Creating Readiness for Adopting a
Health Promoting Schools Framework

by

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Submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

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Access to Thesis - A

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Publications

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<th>Full Form</th>
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<tbody>
<tr>
<td>BOT</td>
<td>Board of Trustees</td>
</tr>
<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
</tr>
<tr>
<td>CFO</td>
<td>Chief Financial Officer</td>
</tr>
<tr>
<td>CSH</td>
<td>Coordinated School Health</td>
</tr>
<tr>
<td>DECS</td>
<td>Department of Education and Children’s Services</td>
</tr>
<tr>
<td>ES</td>
<td>Elementary School</td>
</tr>
<tr>
<td>FCD</td>
<td>Freedom from Chemical Dependency</td>
</tr>
<tr>
<td>HABL</td>
<td>Healthy, Active, Balanced Lives</td>
</tr>
<tr>
<td>HFCPS</td>
<td>Health Framework for Californian Public Schools</td>
</tr>
<tr>
<td>HoS</td>
<td>Head of School</td>
</tr>
<tr>
<td>HPE</td>
<td>Health and Physical Education</td>
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<td>HPS</td>
<td>Health Promoting Schools</td>
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<tr>
<td>HS</td>
<td>High School</td>
</tr>
<tr>
<td>IASAS</td>
<td>Interscholastic Association of Southeast Asian Schools</td>
</tr>
<tr>
<td>IB</td>
<td>International Baccalaureate</td>
</tr>
<tr>
<td>ISA</td>
<td>International School Association</td>
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<tr>
<td>ISC</td>
<td>International Schools Consultancy Group</td>
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<tr>
<td>IT</td>
<td>Information Technology</td>
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<tr>
<td>IUHPE</td>
<td>International Union for Health Promotion and Education</td>
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<tr>
<td>LET</td>
<td>Learning Evidence Team</td>
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<tr>
<td>LT</td>
<td>Leadership Team</td>
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<td>LWLW</td>
<td>Live Well Learn Well</td>
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<tr>
<td>MS</td>
<td>Middle School</td>
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<tr>
<td>NGO</td>
<td>Non-government Organisation</td>
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<td>National Health Education Standards</td>
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<td>Professional Development</td>
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<td>Substance Abuse Prevention Committee</td>
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<td>SBA</td>
<td>Settings-based Approach</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<td>--------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>SHPPS</td>
<td>School Health Policies and Program Study</td>
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<tr>
<td>SLP</td>
<td>Strategic Learning Plan</td>
</tr>
<tr>
<td>TCK</td>
<td>Third-culture Kid</td>
</tr>
<tr>
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<tr>
<td>UNESCO</td>
<td>United Nations Education, Scientific and Cultural Organization</td>
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<tr>
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<td>United States</td>
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<tr>
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Abstract

The purpose of this research was to examine the challenges surrounding the implementation of whole-school approaches to health in schools, which in this case was referred to as a ‘Health Promoting School’ (HPS) approach. The setting was a large international school in South East Asia, and this single case study followed the process of creating readiness in the early stages of adopting a HPS approach, and captured the critical factors affecting leaders’ beliefs and support for the program. The literature on readiness for change, whole-school or settings-based change, and guidelines for establishing a HPS provided the theoretical and conceptual foundation to guide the research process and interpret the findings.

A qualitative approach was used that included semi-structured interviews, a researcher’s journal and document analysis. The participants included 11 members of the school’s leadership team, three members of the board of trustees, four parents and five staff members.

Readiness for change was established in the leadership team who adopted a HPS approach. That is, they adopted a comprehensive model to address health-related priorities in the school and changed the school’s mission and accountability processes to specifically include health. A number of factors were identified as influencing this process of change, with the most critical arguably being the development of a carefully constructed and executed change message, and simultaneously using top-down and bottom-up approaches. This paper proposes some alternative strategies for establishing HPS in the international school context, including linking HPS to accountability processes, assessing local needs related to both health and educational outcomes, and building a model that represents the school’s mission. The findings also indicate that a setting-based approach is a realistic framework for creating readiness, although some challenges are discussed and some modifications are suggested.
Chapter 1: Introduction

An effective school health programme can be one of the most cost effective investments a nation can make to simultaneously improve education and health (World Health Organization [WHO] 2013a).

In the quotation above, school health is highlighted as an important avenue to address two areas that constitute a large share of public spending globally—education and health (Verhoeven, Gunnarsson & Carcillo 2007). Maximising the efficiency of the spending allocated to these large sectors continues to be a primary concern for organisations and governments throughout the world (Verhoeven, Gunnarsson & Carcillo 2007). Comprehensive, whole-school or Health Promoting School (HPS) approaches are recommended as the most effective way to implement school-based health programs. However, there have been challenges in implementing these complex approaches, which are mirrored by the challenges facing researchers examining comprehensive approaches. This research is focused on understanding the challenges related to implementing whole-school, HPS approaches and contributing evidence on how to potentially increase the uptake of such approaches.

When this case study began, the researcher’s primary concern was understanding the most effective way to approach health in the school setting, and, more specifically, how that would appear in an international school. With a background in both education and health promotion, it seemed to the researcher that there was more potential to positively influence health in the school setting than what she had observed as a teacher and administrator. Additionally, she was interested in the dual outcomes of simultaneously improving education and health, and the blend of these two key sectors. As the journey to answer these enquiries unfolded, understanding the complexity surrounding school change and leadership decisions took centre stage.

The research undertaken in this case study provides a unique view of change in schools, and how to create readiness for change in adopting a HPS approach. The setting was an international school in Thailand and the process of change spanned over a decade. The period from 2009 to 2013 represents the formal aspect of this research; however, the activities before and after this timeframe were examined to provide a more detailed account of how change was initiated and adopted. The outcome of the change
intervention was described by a senior member of the school’s leadership team as ‘a real success story’, which resulted in the school’s mission statement being altered to explicitly include health as part of the school’s core business. The case study was complex and messy, and the organic process required flexibility and patience. As the process unfolded, different theories and suggested methods to build effective health programs were examined to analyse the data and contribute to the evidence relating to school health.

Health education in schools has been given renewed focus in many countries around the world due to acknowledgement of the critical role health plays in academic performance, and of schools as potential settings to address emerging and present health problems (Verhoeven, Gunnarsson & Carcillo 2007; WHO 2013a). Fuelled by research-based evidence and collaboration between education and health departments and other government and non-government organisations, changes are occurring at multiple levels in countries such as the United States (US), the United Kingdom (UK), Canada, Singapore, Hong Kong, Taiwan, Australia and throughout Europe and Latin America. The breadth of these changes are discussed more fully in the literature review, but encompass the curriculum1, professional preparation of teachers, and organisational structures and processes in schools and local and regional education agencies. Further changes include the development of specific government policies and incentives aimed at improving schools’ health-related programs (Bruun Jensen & Simovska 2002; Department of Education 2003; Department of Health 2005; Deschesnes et al. 2010; Ippolito-Shepherd 2003; Lee, St Leger & Cheng 2007; Mikhailovich, Louise & Morrison 2007).

The Ottawa Charter for Health Promotion (WHO 1986) has had a significant effect on the theoretical framework of these changes. The multi-strategy approach for health promotion advocated in the Ottawa Charter combines knowledge and skills, health policy, supportive environments, community action and a reorientation of health services, and is in contrast to the traditional knowledge- and skills-based approaches taught in the classroom. As discussed below, the more comprehensive approach is evident in many broad-based, whole-school approaches that have emerged as a way to integrate health into the school environment. A combination of these strategies, creating

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1 The term curriculum refers to the taught curriculum.
consistent messages and supportive environments, is proposed to enhance both educational and health outcomes for all members of the school community (Australian Health Promoting School Association 1997; St Leger 2005). Such comprehensive health promotion programs in the school setting are referred to in different ways around the world—as HPS, ‘Coordinated School Health’ (CSH), a ‘Whole-School’ approach or (more recently) ‘Healthy Schools’ (Centres for Disease Control and Prevention 2011a; International Union for Health Promotion and Education [IUHPE] 2009; Queensland Government 2010; Rowling & Samdal 2011; Samdal & Rowling 2011). As advocated in the Ottawa Charter, these programs target multiple facets of a school, including the curriculum, school ethos or culture, and broader community (including the parents). For example, in a call to action, the WHO’s Global School Health Initiative emphasised its aims to ‘increase the number of schools that can truly be called “Health-Promoting Schools”’, which is defined by the WHO (2013b) as ‘a school constantly strengthening its capacity as a healthy setting for living, learning and working’. The HPS framework was chosen as the recommended framework for the school examined in this research due to the model’s endorsement by the WHO and wide use and adaptation in settings across Europe, Canada and Australasia (Bruun Jensen & Simovska 2002; Deschesnes, Trudeau & Kebe 2010; Lee, Cheng & St Leger 2005; Lee, St Leger & Cheng 2007; Queensland Government 2010).

The efforts to promote health in the school setting are significant; however, there is still a struggle to achieve wider implementation of HPS (Deschesnes, Trudeau & Kebe 2010; Samdal & Rowling 2013). This research explores a case study of a promising example of integrating health into existing structures of an international school in Thailand. The process involved the simultaneous use of top-down and bottom-up strategies characteristic of a settings-based approach (SBA), which are discussed further in Chapter 4 (Barton 2014; Dooris et al. 2007). This research followed the process of change in the early stages of adopting a HPS approach, which is referred to as the stage of ‘creating readiness for change’ (Armenakis & Harris 2009), and captured the critical factors affecting leaders’ beliefs and support for the program.

This case study research focused on analysing and interpreting the intentions and reactions of the school’s leadership and other key personnel involved in the initial planning and adoption of a HPS approach. The factors that influenced the decision were closely examined to understand more fully the conditions that support or hinder the
adoption of a HPS approach. As stated by Deschesnes, Trudeau and Kebe (2010, p. 447) ‘the formal decision to adopt an innovation represents an important stage’ and if understanding Healthy Schools’ principles and components are important in supporting Healthy Schools, then the ‘conditions rendering it possible are even more essential’.

The outcomes of this research have the capacity to add to the evidence base by finding ways to introduce the HPS concept and integrate the model into established school structures and improvement plans. Additionally, approaching the process of change from an educational perspective arguably reduced previously cited barriers, such as language disparities and misaligned goals between the education and health sectors. The change process employed throughout this research was guided by the literature on implementing a HPS approach. It aligned policies and plans to clearly articulated outcomes, and aimed to build the capacity of the school to be ready for the proposed change. The lessons learnt indicate the strategies that were successful in facilitating change and building a sustainable model for a HPS or whole-school approach, in this case.

Investigating the feasibility of the HPS approach in the international school setting was a further purpose of this study. The international school setting is unique with a culturally diverse, often transient clientele who present with particular health needs and varying access to health resources. The US National Health Education Standards (NHES) (Joint Committee on National Education Standards 2007) direct schools to develop their health curriculum in a comprehensive, whole-school model that is more effective in building a healthy community and enhancing learning. However, as aforementioned, there is a lack of evidence on how to implement a comprehensive model and close the gap between theory and practice. This research endeavours to fill part of this gap by addressing the modification, integration and uptake of HPS in an international school whose curriculum is closely aligned to the US.

