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CSHI Lessons from the Field
Comprehensive School Health Initiative

Part Four:

Creating Lasting Comprehensive School Health Programs

The Connection Between Health and Achievement

Student health has a profound effect upon student academic performance. In 1994, with a focus on increasing student achievement, the Public Education Network (PEN) began working with the Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC/DASH) to integrate coordinated school health programs (CSHPs) into a larger, systemic school reform effort at the local and national levels. PEN provided funding and technical assistance to five local education funds (LEFs) to implement projects that would create, enhance, and/or institutionalize school health programs within their districts. This report—the last of a four-part series—looks at the process of institutionalization based on a model developed by PEN in collaboration with the five LEFs. A major component of this work involved engaging public support by clearly articulating the need for, and value of, comprehensive school health programs.

Through the Comprehensive School Health Initiative (CSHI), PEN and LEFs are linking school health and school reform through the critical issue of school and adolescent health which includes HIV prevention as a major focus. This report looks at some of the indicators for institutionalization used by the LEFs in order to sustain their activities in establishing and enhancing comprehensive school health programs in their schools and communities.

On August 27-28, 1998, PEN convened a meeting in Washington, DC of representatives from the five participating LEF sites. The five CSHI sites represented at the meeting included: the Academic Distinction Fund (Baton Rouge, LA); the Mary Lyon Education Fund, Inc. (Shelburne Falls, MA); the Lincoln Public Schools Foundation (Lincoln, NE); the Public Education Fund (Providence, RI); and the Education Alliance (Charleston, WV).

Since 1995, these five CSHI sites have been engaged in intensive and challenging efforts to implement comprehensive school health programs at the district and school levels. PEN and the five LEFs have adopted the position that “systemic school reform must embrace the development of comprehensive school health services as a viable solution to the full range of health related issues and problems facing schools and communities across the country.”

LEF sites have been able to successfully build partnerships among local stakeholders and implement a variety of community-based health related programs and social services. These services, often the only services available to poor children, are integral parts of a larger comprehensive and effective school reform strategy. However, to ensure that the successes achieved are maintained and expanded, the programs and services need to be incorporated into the broader fabric of each community’s school reform effort. Often when grant funding ends, so do the critical programs. LEFs are resolved not to let this happen.

Leadership at the site level has identified the essential components of institutionalization, and are developing a model that will be used to guide the process of institutionalizing coordinated school health programs, including HIV-prevention education and services.

PUBLIC EDUCATION NETWORK

Defining "Institutionalization"

An initial step in the development of the institutionalization model involved having PEN's meeting participants describe what the term "institutionalization" meant to them. What comes to mind when one thinks about the relationship of institutionalization to school health initiatives? The American Heritage Dictionary defines institutionalization as the process of making something, "part of a structured and usually well-established system." Building upon that definition, LEF leaders articulated that the term meant, "being well-established…existing over time…being involved at all levels…becoming part of the culture/system…being mandated in some way…and existing as a 'process.'"

The discussion of these various perspectives of institutionalization resulted in a general consensus among the participants that *institutionalization refers to "a process by which a program or activity becomes a sustained part of community life."* Making health promotion programs an integral part of academic life needs to become a permanent fixture on the education reform landscape if we want all students to achieve at high levels.

The quality of the institutionalization process is determined to a great extent by the culture of the community in which the process occurs.

A Workable Model of Institutionalization

The CSHI institutionalization model is comprised of four components: culture, policy, relationship and resources. Each component has a set of clearly identifiable indicators and is interrelated (see Figure 1). For example, the ability of a community to build commitment and support from stakeholders will impact upon the community's ability to acquire the necessary resources to implement school health programs. This process, in turn, will impact the types of programs and policies that are developed consistent with the culture of the community. Obviously, the stronger the connections between these components, the greater the likelihood that the school health initiative will be successfully institutionalized.

Culture

Institutional culture relates to the set of shared beliefs, values, or assumptions that are present within a community. This culture is represented within the structure and content of the school health services that are offered to address health related problems of its youth. A community with shared values will often share language, rituals, beliefs, and symbols. The quality of the institutionalization process is determined to a great extent by the culture of the community in which the process occurs.

Some indicators of the influence of culture in the institutionalization of the CSHI include:

- The use of a common language and common terms to communicate about the health issues and needs of youth;
- The scheduling of regularly occurring events for health promotion; a variety of strategies to increase the level of knowledge and awareness of school health issues and services within the community;
- Logos, signs, or symbols that are recognized within the community to be associated with the initiative; and
- Media coverage of school health activities.

