students feel safe and comfortable when in their classes."

"People working together, showing respect for others, good DPA [Daily Physical Activity] program, a good learning environment, students who make healthy choices, and have an education on how to make their school a better place."

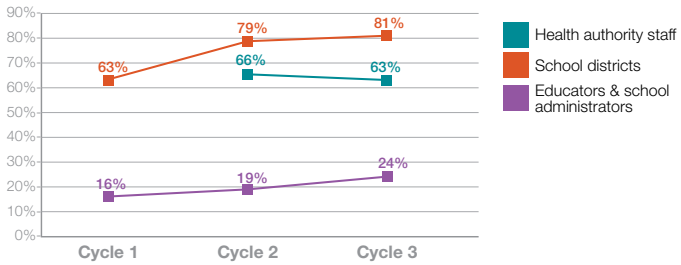
Future considerations

- Explore mechanisms that connect students more firmly to an existing infrastructure of adult/educator champions at the local/regional level (e.g., the Healthy Schools Network), so that students can benefit from more opportunities for collaboration and broader perspectives.
- Engage students more meaningfully in the healthy schools process (i.e., assess, plan, act, and evaluate healthy school initiatives), including leadership and other opportunities that meet students' needs and interests, within and beyond healthy living inquiry projects.

Healthy Schools BC outcomes

Knowledge and application of the comprehensive school health approach increased. For school district representatives, and educators and administrators at schools, knowledge and application of CSH increased over the evaluation years (see Figure 7). The proportion of educators and administrators who had never heard of CSH declined from 46% in cycle 1 to 29% in cycle 3. The majority of health authority staff were consistently applying their CSH knowledge (63% in cycle 3).

Figure 7. Proportion of stakeholder groups reporting knowledge and application of CSH in their work.

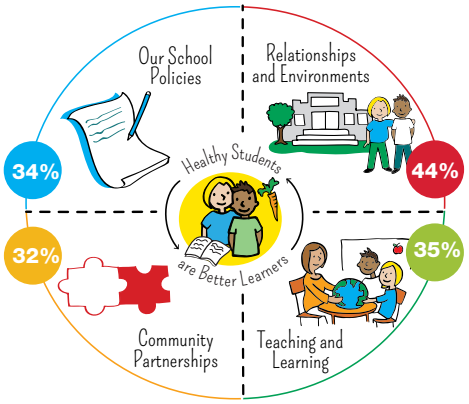


Note: Health authority staff were not asked about knowledge and application of CSH in cycle 1.

School districts used the CSH approach when they developed their healthy schools action plans, policies, goals, committees and plans. The majority of school districts that had developed a healthy schools action plan, goal, policy or committee (53%-77%, depending on piece developed), reported doing so with a focus on the CSH approach, an indication of implementation of the CSH approach.

Schools continued to strengthen their healthy schools approaches. Some educators and school administrators indicated that they had become stronger over the last year in each pillar of the CSH approach (see Figure 8). Healthy relationship-building between students and staff (which falls under the 'Relationships and Environments' pillar of the CSH approach) consistently made the greatest progress, with 44% of educators and administrators indicating that their school had strengthened in this pillar area over the last year, in cycle 3. A minority (28%) of educators and administrators believed that their school had not become stronger in its healthy schools approach over the last year.

Figure 8. Educators and administrators reporting a strengthened CSH approach in their school, by CSH pillar, cycle 3.



Positive changes to the healthy school environment continued to unfold. Over half of the educators and school administrators surveyed reported that they had observed some or slight changes towards a healthier school environment at their schools over the last year, as a result of HSBC activities (51%). It was uncommon for educators and school administrators to report that they had observed a negative change (1%). Some felt it was too early to tell (18%) and many had not yet observed a change (30%). These figures were consistent over the evaluation years. Illustrations of the changes educators and school administrators observed at their schools are provided in the sidebar on the following page.