In the international school environment, this research may provide an important starting point for discussions in determining whether the present practice of international schools is optimally meeting the health needs of the students and communities they serve. The results may also help other international schools address the issue of effective health education by providing a possible framework and process of
development, and by identifying and providing solutions to the aspects of the HPS model that prove most challenging.

1.1 The Research Question

The research question guiding this research was:

What are the factors influencing the adoption of a HPS approach in an international school?

The overarching proposition for this research was:

If the HPS approach can be modified to suit the school context, and the change message can be presented in a way that addresses the key beliefs suggested by Armenakis (2009) to create readiness for change, then there is greater likelihood that the leaders will adopt the change. By examining the leaders’ responses to the change message and analysing an SBA to change, the findings may assist in understanding how to engage school leaders and potentially increase the uptake of comprehensive approaches to health in schools.

This thesis is structured as follows. Chapter 1 has introduced the research and rationale. It has also positioned the research and its aims in the broader picture of HPS research. Chapter 2 places this research in context. It examines the host country and the factors influencing the setting in which this research was conducted, including the demographics and management structure of the school. It also identifies key historical events that may influence the change process.

Chapter 3 presents a rationale for the case study method that guided this research, and explores the contributing theories, ethical considerations and dual role of the researcher. It details the data chosen to answer the research questions, as well as the participants and analytical process. It explores the five specific questions that guided this case study research. This chapter also examines the complex role played by the researcher as change agent, teacher, parent and friend, as well as researcher, including the benefits and conflicts these multiple roles presented and the lessons learnt. In addition, this chapter examines the contextual factors specifically related to the process of creating readiness for a HPS approach, and identifies potential contextual benefits and barriers.
Chapter 4 focuses on understanding why a HPS approach is advocated by the WHO (2013a) and considers the evidence on how to implement this approach. This includes a historical perspective of health in schools to understand the evolution and rationale for comprehensive approaches. The guidelines for establishing HPS and SBA are discussed as ways to implement comprehensive school health approaches.

Chapter 5 reviews the literature on creating readiness for change that needed to be considered to answer the questions guiding this research. The chapter begins with a focus on organisational change theories and narrows to discuss the initial stage of creating readiness for change. This discussion examines the necessary tasks involved in creating readiness for change in relation to adopting a HPS approach. The contributing macro-level factors of content, context and process are discussed in detail, as are the key beliefs to be addressed in an effective change message.

Chapter 6 is a comprehensive description of the process of change. It describes the intervention or circumstances that unfolded to cause change, including the modifications made to the HPS approach and the final model chosen by the school. The aim of this chapter is to immerse the reader in the context and setting, and provide a detailed account of the complex and complicated process, which included top-down and bottom-up strategies.

Chapter 7 studies the factors most influential in creating readiness for change. It begins by examining the conveying strategies used to deliver the change message, and then identifying which of the key beliefs were most influential in the leadership team’s decision to adopt a HPS approach.

Chapter 8 examines the top-down and bottom-up strategies presented in Chapter 6 in light of theories for change and establishing HPS. This chapter explores the findings and discusses questions related to the feasibility of the HPS approach in the setting, as well as the degree to which the final model retained the integrity of the HPS approach. Additionally, it examines the complex process of change in the SBA presented by Dooris et al. (2007). It discusses the contribution of the ‘readiness for change’ theory to guidelines for establishing HPS and SBA, and makes suggestions for establishing HPS in the international school setting.
Chapter 9 explores the role of the change agent, including identifying attributes that may have contributed to the outcomes of the change process. Additionally, it presents the challenges and benefits of leading change internally as a teacher in a non-managerial role.

Chapter 10 reflects on the findings presented and explores possible answers to the questions that guided this case study. It examines the contributions of these findings to the theory and practice of implementing HPS, and discusses possible strategies to propel the implementation of HPS. Finally, it discusses the limitations of the research and potential avenues for further research.
Chapter 2: The International School Bubble

The international community in which the studied international school is housed is commonly referred to as a ‘bubble’. It is a gated, secure community where English is most commonly spoken, Western culture is all pervasive, and families are predominately middle class and educated; thus, the lines of living in a developing country become blurred to create the concept of a bubble. For those unfamiliar with such international communities scattered throughout the world, it might be difficult to comprehend this unique context. This chapter explores the context of this case study in depth and positions the researcher within this context.

Contextual considerations are critical in the process of creating readiness for change and, alongside content and process, form the three macro-level factors influencing change described by Armenakis and Bernerth (2007). As stated by Rowling and Jeffreys (2006, p. 707), ‘strategies for school development need to “fit” the growth state of a particular school’. Thus, there is a need to interpret global HPS principles in the context of the particular setting (Bruun Jensen & Simovska 2002; Deschesnes, Trudeau & Kebe 2010) and adapt the chosen model to fit the context of the school. The international school in this case, as well as its associated internal and external context, present a unique setting. It is necessary for change agents to understand the context well to plan for effective change, which arguably starts with creating readiness. The context not only affects the development of the model, but also affects the process employed to create readiness for change. This chapter examines the specific internal and external contextual factors that may influence the change agent’s attempt to create readiness for the change of adopting a HPS approach.

This chapter begins with examining the external contextual factors in the host country of the school, and then examines the broad context of the school, before moving to an analysis of the internal context relating to the capacity of the school to implement a HPS approach. This chapter also discusses the historical events that influenced this research and occurred before its formal start in 2009. The chapter concludes by identifying the potential supports and barriers for creating readiness in this case study. The primary school document referenced in this chapter is the Western Association of Schools and Colleges (WASC) Self Study Visiting Committee Report from November 2007.
2.1 The International School Context

The International Schools Consultancy Group (2013) identifies a school as international if:

- the school delivers a curriculum to any combination of pre-school, primary or secondary students, wholly or partly in English outside an English-speaking country,
- or if a school in a country where English is one of the official languages, offers an English-medium curriculum other than the country’s national curriculum and is international in its orientation.

While there is some debate regarding the definition of international schools (Nagrath 2011), the criteria chosen by the ISC is representative of the school in this study, and the research from ISC provided the figures referenced in this thesis. In 2013, more than three million students were educated in international schools, while, in 2015, that number rose to over four million (Keeling 2015) and is predicted to increase further in future years (Custer 2014; Dixon 2012). The number of staff employed in international schools globally in 2013 was 295,000, with the growth of staff keeping pace with the increase of students (Keeling 2013). Thus, with the potential to influence such a large and growing number of people, international schools can be viewed as important settings for health promotion. Figure 1 below highlights the distribution of international schools globally, and the high concentration in Southeast Asia.
The setting and background context of this case study was a large international school in Bangkok. The school is described on its website as ‘one of the premier international schools in the world’ and in its introductory video as the oldest international school in Thailand.

2.2 External Contextual Factors

2.2.1 Host Country

Bangkok is recognised by the United Nations (2011) as a middle-income country with a population in 2010 of 66.4 million, of which approximately 9.3 million live in and around Bangkok. Over 90% of the population are Thai-speaking Buddhists (United Nations 2011). Thailand’s governance is a constitutional monarchy with a Prime Minister as the Head of Government. There have been vast improvements in human development during recent decades, with poverty dropping from 27% in 1990 to under 10% in 2002; however, there are still disadvantaged groups who lack access to services and experience income and social inequality (United Nations 2011).
In 2010, during the second year of this research, there was a period of considerable political unrest in Bangkok, which caused disruption to normal operations in the school. As reported by the US Department of State (2011):

Between March and May, antigovernment protesters affiliated with the United Front for Democracy Against Dictatorship (UDD, or red shirts) established two separate protest sites, including the commercial center of Bangkok, while calling for the dissolution of parliament. Ensuing clashes with government security forces left 92 persons dead.

During this time, staff living near the demonstrations were moved into temporary accommodation closer to the school, while some students left Thailand early and the leadership team in the school were involved in daily monitoring and decision making concerning the safety of all in the community. The change process was stalled for approximately three months during this time of unrest.

Additionally, in October 2011 Bangkok experienced severe flooding and again the school was required to shut down for approximately one week. The research process was interrupted again for approximately 3 months from October 2011 until January 2012.

### 2.2.2 The School Site

The school is a private, non-profit, non-sectarian, co-educational school originally established in 1952 to educate the children of American Embassy and United Nations diplomats. The present campus is located approximately 20 kilometres from the city centre of Bangkok and houses three separate schools in one complex: elementary (648 students), middle (462 students) and high (708 students). The elementary school (ES) offers education for pre-kindergarten to Grade 5, middle school (MS) from Grades 6 to 8, and high school (HS) from Grades 9 to 12.

The school is housed in an expatriate housing community in which ‘about 53% of the families live within 5 kilometres of the school’ (WASC Mid-Term Progress Report 2011, p. 5), and are part of a community that has been described as being like a village by many who live there. The expansive school facilities include a venue for after-school and weekend sports and cultural activities; adult education; and large community activities, such as an International Food Fair and Thai Craft Sales. As such, the school is
the focal point for many community activities. The shops in this gated community house a supermarket, pharmacy, florist, travel agent, dry cleaner, beauty/hairdressing salon, carpet shop and food outlets. There is also a clinic that houses doctor, dentist and physiotherapist services, as well as a bank. Thus, there are regular interactions between members of the community. The school, in conjunction with the community, supports a number of Thai charities, including Operation Smile (providing reconstructive surgery for young people with cleft palate or lips), After the Wave (tsunami relief) and Habitat for Humanity (building houses and supporting communities), as well as local orphanages and schools, with the school site the venue to manage these activities.

2.2.3 Governance and Accreditation

The school is accredited by the WASC and licenced by the Thai Ministry of Education and Private Schools Commission of Thailand. The school is owned and governed by the International School Association (ISA), whose membership consists of the parents of current students. The approximately 15 members of the board of trustees (BOT) are elected volunteers from the ISA. The BOT employs the head of school (HoS) to implement the school’s vision and daily operation. The BOT meets monthly and participates in two planning retreats a year—one at the beginning and one at the end of the school year. There are subcommittees of the BOT that meet as required to discuss designated BOT goals.

The Thai Ministry of Education stipulates that the school must have Thai national citizens represented in the roles of school manager, license holder representative (the ISA is the overall license holder) and headmistress. The school must also show that their employees have the appropriate qualifications to satisfy the Thai government’s requirements for teaching and work permits. Thai students are required to learn the Thai language, and all students and staff are required to learn about Thai culture. Other curriculum decisions are at the discretion of the school.

The school receives no subsidies or other government support, and subsequently operates independently and autonomously. This autonomous nature means that the BOT can decide how to allocate funds to align with the mission and vision of the school. The three separate schools and administrators provide a complex framework to work with when initiating and implementing change.
2.2.4 External Support for Health Promotion

The school has a close relationship with two large hospitals in Bangkok that provide services to the expatriate community. Both these organisations provide ambulance and nurse support for sporting events and medical check-ups at the school for athletes. They also provide health promotion activities at special events, such as testing bone density, blood pressure, body mass index, sight and hearing. They also conduct information sessions on nutrition, women’s health and other health issues. There are no known partnerships relating to HPS. In Thailand, the Ministry of Public Health works in conjunction with the Health Promotion Foundation of Thailand to provide health promotion programs (WHO Country Office for Thailand 2010). The foundation’s mission is ‘To Spark, stimulate, support and develop health promotion process leading to good health of Thai people and society’ (Thai Health Promotion Foundation 2011). It is understood by the researcher that the international school community is not part of this vision. As such, there is no known HPS support available to the school from within Thailand. As described, there are health promotion resources and programs to access; however, no organisations were identified that provide specific HPS support. Similarly, the health needs of the school are not monitored by any external organisation.