Considerable evidence of the influence of cultural indicators exists at the site level. The Mary Lyon Education Fund (MLEF) in Shelburne Falls, MA, sponsors a health fair every April for all school staff, students, and the community. The Health Fair is now firmly entrenched as an annual ritual drawing together hundreds of students, teachers and community members.

The Lincoln Public School Foundation (LPSF) in Nebraska conducts an annual two-day retreat for its CHET (Comprehensive Health Education Team) members. This retreat provides both new and existing teams with an opportunity to review and refine their individual objectives and to participate in ongoing staff development opportunities in comprehensive school health education. In an effort to increase the level of knowledge and awareness of the Comprehensive School Health Initiative, LPSF also designed and compiled "Teacher Idea Booklets" and parent newsletters that address identification of youth risk behaviors. The project provides a means for ensuring that teachers and parents throughout Nebraska understand and use a common language to communicate about the health issues and youth wellness problems.

The Academic Distinction Fund (ADF) in Baton Rouge, LA, distributed a School Health Calendar to all district faculty members that contains a health-related topic selected for each month. Each school is provided a minimum of two activities each month

that are devoted to advocating healthy approaches to addressing the monthly health topic. ADF also sponsors numerous workshops on a variety of intervention activities for students, parents, teachers, and support staff.

In West Virginia, the Education Alliance (EA) reports that CSHI partners receive informational updates from them via telephone calls, newsletters, faxes, personal site visits, staff meetings, and email. Working on Wellness (WOW!)—the name of the program in West Virginia—partners share information about their individual organizations using the same communications vehicles. EA also now has a website (www.EducationAlliance.org). Email has proven to be a very beneficial communications tool for connecting WOW! members and schools across the state. Their web page is currently being updated to include health links and summaries of what WOW! funded schools are doing to address major health risks through their coordinated school health program.

Policy

Policy refers to all aspects of governance, administration, and priority-setting behaviors and approaches that are undertaken in the implementation of the school health initiative. Also included in the policy component are activities that address funding priorities, programmatic guidelines, the direction or mandate of the community's leadership, and the specific programs that are established under the school health program.

Indicators of institutional policy influence of the CSHI may include:

- priorities in funding allocations,
- preset programmatic guidelines and protocols,
- placement of CSHI issues on leadership discussion agendas,
- periodic reviews of school health activities by agencies and boards, and
- legislation of school health programs and services.

The following are examples of policy indicators of institutionalization in the five CSHI sites:

MLEF is making excellent progress in their priority effort to develop a policy booklet examining school district health issues. A "Comfort Care" policy, regarding the use of cardio-pulmonary resuscitation (CPR) on students, has been presented to the school committee and adopted. In addition, a strong policy regarding tobacco use and possession on school property is being examined. A teen dating violence policy is also on the agenda for future adoption.

In Rhode Island, the Community Planning Committee of the Public Education Fund (PEF) is highly valued by its members as an ongoing vehicle for keeping school health issues "on a front burner" in the district. They comfortably discuss and plan school health programs and activities as "comprehensive" and "coordinated". The state level school initiative, Healthy Schools! Healthy Kids! has a newsletter which highlights the activities of the Providence CSHI sites and conducts a school health recognition month and an annual awards ceremony that recognizes exemplary Providence schools and organizations. PEF also reports on CSHI in its widely distributed quarterly newsletter and its new website provides links to CDC and other health sites.

In Lincoln, CSHI schools include health curriculum planning as an ongoing agenda item for staff and team teaching meetings. This regularly reinforces the idea that health literacy is expected to be incorporated into each academic discipline.