Student health outcome indicators form a baseline from which to monitor future HSBC activities. The Ministry of Education's Satisfaction Survey provides an important picture of student health outcomes in BC each year. The indicators show that less than half of BC students consume the recommended amount of fruit and vegetables per day, or meet the daily physical activity requirement for their grade level, and neither of these rates has improved noticeably over the last few years. The rate of not smoking improved marginally for older students over the last five years. Currently, the majority of all BC students do not smoke cigarettes. Important to the ongoing monitoring of HSBC, there was a decline in the percentage of students who reported that they were learning to stay healthy at school between 2010/2011 and 2014/2015. The McCreary Centre Society's Adolescent Health Survey further contributes to this picture of student health outcomes with their measure of school connectedness. In 2013, school connectedness was highest among students in Grade 7 as compared to higher grades, where 40% of Grade 7 students reported the highest levels of

school connectedness (16% for Grade 10 students and 21% for Grade 12 students). Those youth who were highly connected to school tended to report good or excellent mental health.

The concentration of action within HSBC between 2011 and 2015 was directed toward establishing cross-sector partnerships and building capacity so that health authority staff, school district staff, and educators and school administrators could be effective in implementing the CSH approach. Over this time, regional health authorities worked with education partners on many aspects of the CSH approach. However, the opportunities to work within the fourth CSH pillar — teaching and learning, which would have a more direct impact on student health outcomes — were limited.

Future considerations

- Long term and stable funding and commitment towards supporting HSBC objectives, particularly in the areas of cross-sector partnerships and capacity-building, is required to continue on a path towards widespread implementation of the CSH approach and a positive impact on student health outcomes.
- Plan for a medium-term (2 years) check-in on a small set of HSBC indicators (e.g., partnership progress and strength, CSH knowledge and application, participation in learning opportunities, depth of student engagement, observed changes to the school environment), and a longer term (5 years) check-in on student health and educational outcomes to monitor the impact and progression of continuing work.

Educators' and school administrators' observed changes at schools

"More students eating fruits and vegetables; more students playing sports during afterschool programs and on their own initiative at recess times; community professionals working in the school with staff, students, and families." *(Teacher, SD 57, Northern Health Authority)*

"We have significantly increased awareness about mental health, and the need to keep the body moving in order to improve learning in the classroom." *(Principal, SD 41, Fraser Health Authority)*

"Last year we implemented a school wide buddy system (K-12) to develop and foster stronger bonds between older and younger students. This was such a success, we have continued this program and are again experiencing higher levels of communication and compassion and deeper friendships within our school environment." *(Teacher, SD 67, Interior Health Authority)*

Conclusions

Overall, the evaluation of HSBC demonstrated progress towards strengthening relationships across the health and education sectors and building capacity to support the CSH approach. As a result of partnering efforts led by health authority staff, knowledge translation and skill development opportunities largely led by DASH, and the multitude of resources and tools contributed by DASH, PHSA and the Ministry of Health, there was a positive shift in knowledge of CSH and in ability to partner across sectors. However, an increase in the time available for health authority staff to participate in healthy schools activities would translate to a deeper engagement with the education sector and stronger partnerships. Revisiting healthy schools goals jointly with health authority and school district participation will increase the likelihood of enacting a plan to work towards them together.

Further action in coordination and consolidation of school-based healthy living programs is warranted to fully benefit students. Students were engaged in healthy living through diverse projects and HSBC-related councils and groups at their schools; deeper and broader engagement of students should be a long term focus of continued healthy schools efforts. How changes in CSH capacity for all stakeholders relate to student health outcomes should be an emphasis of longer term evaluation efforts, as HSBC has laid an important part of the foundation for improvements in student health in BC.

Moving forward, the redesigned K-12 education curriculum includes a new Physical and Health Education subject area, which is expected to be fully implemented in the 2017/18 school year. Several BC ministries, including Health and Education, are currently working with the regional health authorities, NGOs and other education partners to enhance resources and regional cross-sector partnerships that will support teachers in effectively delivering this new curriculum. This presents a significant opportunity to contribute to improvements in student health indicators, and especially the "learning to stay healthy" indicator measured across the province.

Acknowledgements

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This summary report was prepared by Context Research (Dr. Kerry MacKelvie), with contributions from the HSBC Evaluation Advisory Team (including DASH (Kathy Cassels and Rebecca Gibbons), PHSA (Dr. Drona Rasali and Bethany Elliott), and the BC Ministries of Health (Scott Beddall) and Education (Sanja Ristic)), and is based on the Healthy Schools BC evaluation final report 2016 completed by Context Research.

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