2.2.5 International School Associations

The school has a supportive network of international schools through the organisations of the East Asia Regional Council of Schools and European Council of International Schools. It is one of six schools that form the Interscholastic Association of Southeast Asian Schools (IASAS). The other IASAS schools are located in Singapore, Taiwan, Malaysia, Indonesia and the Philippines.

2.3 Internal Contextual Factors

2.3.1 Students

ISC Research—an organisation focused on researching the International School Market throughout the world—has reported that approximately 20% of the student body in international schools are from the expatriate community (ISC 2010). In the school being researched, that percentage is significantly higher. As stated by the school, ‘our primary reason for existing is to educate expatriate students who are temporarily residing in
Thailand’ (Self Study for WASC 2007). The school has a cap of 20% for the number of Thai national students that may be enrolled in the school at any one time, and subsequently can be considered as having an 80% expatriate student population.\(^2\) This is an important consideration because this research, and the adoption of a HPS framework, is considered from the perspective of having a community comprised of a large expatriate population. The implications of this include having a high turnover of students and parents, and a pervasive influence of Western culture.

The school has an enrolment of approximately 1,800 students represented by 54 nationalities, with the students’ average tenure being three to four years. Each year, approximately 30% of the student body changes. The following table displays the enrolment by nationality. All students are day students, no boarding facilities are provided.

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Percentage of Student Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>American</td>
<td>32</td>
</tr>
<tr>
<td>Thai</td>
<td>18</td>
</tr>
<tr>
<td>Japanese</td>
<td>10</td>
</tr>
<tr>
<td>Korean</td>
<td>9</td>
</tr>
<tr>
<td>Taiwanese</td>
<td>3</td>
</tr>
<tr>
<td>Indian</td>
<td>3</td>
</tr>
<tr>
<td>Canadian</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
</tr>
</tbody>
</table>

### 2.3.2 Staff

School staff are identified as certified (faculty) or classified (secretaries, instructional assistants, buildings and grounds keepers, custodians, drivers and security guards). There are 233 certified staff members from 20 different countries (61% American, 11% Canadian, 8% European, 10% Australian and New Zealand, 4% Thai, 6% from other nationalities), of which 77% hold advanced degrees (masters and doctorates). There are 157 classified staff. Among the instructional assistants and secretaries, over 83% hold bachelor or advanced degrees.

\(^2\) The actual percentage of students residing permanently in Thailand is difficult to define because many hold dual passports and are admitted on their non-Thai passports.
2.3.3 Parents

The ‘vast majority’ of parents are described as ‘college-educated professionals’ (Self Study for WASC 2007, p. 20). The parent body work for a number of organisations, including the Centre for Disease Control (CDC), Armed Forces Research Institute of Medical Sciences, United Nations, Chevron and embassies, as doctors, solicitors and company owners. Similarly, their broadly educated travelling spouses, who are not employed, also provide a rich human resource. The WASC Report acknowledged strong parental involvement in terms of the Parent and Teacher Auxiliary (PTA), which is supported by approximately 270 parents as active volunteers. Parents are also representatives on the school board and school-wide committees, such as food service, safety and transportation (Self Study for WASC 2007). The inference made in the 2007 Self Study for WASC was that there are many avenues for parents to be involved, and that many parents take advantage of these opportunities, with the greatest involvement being in the ES.

2.3.3.1 School Leadership

Within the school structure, the HoS or superintendent is supported by a leadership team (LT) that consists of the Deputy HoS for Finance; Deputy HoS for Learning; ES, MS and HS principals and vice-principals; Director of Curriculum; pre-kindergarten to Grade 12 Learning Specialist; two Deans from the HS; Athletic Director and Information Technology (IT) Director. The team meets weekly for approximately two hours in order to plan, implement and assess the Strategic Learning Plan and other projects.

2.3.3.1.1 Decision Making and Collaboration

In the 2007 WASC Visiting Committee Report (School Document) there was some discrepancy regarding collaboration in the school. The report stated that ‘all teachers meet regularly using agendas primarily focused on collaboration and student learning’ (School Document, WASC Visiting Committee Report 2007 p.24); however, it identified a disconnect between the goals set by the LT and the interpretation of those goals by the teaching faculty. It recommended that the school ‘address the concern of

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3To maintain confidentiality the school documents are not included in the reference list. However, copies of these documents are stored along with the other data.
breadth versus depth’, and the LT was encouraged to find ways to include faculty perspective when making decisions so that their effect on daily operations would be identified. Additionally, the LT was advised to be clear in how school targets would improve student learning and move [the school] towards achieving the Vision and Guiding Principles (School Document, WASC Visiting Committee Report 2007, p. 25). As will be seen in the findings presented in Chapters 6 to 9, aligning the school improvement initiatives (and thus a HPS approach) to student learning had significant implications for the process of change in this case.

2.3.3.1.2 Communication with Parents and Staff

The school communicates with parents in multiple ways, including weekly online newsletters, emails, blogs and text messages. In addition, the ES sends a folder home each week with printed correspondence, while the PTA produces a quarterly magazine and has coordinators in each of the schools to enhance parental involvement and information dissemination. In the ES, each classroom has a parent volunteer.

Staff meetings take various forms. At a whole-school level, these mostly occur during professional development (PD) days and on an ad-hoc basis, as needed. On a monthly basis, departments or teams meet, as do separate school groups—that is, the HS, MS and ES.

2.3.3.1.3 Resources and Time

The WASC Visiting Committee Report (School Document, 2007, p. 177) stated that the school’s financial situation was positive and had sufficient resources to achieve the vision and guiding principles, as well as undertaking substantial facilities upgrade. Similarly, funds were available for PD. In this report (School Document, WASC Visiting Committee Report p. 81), the school was described as being ‘extremely committed to staff development, as evidenced by the allocation of 2.1% of the total current school budget’. The WASC review team identified an area of growth to be ensuring that these funds are used on PD that is linked to the school’s purpose and learning.

The report (School Document, WASC Visiting Committee Report 2007, p. 46) referenced the ‘serious task overload’ of teachers and a ‘lack of clear understanding by
the faculty of the school’s priorities’. Thus, in this setting, teachers have limited time and are juggling many different school priorities that they may not fully understand.

2.3.3.1.4 Health-related School Policies

The health-related BOT’s policies encompassed child abuse and neglect, safety regulations, tobacco, alcohol, narcotics and drugs, and included procedures for substance testing. Hats are required in the ES for outside play, and helmets are required for all riders of bicycles and motor scooters, which are commonly used by HS students.

In 2008, the school required for graduation a 2.5 credit of physical education (PE)/health in the HS. The HS health requirement was one semester of health, which equalled approximately 49 hours of instruction. In the MS, the health requirement was a quarter semester class in Grades 6 to 8, which equalled approximately 30 hours of instruction per year. In the 2009/10 school year, the Grade 6 health curriculum was embedded in PE for a trial period, and no extra instructional time was given for this process. The HS program was the only one that provided the recommended annual hours of instruction—of between 45 to 60 hours (see Chapter 4 for more information).

The HPS model requires a collaborative process that builds a shared vision and motivates others to work towards achieving the shared goals (Clarke, O’Sullivan & Barry 2010; Tjomsland et al. 2009). The HS student council comprises four offices elected from each grade level. The function of the school council is described as working ‘on student-sponsored events, fund raising, encouraging school spirit and student life in general’ (School Document, WASC Visiting Committee Report 2007).

2.3.3.1.5 Accountability of School’s LT

The 2007 WASC Visiting Committee Report (School Document, p. 6) summarised the accountability process for the school’s LT as follows:

All Administrators, from the Head of School down, have annual measurable student learning goals. Progress is reported to the Board at the end of the year according to the gains in student learning and accomplishment of action steps linked to the vision.

As can be seen, student learning goals are the criteria for assessing all administrators, and gains in student learning are reported to the BOT. Additionally, the vision and
Strategic Learning Plan, which identify the action steps for achieving the school’s vision, were identified as key areas of accountability. These observations proved critical in achieving readiness.

### 2.3.4 School Curriculum and Calendar

The school’s curriculum is guided by internally written benchmarks and standards informed primarily from North America and the International Baccalaureate Program. In the High School both the US High School Diploma and International Baccalaureate Program are offered, over 40% of the senior class of 2011 chose the International Baccalaureate.

The school year runs from August to June, with two semesters broken by a three-week break in December/January and an approximate eight-week break from early June to early August. The school day starts at 7.00 am for teachers and the first class is 7.20 am for students. This allows students to travel before peak hour in Bangkok. The school day finishes at 2.05 pm for students and 3.00 pm for staff, again allowing travel prior to the evening peak traffic.

### 2.3.5 Cynicism to Change

The school had previously experienced change by introducing new assessment and curriculum processes, with some cynicism developing among staff. The number of initiatives in the past had affected some members of staff in a negative way; thus, there was a degree of cynicism regarding new initiatives and frustration at a lack of collaboration. At the time of the WASC Visiting Committee Report, the researcher was working across departments and had heard staff across the HS expressing relief that the issue of the breadth versus depth of initiatives had been included in the recommendations (Researcher’s Journal, 16 February 2009). This highlighted that a new initiative being introduced at this time could be seen as opposing this recommendation, and cynicism could be a potential barrier to creating readiness.

However, it could be argued that this awareness highlighted the need for effective collaboration so that staff felt they could identify the effect of a HPS approach on daily operations during planning. It also indicated to the researcher that a whole-school approach could potentially be favourably viewed by the LT, as this approach facilitates
collaboration and shared ownership (Clarke, O’Sullivan & Barry 2010). The change agent wished to minimise the effect on teaching staff and avoid the change being perceived as just being about the research, rather than being sustainable change to benefit everyone in the community (Researcher’s Journal, 16 February 2009).

2.4 Timeline of Prior Health-related Activities

The process of introducing the HPS concept and initiating change may have been influenced by a number of specific health-related activities in the school that occurred prior to the formal start of this research (Deschesnes, Trudeau & Kebe 2010). In chronological order, the most significant of these factors will be discussed as follows: the Substance Testing Program, Substance Abuse Prevention Committee (SAPC), Freedom from Chemical Dependency (FCD) program, Wellness Survey Committee, health curriculum review, a survey of the LT and BOT, attendance at a HPS conference and a survey completed by the school psychologists:

1. Substance Testing Program: The school is a tobacco-, alcohol- and drug-free campus. The students in the MS and HS are subjected to random and ad-hoc drug testing using either hair analysis, breath analysis or urinalysis. The aims of the drug-testing program are to identify and provide support to any students who may be using substances found through testing. It also acts as a deterrent and provides an excuse for students to refuse the substances for which they are tested. The program was in place in 1997 when the researcher began work at the school, and had been in place at the school for many years (although the date it began was not found).