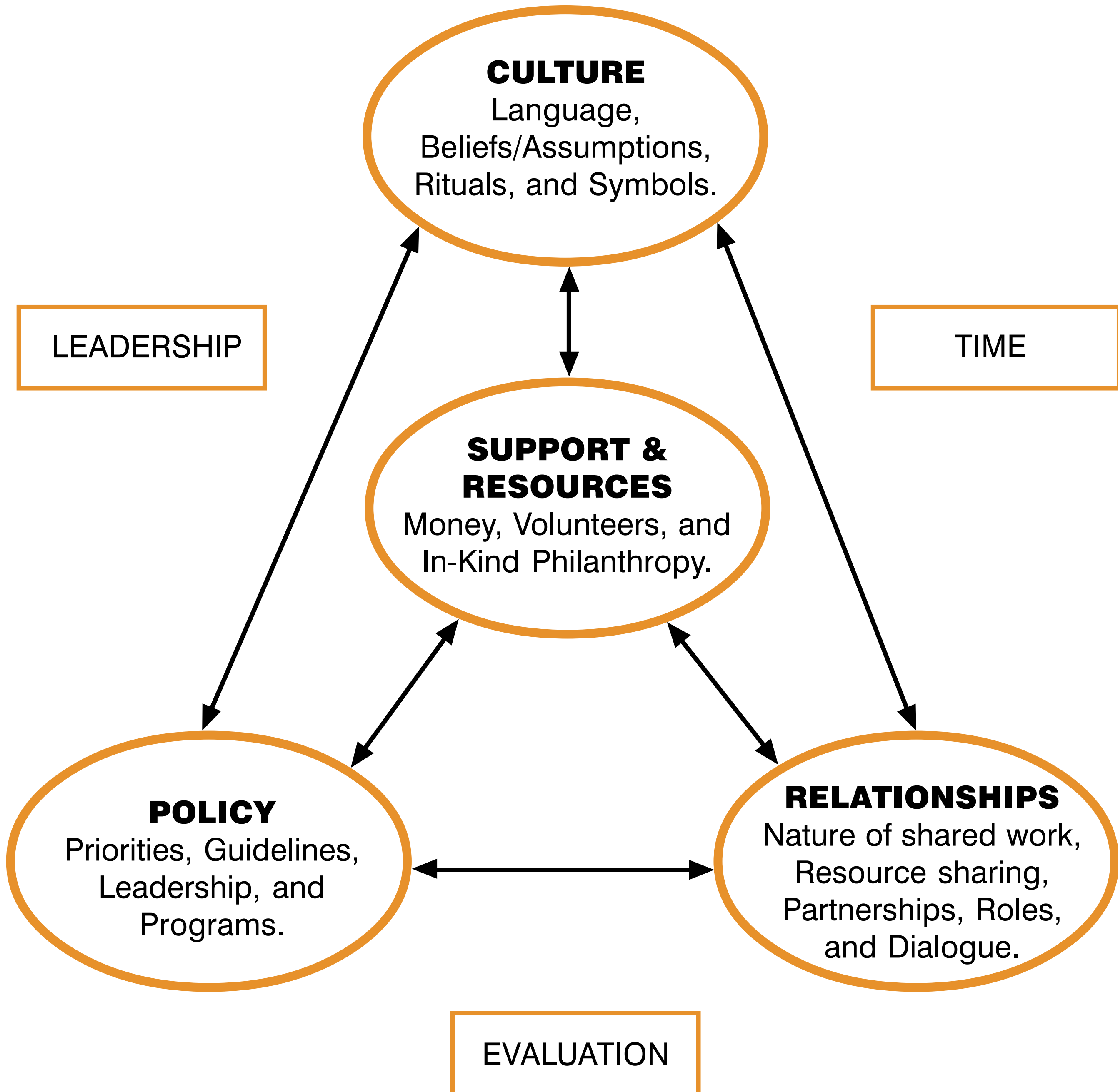
In West Virginia, the Education Alliance is working for policy changes that will improve the state school nurse ratio and impose taxes on tobacco. These two major issues were introduced in the state legislature during the 1998 legislative session, but neither issue passed. However, the Alliance expects to see these issues come up again in years to come.

Indicators of the influence of policy may include priorities in funding allocations, preset programmatic guidelines and protocols, placement of CSHI issues on leadership discussion agendas, periodic reviews of school health activities, and legislation of school health programs

Finally, in Baton Rouge, a peer-mentoring program has been established at the high school, and is proving to be one of the more successful CSH projects. The program will be offered as an elective for the coming school year.