2. SAPC: To provide a more holistic view of substance use in the late 1990s, a SAPC was established that included staff, student and parent representatives. The committee ceased meeting in 2012, and the researcher believes that frequent turnover of members and a lack of HPS program supporting the committee meant that the committee had limited output other than discussing substance-related issues. The committee meetings typically occurred once a semester and coincided with the FCD programs run each semester. As an original member of the committee, the researcher presented the concept of a multifaceted approach to health promotion back in the late 1990s; however, no specific action or changes flowed from sharing this multifaceted approach. Thus, the concept of a
3. FCD is an American-based non-profit organisation with the aim of supporting schools to develop a climate that builds effective knowledge and skills for students to be drug free. FCD visits the school twice a year to talk with students in the MS and HS and provide information sessions to parents. The engagement of FCD represents a considerable investment by the school in a health promotion program.

In 2006, FCD approached members of the LT and suggested using an FCD survey to assess substance use behaviours in the school. Leading on from these discussions, the decision was made (by members of the LT on the committee and the chair of the curriculum review) to conduct an internal Student Wellness Survey that addressed a wide range of health-related issues. The behavioural data being collected were deemed relevant for the SAPC, the health curriculum and other health-related activities in the school.

4. Wellness Survey Committee: The Wellness Survey Committee was formed in August 2007 with representatives from the SAPC and other parents invited from the community. The researcher was the only staff member on the committee when it was first formed. The committee was tasked with developing, implementing and reporting on the surveys conducted over the two years that followed. Some part-time hours were funded for data analysis and preparation of tables to display the data. The first survey was administered to senior students in June 2008, and to Grades 9 and 10 during the 2008/09 school year. The data from the survey proved to be an important aspect of the change message. As such, the rationale and reports are included in Appendices 1, 2 and 3, which may assist other international schools considering undertaking a similar student survey.

5. Health curriculum review: The formal start of the health curriculum review was also in August 2007, even though some research had begun the previous semester. The recommendations stemming from the review were presented to the LT in April 2008 and the BOT in May 2008. These recommendations included embedding the curriculum in a comprehensive HPS approach. As such, this was how the HPS concept was introduced to the school at the start of the change process. The health curriculum and review process was such an
important opportunity to introduce a HPS approach that it is discussed in more
detail below. The formal output of the review was a set of Pre K-12 Health
Standards for the school, with the aim of articulating formal learning conducted
in classrooms throughout the school. The standards were adopted in June 2009
and were based on the US NHES, with modifications made after reviewing
standards in other countries. The data from the Student Wellness Survey helped
define priority areas addressed in the curriculum content.

6. Leadership and BOT Survey: An informal survey was administered to the LT in
April 2008 and to the BOT a month later, and was designed to gauge general
support for health education and awareness of HPS—see Appendix 4. Responses
were given on a four-point scale rated from ‘agree strongly’ to ‘disagree
strongly’. Eleven responses were collected from the LT (one member was
retiring and did not reply, and two others were not available at the time). All
responding members of the LT strongly agreed that health education should be
provided in the school—73% (eight) strongly agreed that health education
affects academic performance, while the remaining 27% (three) marked one
lower on the four-point scale. In regard to staff health needs, 64% (seven)
strongly agreed the school has a role to play in addressing staff health needs
(beyond providing health insurance), while 18% (two) disagreed. There was
some awareness of HPS in the LT—54% had heard about HPS, 18% had heard a
little or not much about HPS, and 28% had not heard of HPS.

7. Five responses were received from the board members. While this number was
not statistically valid, some interesting observations were made. Four of the
respondents strongly agreed that health education should be provided by the
school. One respondent marked three on the four-point scale and asked: ‘What is
health education. Is it more than PE?’. Four of the respondents had not heard of
HPS and one was unsure. The results indicated the need to educate the LT about
the HPS approach and the connection between health and academic
performance, as well as the need to further educate the BOT on HPS and health
education.

8. HPS conference: The concept of HPS was first introduced to the LT in the
2007/08 school year, and the HoS showed initial interest and support for the
concept by funding three members of staff to attend the Australian Health
Promoting Schools Association’s National Conference in April 2008. The
researcher, Athletics Director and a HS PE teacher, who later became the HS head of department, were the three representatives. This was a significant early show of support and helped establish a broad base of knowledge from various levels across the school.

9. Breakfast survey: In August 2008, two school psychologists conducted a Pre K-12 breakfast survey. This survey was initiated due to concern voiced by teachers and other members of the school community about the number of students who did not eat breakfast because of early mornings and long commutes to school. The aim of the breakfast survey was to determine the incidence of school-wide breakfast skipping, and make recommendations about the next steps to increase the number of students eating breakfast before school. The results from the breakfast survey were as follows:

- School wide, 17% of students did not eat breakfast on the day they were surveyed.
- In the ES, 9% had not eaten breakfast.
- In the MS, 16% had not eaten breakfast.
- In the HS, 26% had not eaten breakfast.

![Figure 2: Timeline of Events Prior to the Research](image)

As can be seen from Figure 2 above, a number of events had occurred in the 18 months prior to the research, and the change agent was involved in all except one of these (the breakfast survey). In addition to the activities outlined above, the school had made
previous investments in health promotion activity through visiting consultants—
primarily in the mental health field. Visiting psychologists and specialists in child
development were paid to present information sessions to staff and parents on topics
such as eating disorders and attention deficit disorders. Michael Thompson, a child
psychologist, had been a guest to the school more than once, discussing a range of
topics related to the emotional wellbeing of students, parents and teachers.

2.5 The Multiple Roles of the Researcher

The researcher was a teacher and a parent of two ES students, with more than 10 years
association with the school at the time of the research. The researcher was employed as
a part-time and full-time HS health teacher and wellness coordinator during the
research, and other responsibilities in the school had previously included department
head, chair of health curriculum review and teaching in the HS science department. The
researcher’s experience across departments in a collegial capacity and across the school
as a parent and friend to other teachers and parents resulted in a close connection to the
school community. As will be discussed in detail in Chapter 3 it was necessary for the
researcher to employ strategies that enabled her to maintain objectivity with the
research whilst continuing in the other roles outlined above.

Prior to a return to teaching and employment in the school, the researcher had worked
for several years in health promotion at the New South Wales Health Department and at
Sydney University in workplace health programs. The combined experience of the
researcher working in health promotion in the community, workplace and school is
unusual in the school setting, and provided the researcher with a broader perspective
and appreciation of the language disparities and the process of aligning the health
agenda with the educational agenda. During the return to the school setting, the
researcher noted the possibilities for more effective health programs due to her
experience with health promotion in other settings. The health curriculum review
process, which the researcher chaired, provided the opportunity to introduce the HPS
concept and begin the process of change.
2.6 Health Curriculum in the School

The school curriculum is written and reviewed internally. Thus, curriculum development is primarily autonomous and the responsibility of the Curriculum Department in the school. The school’s mission states that the school is ‘an international school with a North American educational philosophy and curriculum broadened and enriched with Best Practices from other nations’ (School Document 2007). Identifying and implementing necessary changes to the curriculum was already an important part of the school’s regular practice. The health curriculum review played an important role in introducing a HPS approach; thus, it is worth exploring this process briefly.

The first stage of the health curriculum review involved reviewing the literature, with the aim of defining a best practice model for health education, and, more specifically, how this would appear in the international school setting. A number of key documents emerged, including the revised US NHES (Joint Committee on National Education Standards 2007) and Health Framework for California Public Schools (Department of Education 2003). Both these documents provide a thorough account of what is considered best practice in North America, and draw on the expertise of a broad cross-section of experts and industry representatives, primarily from universities and education departments. Other curriculum documents from the UK and Australia also informed the process, including the Personal Development, Health and Physical Education Syllabus from New South Wales, Australia (New South Wales Department of Education and Training 2003, 2007).

The NHES are described in their introduction as a framework of the knowledge and skills that students should have. However, how to achieve these is not articulated. As national standards, they are designed to be a guide and framework, and it is the states’ responsibility to define their localised priorities and make schools accountable to the standards they specify. The NHES and Health Framework for Californian Public Schools (HFCPS) both recognise a number of changes to the traditional approaches of health education, and identify the need for the classroom-based health curriculum to be one component of a much larger coordinated and comprehensive approach to health in schools.
2.6.1 Introducing the HPS Approach

The health review provided a high-profile (the findings were presented to the LT, the BOT and staff groups), internally-driven opportunity to introduce the HPS approach. By the conclusion of the review year, in June 2008, a total of four presentations were given to the LT, BOT, counsellors and PE/health teachers. Several meetings were held with teaching staff in the PE and health departments throughout the year. An external consultant was present at some of these meetings and at the teacher presentation. The consultant became an external source of information and offered support to the change process by reinforcing the importance of health and PE with members of the LT—particularly those in senior positions.

All four presentations covered the process of the review, introduced a comprehensive approach as best practice, and summarised the literature review, with an emphasis on the link between health and learning and the recommended hours and delivery of effective health education. The Australian and US comprehensive models were also shared (see Chapter 4 for diagrams of the models). The LT and BOT presentations included extra slides with further rationale for adopting a HPS approach. The recommendations presented to the LT and BOT included the need to:

1. adopt a HPS model
2. implement health indicators (standards) across the curriculum
3. provide staff training in a HPS approach
4. use the Wellness Survey as a tool to establish and monitor health needs and inform curriculum.

The health review sought to engage a moral purpose or obligation by using a quotation from the European Union of Health Promoting Schools (WHO 2000): ‘Every child should now have the right to benefit from the health promoting school initiative’. By the formal start of this research in February 2009, the HPS concept had been introduced, a mechanism (student survey) to identify health priorities had been trialled in the HS, and the process of building awareness and capacity for health promotion among staff had begun. Similarly, parent volunteers with health promotion experience had been identified and positive relationships between the change agent and key stakeholder were being established. Additionally, the HoS had shown support for the concept by
supporting three staff members to learn more about the approach. There was support for health education in the LT and some awareness of HPS, although this was less evident in the BOT. There had been a number of health promotion activities previously run by the school, with other staff, including the psychologists, being involved in these.

The time made available for health in the curriculum was insufficient, especially in the MS and ES. The school was already managing a number of priorities, which were reportedly overloading the staff, while some staff reported that they felt uninvolved in decision-making processes. The country’s political unrest and natural disasters, such as the 2011 floods, had the potential to create further disruptions, although this did not occur.

This chapter has set the scene for the start of this research. The next chapter examines the methodology used to analyse the change process, and the responses of the key stakeholders. It is acknowledged that a review of the contributing literature and identified gaps that this research will address would typically follow as Chapter 3, as this importantly drives the methodology and research design. However, the project was a messy one, and didn’t follow traditional, linear structures. At times the lines were blurred in what constituted the research, the researcher and the contextual process prior to examining the school’s readiness for change to implement a HPS approach. Including the methodology early on helps to delineate this more clearly so the reader had a sense of the scope of the research. In addition, there are two extensive bodies of literature, HPS as well as the literature relating to organisational and school change and these are examined in Chapters 4 and 5. It was deemed beneficial for these two chapters to be read consecutively and in light of how they will used to illuminate the questions guiding this research. Thus, it was seen as important for the methodology chapter to be presented prior to the literature review in this thesis.
Chapter 3: Methodology

3.1 Introduction

This research was a single case study of health in an international school, focused on creating readiness for change and examining the influential factors in the decision to adopt a HPS framework. A case study methodology was used because it was the most appropriate methodology to capture the experiences, views and values of the participants involved in the research. It provides an approach in which the researcher examines in depth the complexities of the case. It is a ‘study of the particularity and complexity of a single case, coming to understand its activity within important circumstances’ (Stake 1995, p. i)—in this case, an international school in the process of change.

The theory for creating readiness for change, alongside the guidelines for establishing HPS and whole-system change, guided the research enquiry (Armenakis & Harris 2009; Dooris et al. 2007; IUHPE 2009). The school’s LT is responsible for the strategic direction of the school; thus, they were the main participants in this research. However, understanding the perspectives of key staff and parents involved in the change process was also important to examine the whole-system approach to change that occurred in this school. The researcher was another key participant in the research, acting as the main change agent. Interviews, document analysis, the researcher’s journal and questionnaires were the data collection methods used to answer the key questions, which are presented below.

3.2 Research Design

Yin (2003) presented a number of important factors in conducting rigorous case studies. In the design phase, these factors include the study’s questions, propositions and units of analysis; the logic linking the data to the propositions; and the criteria for interpreting the results. The research question guiding this study was:

What are the factors influencing the adoption of a HPS approach in an international school?
The overarching proposition for this research was:

By examining specific components of a change message—alongside content, context and process—the factors that engage school leaders and create readiness in a school (to adopt a HPS approach) will be identified.

To make the research focused and effective, the overall research question needs to be operationalised (Cohen, Manion & Morrison 2007, p. 81). The following are four specific, concrete questions that operationalised the research question and indicated which data were necessary and which types of instruments were suitable. These operational questions aimed at answering the central question of what factors influence the adoption of a HPS approach include:

1. Can the HPS framework be modified to the international school setting and retain the integrity of the approach?
2. How was a HPS approach introduced and integrated into the existing school structures?
3. Using Readiness for Change theory, how did discrepancy, appropriateness, efficacy, principal support and valence influence the leaders’ decision?
4. What contribution can readiness for change theory make to increasing the uptake of HPS?

Research may take the form of a scientific, positivist approach where variables are closely controlled and established theories or hypothesis are tested to understand cause and effect (Lincoln 1985, Golafshani 2003, Cohen, Manion et al. 2007). This type of research, which quantifies the relationship between the variables, is also referred to as Quantitative Research (Frost 2006, Cohen, Manion et al. 2007). Alternatively research can take a naturalistic, qualitative or interpretive approach, which aims to build theories and discover relationships rather than control and test them. This research was focused on the latter and employed qualitative methodologies.

Central to qualitative research is the belief that it is through experience that people actively construct meaning, and that there are multiple interpretations of events; thus, qualitative research needs to be viewed from the perspective of the participants. Also central to qualitative approaches is the acknowledgment that the setting or context is in a constant state of flux, and that the social world should be researched in this natural,
evolving state (Cohen, Manion & Morrison 2007; Lapan, Quartaroli & Riemer 2012; Patton 1990). Thus, to understand the process of change that evolved in the school setting and the participants’ perspectives as they responded to the change message, this study required a qualitative methodology that could accommodate the fluid setting and varied perspectives.

To allow for the constantly interacting relationships and processes that occur in living systems (Senge et al. 2007) and represent the reality of the school environment, it was expected that the plan for change (to adopt a HPS model) would not be rigid, but would evolve with the organisation as a result of the interactions occurring in it. This is consistent in qualitative or naturalistic enquiry, where ‘situations are fluid and changing rather than fixed and static; events and behaviour evolve over time and are richly affected by context’ (Cohen, Manion & Morrison 2007, p. 20; Lincoln and Guba 1985). Thus, keeping the data collection open to possible influencing factors that were not specifically planned was considered important to fully understand the factors influencing the change process. A case study design allowed for the uncertain influence of context to be examined, and provided ‘sufficient flexibility to cope with this uncertainty’ between the context and the phenomenon being studied (McBride & Midford 1999, p. 1211). Luyten, Visscher and Witziers (2005, p. 265) identified the value of qualitative research as an important tool to capture the ‘complex realities of education’, and subsequently avoid the potential to ‘oversimplify’ the research process. The detailed, small-scale and focused qualitative research represented by this case study was designed to capture the organic, real process of change. However, in doing so, many challenges were encountered during the research process of identifying and capturing data, and later in organising the data and structure of the thesis. The reciprocity and web-like interaction between facets of the research made it difficult to separate the data, findings and discussion into judicious sections.

As a researcher with a background in quantitative research, there were some struggles in reconciling the differences between qualitative and quantitative research. These struggles were particularly related to the validity and reliability of data in qualitative research. While initially planning the methodology, there were unnecessary and potentially limiting attempts to manage issues of validity through methods such as triangulating data, which involves generating different types of data on the same issue (Patton 2002), and identifying limited variables. Over time, these perspectives were
replaced by understanding how all the data collected would contribute to developing a rich explanation of the case.

Due to the complex nature implementing HPS, and the critical influence of context, case study and active research methodologies are commonly used in HPS research (Ollis, Harrison and Richardson, 2012, McIsaac et al. 2015). Action Research is a reflective practice that allows practitioners to evaluate their work and make modifications and improvements based on their findings (Mc Niff, 2002). Action Research methodology was thus a possible option for the researcher’s role as change agent. However, other aspects of the case study such as the decision to adopt a HPS approach and the system wide level of change did not lend itself as easily to Action Research as the participants were not reflecting on the data and setting new directions. Therefore, case study was chosen as the preferred methodology as it was able to address all questions in this research.

3.2.1 Case Study

A case study is the preferred methodology when there are more variables than points of data collection (Scott & Morrison 2007; Yin 1999) and when ‘a how or why question is being asked about a contemporary set of events over which the investigator has little or no control’ (Yin 2003, p. 9). When the researcher is acting as the change agent, there are aspects of the change message over which the researcher has some ‘control’—primarily in regard to the process of change. However, in regard to the other influencing factors of context and content, and ultimately the leaders’ decisions, the researcher has little or no control. Of the many advantages of case studies described by Lincoln and Guba (1985), the one central to this research was the ability of case studies to fully examine the context in which the phenomenon is occurring, as illustrated in the following statement:

The case study provides a grounded assessment of context. If phenomena not only take their meaning from but actually depend on their existence on their contexts, it is essential that the reader receive an adequate grasp of what that context is like. The case study represents an unparalleled means for communicating contextual information that is grounded in the particular setting that was studied (Lincoln and Guba 1985, p. 360).
In other words, using case study methodology allows for a detailed examination and description of the context in which the change agent is aiming to create readiness for change. It enables the reader to more fully understand the factors that contributed to the outcome.

Case studies can represent different analytical approaches, which are often related to three broad purposes (Bassey 2003; Gall, Gall & Borg 2003; Lincoln and Guba 1985). They can describe and chronicle events and experiences on a factual level; add explanation on an interpretive level; or be used to evaluate programs, systems and events (Bassey 2003; Lincoln and Guba 1985; Moore, Lapan & Quartaroli 2012). Lincoln and Guba (1985) described how each of these analytical approaches builds on the previous, and, as such, suggested that the first level is to describe and chronicle events. Bassey (2003, p. 117) referred to this as ‘story-telling and picture drawing’, while Gall, Gall and Borg (2003, p. 439) defined it as ‘Description’. The descriptive aspect of a case study provides ‘statements that re-create a situation and as much of its context as possible accompanied by the meanings and intentions inherent in the situations being described’ (Gall, Gall & Borg 2003, p. 439). This detailed record of the studied phenomena is often referred to as the ‘thick’ description (Gall, Gall & Borg 2003; Yin 2003). It allows the reader to be immersed in the context and the researcher to seek constructs and themes relevant to the research. Patton (2002, p. 438) identified description as the ‘bedrock of all qualitative reporting’. Bassey (2003 p. 117) referred to the next interpretive level in case study analysis as ‘theory-seeking and theory-testing’, while Gall, Gall and Borg (2003) referred to it as ‘explanation’. During this type of case study, patterns are identified and explored in analytical frameworks (Bassey 2003; Patton 2002). The final level of case study is more commonly referred to as ‘evaluation’ (Bassey 2003; Gall, Gall & Borg 2003; Lincoln and Guba 1985) and involves making judgements on the studied phenomena.

The case study undertaken in this research could be considered:

- explanatory or interpretive in regard to the reasons for supporting or not supporting the HPS model
- descriptive in regard to the processes involved in adapting the model and integrating the approach into existing structures
Thus, the methodology used included (i) recreating the events in a thick description, (ii) building constructs and themes from this description, (iii) moving to an interpretive level to identify patterns and develop possible explanations for the data collected, and (iv) making judgements about the integrity of the final model. These units of analysis identified in the design then guided the appropriate sampling and data collection, which are discussed below (Patton 2002).

3.2.2 Scope of the Research

Case studies are bound by time and activity—in this case, examining a process of change—and data are collected over an extended period (Creswell 2003; Stake 1995). While this research formally began in February 2009, certain events (described in Chapter 2) influenced the change process and were important to consider. The end of the research is defined as the point of the final plan for change—or the decision to adopt a comprehensive HPS approach. As the change process unfolded, this end point was determined to be the change to the school’s mission and vision to specifically include health. This occurred in February 2012, when the BOT ratified the proposed change to the school mission. However, as the school integrated health into the existing structures in 2013, useful data emerged that were relevant to this study and have also been included. In October 2011, Bangkok experienced severe flooding and the school was required to close for approximately one week. The researcher left Bangkok for one week and a number of staff and students were affected either through their housing or capacity to commute. Flooding in some areas persisted through to mid-January 2012 and again the research process was stalled, as the welfare of members of the community became a priority for the LT and community in general.

Fullan (1991) argued that institutional reform can take in excess of five years, while others have observed that, when seeking to find ways to improve education, ‘actual long-term studies remain scarce’ in the school setting (Luyten, Visscher & Witziers 2005). The time span of this research was in excess of the five years that Fullan described, and this research subsequently seeks to contribute to longitudinal research in the school setting.
3.2.3 Audiences for the Research

There are two audiences for this research, defined by the key sectors involved in HPS: the educational sector and health sector. The research was conducted through an educational lens, with the intention of providing new knowledge to gain a deeper understanding of how HPS can be integrated into the existing structure of schools. While the thesis was written with the health sector audience in mind, it will also be accessible to leaders of schools to help them explore the central role health plays in achieving their key educational goals. This study’s contribution to the body of knowledge in the health promotion field relates to understanding stakeholders’ perspectives in HPS approaches, and what engages these stakeholders. Additionally, it details a process for creating readiness for change in a unique international school context. In the educational field, this research examines the process of embedding health in the strategic planning and accountability process, and explores how and why administrators give priority and focus to health-related issues.

3.2.4 Sampling

This case study employed a homogeneous sampling technique, which enabled the chosen subgroups to be studied in depth (Patton 2002). This purposeful sampling strategy ‘focuses on selecting information-rich cases whose study will illuminate the questions under study’ (Patton 2002, p. 230). The explanatory and descriptive purpose of this case study necessitated different types of data and different people’s perspectives to fully understand the phenomena being examined. This section discusses the people approached to participate in this research in order to observe the influential factors in the decision to adopt a HPS approach, and examine the process of change.