Relationships

The relationship component of the institutionalization model is concerned with the roles and responsibilities assumed by the various stakeholders involved in the school health program. This component focuses on linking different segments of the community who share a significant stake in the outcome of


Comprehensive School Health Initiative
Institutionalization Model
CULTURE
Language,
Beliefs/Assumptions,
Rituals, and Symbols.
LEADERSHIP
TIME
SUPPORT &
RESOURCES
Money, Volunteers, and
In-Kind Philanthropy.
POLICY
Priorities, Guidelines,
Leadership, and
Programs.
RELATIONSHIPS
Nature of shared work,
Resource sharing,
Partnerships, Roles,
and Dialogue.
EVALUATION

Indicators of Institutionalization of Comprehensive School Health Programs

Component	Type	Sample Indicators
Culture	*Language*	• Does everyone understand the language being used in the program? • Are people using the same terms and concepts regarding the program?
	Rituals	• Is there a set of activities that people have scheduled as regularly recurring events? • Have practices been transformed into habits?
	Beliefs	• Is there a shared belief and understanding on the value of the program? • Are people able to make connections between the program and how it affects community life?
	Symbols	• Do people understand acronyms and signage used to promote the program? • Are people familiar with the all the entities involved in the program?
	Assumptions	• Is there a common assumption between the correlation or relationship between the program and its desired result?
Policy	*Priorities*	• Is the program a permanent item on the school district budget? • Is the program part of the sponsoring organization's strategic or operating plan? • Are the issues addressed by the program the same or similar to shared issues and concerns of school and community leadership?
	Protocols and guidelines	• Are the guidelines provided as part of training programs for staff/volunteers? • Is there a preset protocol or guideline to inform people how the program is implemented or realized? • Is there a periodic review to assess if the protocols and guidelines are followed? Is there a process to check if these protocols and guidelines remain effective and efficient?
	Mandates	• Is there a state or local mandate requiring for the program to be implemented? • Is there a state or local mandate requiring funding or other resources to be invested in the program? • Is the current program providing enough lessons and policy recommendations that will open doors for local or even state mandates?
	Leadership	• Do school board members, superintendents, principals, teachers and other community leaders see the program as needed? • Does the program have support from the school and community leaders? • Does the leadership provide a clear vision and direction as to goals and outcomes three or four years down the road?
Relationship	*Partnerships*	• Is the program currently being implemented collaboratively with other agencies? • Are other agencies, schools and community organizations supporting the program?
	Shared work and resources	• Are program activities conducted with other partners? • Is the work on the program delegated to other agencies' staff? • Is funding matched with other resources or in-kind contributions? • Do other agencies/schools have an funding or in-kind investment in the program?
	Communication lines	• Is there a mechanism for informing all partners on the program's progress and successes? • Are regular updates provided to all partners and beneficiaries? • Does every partner/player know how to communicate the program to others?
Resources	*Adequate funding base*	• Is there enough funding to achieve program objectives? • Do funding levels increase periodically to meet cost increases and increasing demand? • Does the program have a diverse funding support?
	Volunteer base	• Does the program have an adequate volunteer base? • Does the volunteer base represent the target audience? • Does the volunteer base come from the school/community where the program is based?
	In-kind support	• Does the program have non-financial support from the school/community?
	Philanthropic guidance and support	• Does the program have support from the philanthropic community? • Do funders, especially community foundations, support the vision and direction of the program?
	Organizational capacity	• Does the organization have the structure, resources, and staff to continue the program beyond the project period? • Is the program in line with the organization's strategic direction and mission? • Does the organization have the capacity to bring the program to scale (i.e., expand its reach/scope)?

the school health program. Building solid relationships includes sharing work and planning responsibilities, sharing resources, forming partnerships, widening your stakeholder base, and coordinating communication among the stakeholders.

Indicators of the influence of relationship in the CSHI institutionalization process may include:

- formal memoranda of agreement,
- standard protocols for programmatic follow-up,
- pooled funding,
- joint proposals developed and submitted by stakeholders,
- periodic meetings, and
- joint board and/or staff meetings among the stakeholders.

The resources are the inputs to which a community has access. The inputs—which can be both financial and non-financial—drive the implementation and ultimately the institutionalization of the school health program.

The MLEF program, which is a co-sponsor of the annual "Healthy Children, Healthy Communities" conference, provides professional development opportunities for all school staff. In Lincoln, NE, the CSHI program is also a partner in a collaborative venture to provide summer enrichment activities for at-risk middle school students. The Lincoln site reports having AmeriCorps members working in local schools directly with students and families. They also created an after-school academic enrichment program for their students that promotes a whole new spectrum of grassroots interventions. It also created significant momentum and leverage for the district to become involved with the CSHI project in a more formalized manner.