3.2.4.1 Participants Examining the Factors Influencing Change and the Integrity of the Model

The interpretive component of this research focused on the decision made—primarily by the school’s LT—to adopt a comprehensive approach to health. Members of the school’s LT were the key research participants, as the LT is responsible for making recommendations for any changes to the school’s mission or strategic plan. In this study, the LT included the 12 school administrators, who were classified as senior, middle or lower level administrators in order to maintain anonymity. The senior level
represented the administrators, such as the HoS and deputy HoS, who were most accountable to the BOT. The middle level included the three school principals and curriculum director. The lower level included the deputy principals and other curriculum and technology administrators. Of the 12 administrators, 11 agreed to participate. One of the senior administrators chose not to be involved in the research. This person’s role did not have an educative focus and thus was not as critical in determining the educative directions of the school. However, this person did have a great deal of influence over financial decisions and, as an insider, the researcher was aware of the potential barrier to change that they could be (Researcher’s Journal, 16 February 2009). Approval was granted from the superintendent for certain documents (outlined below) to be accessed and for staff to be invited to participate.

The sampling related to the LT’s decision could be considered homogenous, as the population to be targeted shared the same characteristic of being in leadership positions in the school. Due to the small population size, the sampling was a census model, in which all members of the population were invited to participate. Members of the school’s BOT were also asked to provide feedback via a questionnaire after the February 2012 board meeting in order to reflect on the reasons for and tensions surrounding the adoption of the comprehensive approach. Of the 15 members of the BOT, 11 were present at this meeting and three returned the completed questionnaire and informed consent that were handed out at the conclusion of the presentation.

The evaluative component of this research involved a judgement made by the LT regarding the degree to which the final model retained the integrity of the HPS approach. As will be discussed in Chapter 4, it is important that the integrity of a HPS approach is maintained while being modified to a specific context, so that it retains the components that are central to its success. This evaluative component involved the LT assessing the school’s model against criteria outlined in the Protocols and Guidelines for Health Promoting Schools (St Leger 2005), as discussed further in Section 3.3 below.

3.2.4.2 Participants Examining the Process of Change

The research was guided by the theory for creating readiness, the HPS guidelines developed by the IUHPE, and a whole-system approach or SBA involving stakeholders
throughout the community. Hearing the perspectives of others involved in the change process was important to describe and examine how the change process was experienced. The LT, staff and parents were the stakeholders that participated in this aspect of the research. While students were identified as key stakeholders, they were not interviewed directly. This may be representative of the management culture of the school, in which students are not directly involved in strategic planning or management, and thus were not seen as being able to illuminate the questions under study. An additional concern was the dual role of teacher and researcher, and the associated ethical implications and potential for bias. The researcher as change agent also contributed to the data examining the process of change.

This aspect of the research also included a sample of 11 from the LT. The staff and parent participants were from the Staff and Parent Wellness Committees. The numbers of people attending committee meetings at any time varied from approximately six to 10 members for the Staff Committee, and four to seven members for the parent committee. The sample size from both these groups for the research was small—five staff members and four parents. However, these were the only participants approached, and all agreed to participate. The small number was representative of the few key stakeholders, apart from the LT, who were able to reflect on the process of change over the sustained period.

The staff and community turnover of approximately 30% each year influenced involvement, as did the busy schedules of staff and their inability to be involved in regular meetings over an extended period. The participating staff members included one from the ES, one from the MS and three from the HS. All three HS representatives were from different departments and had different focuses regarding school health—one was from counselling, one was from PE/health, and one had an interest in staff health. The MS representative had also been regularly involved in the parent committees and Student Wellness Survey in the MS. Of the parent participants, two had been involved in health-related programs dating back to the SAPC and three were involved in the Wellness Survey. The remaining parent representative was regularly involved in the activities implemented by the parent committee, and attended meetings with the LT and school nurses in regard to health promotion and nursing practice. As such, they had been closely involved in the change process.
Participation was optional and coded for privacy. The study followed the pre-approved ethical process of signed, informed consent. The data collection methods and sampling used for each of the five operational questions are summarised in the discussion and tables below.

3.3 Data Collection

Patton (1990) described three types of data collection in qualitative research: in-depth interviews, observations and written documents, with the data typically coming from working in the field. This field-based research used all these methods, with observations recorded in the researcher’s journal from February 2009 to June 2013. While quantitative methods were also employed by using numeric scales in the questionnaires, the sample size was too small to be quantifiable.

3.3.1 Interviews

Two separate interviews were conducted with each member of the LT at the conclusion of the final decision to change the school’s mission to specifically include health promotion. The researcher conducted the first of these interviews. To reduce the potential challenges that can exist for an insider researcher collecting data, a research assistant conducted the second interview. These interviews were conducted in 2012 over a period of approximately six weeks and the time between the two interviews was dependent on the LT member’s availability and thus varied. A semi-structured interview format was used for both interviews as a way of collecting comprehensive, comparable data from participants (Patton 2002) and these were not modified for senior, middle or lower level LT members. As Stuckey (2013) maintained, this format also allowed issues to emerge as the interviewee explored different thoughts and paths, and ensured consistency. The interviews conducted by the researcher focused on the five key beliefs addressed in the change message, and lasted between 16 and 40 minutes, with 27 minutes being the overall average. The research assistant focused on the role of the change agent, who was also the main researcher. These interviews lasted between 13 and 23 minutes, with the average being 17 minutes. The interview questions were piloted on a teacher who had participated in both the staff and parent committees and conducted the MS survey, and thus had a broad understanding of the process (see Appendices 5 and 6 for the outline of the interview questions).
Staff and committee members were given the option to be interviewed or complete a written response at the conclusion of the process of change in 2013. These interviews were also semi-structured and provided data on their experience of the change process. Two parents chose to complete their questions in written form and returned them via email, and the other two were interviewed and their responses were recorded on paper. The recorded responses were returned to the participants for checking—a process called ‘member checking’ (Lincoln and Guba 1985). Three staff were interviewed and recorded in the same way as the parent interviews, and two staff chose to return their responses via email (see Appendices 7 and 8 for the staff and parent questions).

3.3.2 Document Analysis

This study analysed the school’s mission, vision and strategic plan; Student Wellness Survey and results; Staff Wellness Survey and results; annual surveys conducted by the HoS with the students, parents and teachers; and minutes of meetings and content of presentations discussing the proposed change. These documents contributed to the detailed description of the process of change, and were records of key messages relayed to the LT, as well as records of the adaptation of the HPS model over time. There were over 23 PowerPoint presentations and two Prezi presentations that contributed to the document analysis and multiple drafts of the documents, which totalled in excess of 70.

3.3.3 Researcher’s Journal

A researcher’s journal was kept throughout the four years of the research process, recording ideas, thoughts, feelings, observations and interactions, as well as identifying possible biases that may have influenced the data collection process. The journal, of approximately 9,000 words in length, also mapped internal struggles and issues that needed to be resolved to facilitate the adoption of a HPS approach, and captured responses and conversations that were not recorded in other ways. Drake (2010, p. 85) recommended the use of ‘diaries and external perspectives to stimulate reflexivity whenever possible’. These diaries or journals documented the researcher’s position throughout the research process (Workman 2007). They also highlighted aspects of the process of acting as a researcher to collect data from those in a senior position. It was sometimes cumbersome to record all necessary details in the journal, and two diaries that served as the initial journal were abandoned for a digital format. A template was
used and recorded the researcher’s reflections, date, individuals involved, a description of the activity or event and if it involved top-down or bottom-up stakeholders. Upon reflection, having an audio device available at all times would have allowed for more informal interactions to be routinely recorded, and may have revealed values or beliefs that were not evident in the delayed, written format.

3.3.4 Questionnaires

Two questionnaires were used with the LT in this research: the Organizational Change Recipients’ Beliefs Scale and a HPS checklist. The Organizational Change Recipients’ Beliefs Scale measures key beliefs and was administered to the LT on two occasions (see Appendix 9). The first occasion was following the initial presentation of the model to the LT in 2009, and the second was after the LT presentation in 2012. The averages of the items on the scale were compared to seek differences in key beliefs early and later in the process of change.

The scale was initially chosen to provide formative feedback to the change agent regarding the key beliefs established early in the process of change, and to later enable triangulation between the data collected from the interviews and documents relating to the key beliefs. However, as already discussed in section 3.2 above, this attempt to quantify aspects of the research was unnecessary and the small sample size did not generate significant differences. The survey did represent a significant aspect of the early preparation of the research and, by examining the limitations in this case, the survey could potentially be successfully employed in subsequent HPS research. Thus, the use of the survey will be discussed here and the results from the survey will be presented in Chapter 7. Although not quantifiable, these results provided insight regarding which of the key beliefs were shared or questioned by the LT.

The survey was developed from scales proposed by Holt et al. (2007) and Armenakis et al. (2007). In reviewing these scales, the Organizational Change Recipients’ Beliefs Scale developed by Armenakis et al., which included a scale on discrepancy, was deemed more appropriate for the initial decision-making phase in creating readiness. The scale is presented as a psychometrically sound measurement tool that can be ‘administered to employees during any of the three stages of organizational change’ (Armenakis et al. 2007, p. 500). The feedback gained from the scale highlights which
aspects of the message are most supported and which areas may need modification to gain support. The feedback may also direct questions during the interview process, and thereby provide specific information on which factors lead to support and which areas need further consideration.

In summary, an appropriate instrument for the purposes of this research needed to satisfy the following conditions: be psychometrically sound, be incorporated as part of an ongoing process, be able to be implemented prior to the decision to adopt the change, provide specific feedback about the recipients’ support of the change message, and indicate individual responses to the proposed change. The Organizational Change Recipients’ Beliefs Scale satisfied these requirements and was adapted to the educational setting and proposed change. However, following the analysis of the LT’s first responses, the data were not definitive enough to guide the next phase. As will be shown in Chapter 7, a number of factors may have influenced this, and trialling the scale first in a pilot study would represent a better methodological approach (Yin 2011). Given the dynamic nature of the change process and the tight timeframe leading up to the first LT presentation, there was no opportunity for such a trial in this case study.

A questionnaire was also used to analyse the degree to which the final model maintained the integrity of the HPS framework and was measured with a questionnaire/checklist administered alongside the second Organizational Change Recipients’ Beliefs Scale. This checklist (see Appendix 10) was given to the LT at the conclusion of the change process in 2012, and was based on the principles and essential elements of HPS (IUHPE 2009; St Leger 2005). After the data were collected, the analytical process of identifying themes and constructs, emerging issues and trends occurred.

3.3.5 Coding

Interviews were recorded and then transcribed and coded using NVivo software, with readiness for change constructs used as the main coding framework. A total of 98 nodes were used to code the interview data (see Appendix 11 for the Node Structure Report) and broadly classified under the main headings presented in Table 2.
The LT were classified as senior, middle or lower level management to facilitate comparisons of the data and determine whether the key beliefs varied between the management levels. Some variance was noted and is presented in the findings in the following chapters.

3.4 Analysis

The data from the interviews, documents and researcher’s journal were analysed using content analysis, which, according to Patton (2002, p. 381), is the process of ‘identifying, coding and categorising primary data’. The data were read for patterns, similarities, differences and inconsistencies over the research period. NVivo was used to organise and manage the data, and to explore the data and find patterns. The number of LT members reporting on themes could be easily identified, which helped keep the analysis robust and transparent. Table 3 shows the coding for concerns the LT had with adopting a HPS approach. As can be seen in the table, eight (sources) of the LT members made comments (23 references) in regard to efficacy or the school’s ability to implement the approach.
A deductive approach (see Table 3) was used to initially set the broad headings for the coding structure, such as for the broad areas of content, context and process, and the five key beliefs. An inductive approach was then used to code the responses from the LT, meaning that the patterns, themes and categories of analysis came predominately from the data gathered (Patton 2002). The example below in Table 4 shows the nodes for the LT responses regarding why the LT felt a HPS approach was appropriate. These categories were built from the responses. Nine LT members identified the comprehensive nature or broad reach of the approach and the link to the school mission as important for building the belief of appropriateness. As can be seen in Table 4, there were many responses discussing the broad reach or comprehensive nature (22) of the approach.