Education Alliance staff were members of the 1997 West Virginia School Health Task Force, which was designed to make recommendations on the direction of school health during the next five years. Massachusetts and Rhode Island CSHI sites have taken important steps toward strengthening the relationships between their respective partners to support the institutionalization of the CSHI. MLEF has already completed an objective to integrate the CSHI with the school reform efforts of the Shelburne Falls school district through the permanent partnering of the Mary Lyon Education Fund and Western Massachusetts Special Education Directors Association. Through this partner relationship, special education teachers can obtain their required professional development points toward recertification through a permanent CSHI mechanism.

Rhode Island has strengthened the linkage between their Community Planning Committee and district, state, and national school health resources and programs. This linkage ensures a closer fit between the local CSHI and the state's school health efforts. Along with the strengthened relationships among the partners in these two sites, there also has been greater clarification of the partners' roles and responsibilities in the CSHI program efforts. It is evident that the CSHI sites are placing considerable emphasis on efforts to maintain effective communication networks.

Resources

This critical fourth component of the model refers to the resources required for institutionalization of the comprehensive school health initiative. In effect, the resources are the inputs to which a community has access. The inputs—which can be both financial and non-financial—drive the implementation and ultimately the institutionalization of the school health program.

Resources may include:

- funding,
- volunteers,
- in-kind support (reallocating existing funds, new additional funds), and
- philanthropic support.

In Rhode Island, the relationship between Brown University and the CSHI school sites continues to flourish through the sharing of resources. Medical students from Brown spend time conducting health education programs for students under the auspices of the school nurse or the health/physical education teacher. In addition, the Chief of Epidemiology in the Department of Health has provided staff, hardware, and software for processing the needs assessment survey data each year.

During the 1997-98 program year, the Rhode Island CSHI site received a small grant from the Association for the Advancement of Science to promote health education and science education among youths and their families. Through this project, the site recruited and trained volunteers, from Brown University medical students to AmeriCorps volunteers, to conduct health education and science activities in

community centers, housing projects, and Boys and Girls Clubs, among others. They coached their Healthy Schools sites in leveraging their current school health efforts for private and public grant dollars to implement and expand their comprehensive school health programs.

The sites are making varying degrees of progress toward CSHI institutionalization in fundraising. For example, during the 1997-98 project year, MLEF received state grant funding as well as federal funding as part of an allocation to a county community health center. This CSHI site also received substantial support in the form of in-kind contributions valued at more than $10,000. In Lincoln, the site has received financial support from outside sources and more than $65,000 of in-kind and volunteer support within the state. In-kind contributions to the Rhode Island CSHI were valued at approximately $21,000. In-kind contributions to the Louisiana site, are valued at more than $55,000. This is a considerable sum for a relatively small school health program.

MLEF reports tremendous success in garnering community support for the CSHI. Evidence for this success is found in the significant number of volunteers who come forward to assist with projects (52 total volunteers helped with the establishment of the Cowell Fitness Center). Lincoln reports that the most significant organizational change in the initiative was the addition of the twelve AmeriCorps Members. The AmeriCorps program has added substantial volunteer resources to the CSHI program.

The funding awarded to the sites through the CSHI has enabled them to provide incentives that help to facilitate the institutionalization process. In order for schools to further develop their coordinated school health programs, the Education Alliance offered 18 competitive grants of $1,000 each for all West Virginia schools. The West Virginia Bureau for Public Health ASSIST grant money allowed the Alliance to offer eight grants specifically targeted toward disseminating information on the dangers of tobacco. Grant money has been set aside to address behaviors leading to unintended pregnancy and sexually transmitted diseases including HIV and drug use prevention. The Education Alliance also requires potential grantees to identify community resources and explain how these resources will support their coordinated school health program.

The Nebraska and Rhode Island sites also use portions of the CSHI grant as incentives for program development. In Lincoln, for example, CSHI grant funding is used for staff development at CSHI pilot schools. These activities are designed to enable educators to develop strategies for curriculum development related to health education.

In Rhode Island, schools are awarded $1000 grants to pay for expenses, chiefly staff time, related to conducting a school-wide assessment and designing a comprehensive school health plan.

Building Blocks of Institutionalization: Time, Evaluation and Leadership

The model also contains a set of basic foundations in the institutionalization process. These foundations are time, evaluation and leadership.

Time

The first foundation refers to the understanding that the institutionalization process requires a minimum of four or five years for completion. The first two years of any program are focused on the planning and partnership forming processes. It is also when specific program elements are "tested" and a variety of programs and services are implemented, modified and refined. The third year of the program is characterized by firmly established relationships and activities that begin to yield results conducive to a comprehensive evaluation.