Table 3: An Example of NVivo Coding used for the LT Interviews

<table>
<thead>
<tr>
<th>Code</th>
<th>Source</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriateness</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Discrepancy</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Efficacy</td>
<td>8</td>
<td>23</td>
</tr>
<tr>
<td>Principal Support</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Valence</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sustainability</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 4: An Example of NVivo Nodes Developed Inductively

<table>
<thead>
<tr>
<th>Code</th>
<th>Source</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holistic model</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>Includes school culture</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Good for kids</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Linked to the school mission</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Makes sense</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

The journal and documents were then examined to identify corresponding or contrasting patterns. Inductive analysis was again used, which is what Patton (2002) called a ‘constructed typologies’ approach. This approach was used because the analysis was
guided by the research questions identified at the beginning of the study (Patton 2002, p. 405). The analysis also involved recreating the events in a thick description, building themes from this description, and then moving to an interpretive level to identify patterns and develop possible explanations for the data collected (Bassey 2003). Questionnaires were collated in tables and the responses were compared using averages and totals.

As can be seen from Table 2, the readiness for change literature provided the theoretical framework used to explain the factors influencing the LT’s decision to adopt the HPS approach, and provided an instrument to measure the factors involved in their decision. However, there were additional opportunities to analyse the data through the lenses of other theories and guidelines. This practice is described by Jackson and Mazzei (2013, p. 269) as ‘Thinking with Theory’ and recognises that both ‘data and theory flow along the same connectives’. It was useful to analyse the data through the lenses of the existing guidelines for establishing HPS and whole-school approaches or SBA to change.

As presented in Chapter 4, the Protocols and Guidelines for Health Promoting Schools (St Leger 2005) and version two of this same document, Achieving Health Promoting Schools: Guidelines for Promoting Health in Schools (IUHPE 2009), recommend certain processes for establishing HPS, which are summarised in Table 5. This summary was used to compare the findings in this research and those advocated in other organisational change literature. This identified some alternate steps to be considered in establishing HPS in the international setting, and may have relevance in other settings.

<table>
<thead>
<tr>
<th>Table 5: Steps Recommended by IUHPE (2009) for Establishing HPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing a supportive government/local authority policy for HPS</td>
</tr>
<tr>
<td>Achieving administrative and senior management support</td>
</tr>
<tr>
<td>Creating a small group that is actively engaged in leading and coordinating actions, including teachers, non-teaching staff, students, parents and community members</td>
</tr>
<tr>
<td>Conducting an audit of current health promoting actions according to the six essential elements</td>
</tr>
<tr>
<td>Establishing agreed goals and a strategy to achieve them</td>
</tr>
<tr>
<td>Ensuring appropriate staff and community partners undertake capacity building programs and have opportunities to put their skills into practice</td>
</tr>
<tr>
<td>Developing a HPS charter</td>
</tr>
<tr>
<td>Celebrating milestones</td>
</tr>
</tbody>
</table>
Comparing the findings from the data analysis—particularly in regard to the process of change—resulted in the connection being made to the whole-system approach or SBA developed by Dooris et al. (2007). As outlined in Chapter 4, Dooris et al. proposed a complex interplay of top-down and bottom-up strategies in using an SBA for change. This provided a realistic way to explain and examine the process of creating readiness for change, and was consistent with the opportunities provided by Thinking with Theory for analysing data (Jackson & Mazzei 2013). Thinking with Theory represents a shift away from traditional qualitative analysis of coding and seeking themes to exploring the same set of data in different theoretical frameworks (Ringrose & Atta 2015). However, using this process in addition to traditional qualitative methods presented challenges. These challenges included the breadth of literature to critique, and organising the data and discussion in a practical, effective way to minimise repetition, while trying to make clear connections between the data and literature. Chapter 8 examines how the data were interpreted through the lens of an SBA to change and the IUHPE guidelines.

3.5 Roles of the Researcher

The role of the researcher changed in accordance with different aspects of the case study, as illustrated in Figure 3 below. The descriptive component of the case study saw the researcher as a complete participant, while the explanatory component saw the researcher as a ‘participant as observer’ (see Figure 3). Both these roles are consistent with the position of an insider researcher. The researcher did not move to a position of outsider researcher either as ‘observer as participant’ or ‘detached observer’. To help maintain clear roles throughout the study, the adoption of ‘third-party’ terminology was deemed necessary; thus, the term ‘change agent’ was used when the researcher was in a ‘complete participant’ role, while ‘researcher’ was used when the researcher was in a ‘participant as observer’ role. The continuum in Figure 3 indicates the researcher’s progression from an outside orientation to an inside orientation, and the corresponding analytical level and terms.
3.5.1 Role Duality

‘Role duality’ is a term often used to describe the two roles of researcher and employee for individuals conducting insider research (Unluer 2012). In this case study, the roles of the researcher extended beyond being a researcher and teacher to include being a change agent, parent, friend and colleague—six roles altogether. Juggling these roles, with the aim of maintaining integrity in all roles, was a challenge and it was sometimes unclear which role was being played. In regard to the professional roles, as a teacher, the goal was to provide the students with the best educational experience possible—and remain employed! As a researcher, the goal was to add to the evidence base for health in schools through the findings of a detailed case study. As a change agent, the goal was to influence the change recipients in a way that would build support for a HPS approach.

The complex role of the researcher and change agent involved attending meetings; presenting to the LT, staff and parent groups; circulating research; preparing plans; and coordinating school-wide health promotion activities to actively involve key stakeholders. It also required collecting formal and informal data, and seeking to maintain an objective perspective by making observations from a distance (Sikes & Potts 2008; Smyth & Holian 2008). Herrmann (1989) argued that being a member of a group or an organisation, as well as a researcher, is one of the most challenging and important instruments available to qualitative researchers, which proved true for this research, and will now be explored.
3.5.2 Insider Research

As an existing member of the group, the researcher was considered an insider researcher (Herrmann 1989; Patton 1990). In the introduction, the researcher was identified as working at the school as a teacher in a non-managerial role. Previous roles included working as a head of department in both the MS and HS. The researcher had a history longer than five years at the school, and was a colleague, parent, friend and strong advocate for health education and a comprehensive approach to address health-related issues. Edwards (2002, p. 71) referred to researchers who have been members of a group or organisation for at least five years as ‘deep insiders’, and there are both advantages and potential limitations to researching from this position. The advantages include the historical and cultural knowledge the researcher brings to the research, and the existing relationships with trust and rapport established. This enhances the researcher’s access to participants and the depth of knowledge of the phenomena being examined (Edwards 2002). It also enhances the chances of obtaining permission to conduct the research, and of gaining access to documents and records throughout the research process. Another advantage of an insider researcher is that the position does not alter the natural flow of interactions because of ‘having an established intimacy between the researcher and participants which promotes both the telling and the judging of truth’ (Bonner & Tolhurst 2002, p. 9).

However, as an insider researcher, there is the potential for bias during the data collection and analysis process, including the risk of missing important data, making prior assumptions about the research process, becoming part of the data through personal bias, and loyalties between the participants and researcher influencing the data (Bonner & Tolhurst 2002; Galea 2009; Rooney 2005; Sikes & Potts 2008; Unluer 2012). This potential for a lack of objectivity during the research process was identified, and various measures were taken to reduce this risk. Interviews were semi-structured to keep responses focused on the questions, while still allowing for emerging issues. A research assistant was employed to collect data pertaining to the researcher’s role as the change agent in order to reduce the risk of bias from the close relationships that existed. The assistance of academic supervisors was another strategy used to provide an objective perspective throughout the research process (Galea 2009; Rooney 2005; Unluer 2012). Managing and balancing the dual roles of researcher and worker can raise challenges and ethical concerns (Holian & Coghlan 2013).
3.5.2.1 Reflexivity throughout the Research Process

The concept of removing all subjectivity from insider research is presented by some authors as an unnecessary goal (Alvesson 2003; Rooney 2005) and as ‘a more reflective approach in which data management matters less than a revealing, insightful account and interpretation’ (Alvesson 2003, p. 190). This process of reflexivity is important in conducting research, and acknowledges the reality that researchers bring their own perspectives and experiences to the research, and rather than control or deny these, researchers must identify and hold themselves accountable to them (Cohen, Manion & Morrison 2007). It also enables issues to emerge that may be hidden from view on first analysis (Bourdieu & Wacquant 1992). Adopting a reflexive approach by recording and reviewing data regularly; seeking different interpretations, rather than consensus; and discussing observations with stakeholders and academic supervisors added to the reflective process that occurred throughout this research. The researcher’s journal was an important tool for this process, as was seeking links to other theories when analysing the data. Arguably, a part of this reflective process was acknowledging the benefits and frustrations experienced from being an inside researcher, which will now be explored.

3.5.2.2 Ethical Concerns as an Inside Researcher

The position of an insider researcher is complex because the greater access to organisational information and knowledge is accompanied by greater ethical concerns (Drake 2010; Galea 2009; Workman 2007). It is important to ensure that the benefits outweigh any potential risk to the organisation, participants or researcher. In the case of a postgraduate conducting research in their workplace, with the intention of continuing to work in the organisation, extra care needs to be taken to define boundaries and manage working relationships (Galea 2009; Smyth & Holian 2008). As the main participants were the LT, this study included researching others in positions of power. Imbalances of power during research can be experienced in a number of different ways, including dominance, gender, age and class (Riley, Taylor & Elliott 2001). There were occasions during the research process in which this imbalance of power was felt while leading change from a bottom-up position.
3.5.2.3 Benefits as an Insider Researcher

3.5.2.3.1 Identifying the Research Focus

The researcher had a deep contextual knowledge from being part of previous accreditation and review processes, as well as being an employee of more than five years. The various teaching and middle management roles meant that the researcher understood the school’s priorities, as well as the diverse community the school served. This was further enhanced by the researcher being a parent in the school community. These close ties meant that the researcher had an established understanding of the school culture, as well as areas of potential need. A specific need was that the health curriculum and health promotion activities were not driven by identified priorities, nor supported by a school-wide approach. This combination of factors led to the researcher identifying how the school could approach health differently, and how a different approach would benefit organisational goals and ultimately the wider community. With a personal commitment to push for change in approach, the researcher thought it was important to record the journey in the hope that the experience would benefit others’ efforts to improve school health, whether the change was successful or not. Knowing how an organisation actually operates and its associated politics gives the advantage of knowing how to best approach people (Smyth & Holian 2008; Unluer 2012). This was immediately evident in this research when seeking to gain administrative support.

3.5.2.3.2 Gaining Administrative Support for the Research

The school superintendent was very supportive of the research, and demonstrated this by providing written permission for the research to be undertaken and allowing the researcher access to documents—some of a sensitive nature. He thought the research was valuable to the school (Researcher’s Journal, 16 February 2009), which can be another advantage of insider research—that is, identifying real organisational needs (Galea 2009; Unluer 2012).