Evaluation

Effective implementation requires solid evaluation. It is the evaluation process that determines what will be institutionalized. No institutionalization process will succeed if the program is not properly evaluated.

For more information on each CSHI site, please contact the following:

Jan Melton
Executive Director
Academic Distinction Fund
Baton Rouge, LA
Phone: (504) 922-4560
Fax: (504) 922-4562

Margaretta Edwards
Executive Director
Andrea Ferreira
Project Director
Public Education Fund
Providence, RI
Phone: (401) 454-1050
Fax: (401) 454-1059

Susan Silvester
Executive Director
Mary Lyon Education Fund
Shelburne Falls, MA
Phone: (413) 625-2555
Fax: (413) 625-0065

Barbara Bartle
Executive Director
Laurie Sutter
Project Director
Lincoln Public Schools Foundation
Lincoln, NE
Phone: (402) 436-1612
Fax: (402) 436-1620

Jim McKay
Program Director
The Education Alliance
Charleston, WV
Phone: (304) 342-7850
Fax: (304) 342-0046

Is the program meeting its goals and objectives? What improvements can and should be made? How does one know that required improvements were made? The evaluation should focus on the outcomes of those activities (i.e., what difference the school health program made). In short, the evaluation should provide guidance to leadership and staff regarding the program's direction. Based on the findings from the evaluation, communities can make whatever modifications are deemed necessary and appropriate to enhance the success of their institutionalization efforts.

Leadership

Leadership is the very bedrock on which institutionalization effort rests. Leadership at the policy level is necessary to the success of change efforts, particularly those involving resource allocation. More important to institutionalization is the diverse leadership at the community and school levels that evolves from the involvement and intervention of new change agents. In the case of comprehensive school health programs this includes teachers, health care professionals, and parents playing leadership roles. Leadership at these levels of impact and contact ensures that policies that support institutionalization efforts are implemented and that changes in strategy, policy, and resources reflect the needs and priorities of the program.

Conclusion: Making Lasting Changes

As previously noted, the four major components of the institutionalization model are interrelated. The influence of one component is felt in the other three components. The impact of a community's shared values, (i.e., its culture) around the health issues and problems of youth will help to define the kinds of working relationships that are established, the kinds of policies that are promoted, and the amount of resources garnered to address those issues and problems. Therefore, any efforts undertaken by the stakeholders in a community to institutionalize a comprehensive school health initiative must reflect their understanding of the interrelated nature of these components. In other words, if the stakeholders understand that these components are connected, then their efforts to institutionalize the initiative also must be interrelated, both conceptually and practically.

Because the school health initiative involves many diverse stakeholders, maintaining effective communication among them is essential. Information about the status of school health activities and programs can be disseminated to the community by way of print materials such as newsletters and brochures, or by electronic means such as fax and the Internet. The more diverse and overlapping the methods, however, the better for reaching diverse segments of the community.

Finally, program designers and implementors must be clear what is being institutionalized. Is it the program itself or the kinds of activities, services and relationships that have been established that need to be sustained and be made into a more permanent fixture of the community's structure? This question can be better answered once the community has a clear awareness and understanding of how school health programs benefit not only the children and young adults within the schools and community, but also other systems that make up the community of health and support service providers. By addressing student health, LEF communities are increasing the bottom line of student achievement and academic performance.

MISSION STATEMENT

The mission of the Public Education Network (PEN) is to create systems of public education that result in high achievement for every child.

PEN works to educate the nation about the relationship between school quality and the quality of community and public life. Equal opportunity, access to quality public schools, and an informed citizenry are all critical components of a democratic society. PEN's goal is to ensure that the availability of high-quality public education is every child's right and not a privilege.

The achievement of that goal is dependent upon public support for substantial structural changes at every level in the nation's public school systems. This includes making significant changes in how schools are funded, overhauling curriculum and assessment practices, ensuring authority and decision-making at the school level, providing ongoing professional development for teachers, and building relationships between citizens, schools, and the communities they serve. For more information on PEN, call 202-628-7460.

PUBLIC EDUCATION NETWORK

601 13th Street, NW
Suite 900 North
Washington, DC 20005
Phone: (202)628-7460
Fax: (202)628-1893
www.PublicEducation.org

Richard Tagle
Program Director

Melissa Zack
Program Assistant

Howard Schaffer
Editor

Design and Layout
Nicolas F. Shi
Wow! Designs