3.5.2.3.3 Accessing Participants and Capturing Natural Interactions

Established, respectful relationships with other administrators, teachers and parents meant that the researcher had their support in participating in interviews and accessing appropriate documents. This was an advantage of being a trusted, accepted member of
staff (Bonner & Tolhurst 2002; Herrmann 1989). A number of the LT specifically referred to this: ‘The person presenting was a credible member of the community to begin with’ (Middle LT member).

During the change process, when interacting with staff, the role played by the researcher was teacher as change agent. Early in the research, only the LT were involved in providing data in the form of questionnaires, while other staff were not necessarily aware that the change agent was conducting research. The committees and associated activities were part of the school’s existing planning processes and priorities. As a member of these committees, the researcher was able to view and record the natural interactions occurring, which (as argued above) can facilitate honest interactions.

3.5.2.4 Risks as an Insider Researcher

3.5.2.4.1 Missing Data

The researcher was conscious of minimising the time requested of Senior LT members during meetings and interviews. This may have been a limitation caused by researching others in positions of power, and may have affected the breadth of data received from the LT. Thus, potentially important data may have been missed. The length of the interviews indicated some differences in the LT. The researcher interviewed the most senior administrator for the shortest period, with the next shortest interview being the administrator with whom she had the closest friendship. In the interviews conducted by the research assistant, these two administrators were not the shortest interviews, although they were both in the five shortest. Thus, it was difficult to determine whether the position of the senior administrator or the close friendship influenced the length of the responses or questioning process. As aforementioned, the role duality of being a teacher and manager of school wellness initiatives and a researcher was difficult to juggle. The teaching and wellness responsibilities were demanding and, when these roles were taking priority, there was also a risk that data were missed. While detailed planning and preparation was undertaken before meetings and interviews to minimise these risks, it was sometimes necessary to follow-up and clarify issues through emails and more informal interactions.
3.5.2.4.2 Access to Sensitive Information

An ethical consideration was that the access to surveys meant that the researcher was privy to some sensitive data and comments. It was important that this information was not inadvertently shared with various stakeholder groups during the research process. It was also important to respect anonymity and only raise issues that were relevant to the research. This meant that the researcher needed to be aware of the potential for others’ agendas to be included in the reporting. Again, reflexivity throughout the process was a critical part of the research.

Research conducted from within an organisation, as in this case, can make many contributions to practice, which derive from the benefits of capturing unique features and uncontrolled variables, helping solve practical problems, and providing opportunities for reflective learning—all of which make this form of research worthwhile (Cohen, Manion & Morrison 2007; Smyth & Holian 2008).

Given that this research involved human subjects, ensuring their safety and wellbeing was paramount. The following section discusses other ethical considerations in research using human subjects, and how they were managed in this study.

3.6 Ethical Process

The ethical conduct of research entails important responsibilities—specifically, to ensure the safety of all those involved and to maintain honesty and integrity throughout the research process (Deakin University 2009, 2010). In Australia and Thailand, all research must be reviewed by an ethics committee as a way of controlling and enforcing ethical codes of conduct. This research needed to meet ethical requirements in both Victoria, Australia, and Thailand for research on human subjects.

Ethical approval was granted in February and May 2010 (see Appendix 12) by the Deakin University Ethics Committee. Deakin University abides by the guidelines described in the Australian Code for the Responsible Conduct of Research (Deakin University 2009; National Health and Medical Research Council 2007). The Ethical Guidelines for Research on Human Subjects in Thailand 2007 were closely consulted and showed that the requirements for Thailand were fully addressed within the requirements for Deakin University (Sueblinvong, Mahaisavariya & Panichkul 2007).
Three general principles guide research on human subjects: respect for people, beneficence and justice (Sueblinvong, Mahaisavariya & Panichkul 2007).

Prior to voluntary participation, the researcher disclosed all aspects of the research process to the participants, including what was being asked of them and how the data generated were being used and stored. This was explained in the Plain Language Statement given to each participant, which also addressed their right to refuse to participate or withdraw their consent at any time. Participants were asked to sign an informed consent after reading the Plain Language Statement, prior to their involvement. Consent was obtained from the HoS for the overall involvement of the school and for access to school documents. Participants’ privacy and confidentiality were ensured by using coded surveys and interview references, and maintaining documents and tapes in a secure cabinet.

The primary aim of research on human subjects should be ‘to provide direct benefits to participating subjects and then to others and society at large’ (Sueblinvong, Mahaisavariya & Panichkul 2007, p. 9). An important aspect of this research was how a HPS approach supported the school’s mission and vision, and was subsequently of benefit to the school in achieving its educational aims. Information regarding the change process and creating readiness was also made available to the LT in the final thesis. In regard to harm, the most at-risk participant could be considered the researcher themselves. As an employee, researching individuals in positions of power entails a degree of risk. The researcher was aware of the risk and committed to the potential value of the research to the school, and to themselves as a practitioner.

A staff member who was a counsellor with a doctoral degree and experience supervising research students agreed to deal with any complaints or concerns arising from the research. This process of reporting grievances was explained in the Plain Language Statement.

3.6.1 Generalisability

Generalisability or transferability in qualitative research refers to how the research may relate to other settings and cultures (Cohen, Manion & Morrison 2007). Rather than the researcher attempting to make these generalisations, in qualitative research, the reader decides if transferability is appropriate. Thus, it is the researcher’s role to ‘provide a
clear, detailed and in-depth description so that others can decide the extent to which findings from one piece of research are generalizable’ (Cohen, Manion & Morrison 2007, p. 137). Patton (1990, p. 375) and Lincoln and Guba (1985) referred to this as the ‘thick description’. As stated by Denzin (cited in Patton 1990, p. 430):

A thick description does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard.

The research design is summarised in the table below, which outlines the methodological approach used to examine the effect of a specifically constructed change message on creating readiness for change to a HPS approach in an international school setting. The case study captured data over a long period to build a detailed account of the process of change. The primary subjects were the school’s LT, and the aim was to use readiness for change theory to understand the factors that influenced the leaders’ decisions. However, different analytical approaches were used to allow the data to be examined in an SBA to change, and compared to the HPS guidelines.

The next two chapters critically examine the literature that guides this research, and identify the gaps in this knowledge base.
3.7 Research Design Summary

Table 6: The Research Design Summary (Lincoln and Guba 1985; Patton 1990)

<table>
<thead>
<tr>
<th>Issues</th>
<th>Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus of study</td>
<td>Case study of the HPS framework in an international school</td>
</tr>
<tr>
<td>Units of analysis</td>
<td>Examine the feasibility of the HPS approach in an international school setting</td>
</tr>
<tr>
<td></td>
<td>Explore the modifications made to the HPS model and how the approach was integrated into the specific context</td>
</tr>
<tr>
<td></td>
<td>Analyse the process of creating readiness for change, focusing on the delivery of the change message</td>
</tr>
<tr>
<td></td>
<td>Analyse the school leaders’ decision regarding the adoption of a HPS approach</td>
</tr>
<tr>
<td>Sampling strategy</td>
<td>Single case study, census and homogenous for the LT, homogenous for staff and parent representatives</td>
</tr>
<tr>
<td>Data collected</td>
<td>Qualitative</td>
</tr>
<tr>
<td>Analytical approach</td>
<td>Inductive typologies approach</td>
</tr>
<tr>
<td>Validity</td>
<td>Multiple data sources</td>
</tr>
<tr>
<td>Timeline of study</td>
<td>Four years of long-term fieldwork</td>
</tr>
<tr>
<td>Gaining organisational support</td>
<td>Written organisational support</td>
</tr>
<tr>
<td>Ethical issues</td>
<td>Human ethics review</td>
</tr>
</tbody>
</table>
Chapter 4: HPS—A Whole School Approach

Two bodies of literature contributed to this research and are presented separately in the next two chapters. The first part, presented in this chapter, examines the development and efficacy of the HPS approach and the challenges reported in its implementation. The second part, presented in Chapter 5, critiques the organisational change literature with a focus on creating readiness for change to a HPS approach. It discusses the gaps in the literature and opportunities to extend the existing knowledge base.

This chapter begins by acknowledging the importance of the school curriculum as a focal point for school improvement strategies, and providing a brief historical account of health in schools. Following this is a critique of the evidence for HPS as a best practice approach (WHO 2013), and then an exploration of the challenges and calls for research to understand the present dynamics in the HPS field.

4.1 Curriculum in a School

There is a need to frame HPS issues in educational terms (Mohammadi, Rowling & Nutbeam 2010; St Leger et al. 2007). The articulated school curriculum is arguably the driver of the school educational agenda, and not only provides an avenue to introduce the HPS concept, but also serves as a vital component of a comprehensive approach (Hansel & Dubin 2010–2011; IUHPE 2009). The US best practice model for school health curricula recommends embedding the curriculum in a broad-based program that supports and reinforces the learning occurring in the classroom—that is, a HPS approach (Joint Committee on National Education Standards 2007). In the international school being studied, curriculum development is primarily autonomous and the responsibility of the Curriculum Department in the school. The curriculum can arguably provide a familiar and important avenue to introduce a comprehensive approach, and the autonomous nature of curriculum development in the studied school had the potential to be advantageous to effect change from a bottom-up position.

In many countries around the world, the national curriculum reflects an articulation of what students are expected to know and be able to do (Schmidt, Wang & McKnight 2005). Typically, these curriculum documents are composed of a series of standards that guide many of the processes in schools, including student assessment, PD of staff and
school accountability—to name a few. While there is ongoing debate about how realistic and effective some of these documents are—especially regarding being too broad and not fostering deeper thinking skills—they are a widely identified tool throughout many countries that directs the educational focus of schools (Ravitch 1995; Schmidt, Wang & McKnight 2005). The development of standards varies around the world, with the majority of countries using ‘a national centre responsible for curriculum policy’ (Schmidt, Wang & McKnight 2005, p. 526) to develop national standards. In the US, the states are responsible for educational policy; thus, schools are more legally connected to state standards. Other types of standards include global standards, which allow some comparison across nations, and professional standards, which define credential requirements for school staff and their associated performance standards. To help states in the US, there have also been content group standards developed as frameworks that the states can use and adapt to their localised needs (Ravitch 1995).

One of the six essential components of a HPS approach is building knowledge, understanding and competencies, which empower people to take action to improve their health and the health of others (IUHPE 2009). The formal curriculum is an important avenue to develop these objectives, and subsequently an integral part of adopting a HPS approach.

The process of developing standards and the standards themselves vary around the world. While many international schools align themselves with a certain national curriculum or philosophy—such as the US, British, Australian, Japanese, Montessori or International Baccalaureate—they are often fairly autonomous in their development of standards, and subsequently quite similar to the school studied in this case.

4.2 Moving from the Classroom to the Whole School

The content in the health curriculum, as well as the emergence of a HPS or whole-school approach, have been influenced by many factors over the past century (Mikhailovich, Louise & Morrison 2007; St Leger 2004; Young 2005). Understanding the history of these influences helps put the present developments into perspective, and will be briefly examined as they occurred in Australia.

In developed countries such as Australia, compulsory education began at the end of the nineteenth century, and the school was viewed as a setting to address health-related
issues in addition to academic subjects. Hygiene, including handwashing and using uncontaminated water, was the basis for the school health curriculum in the late 1800s. In the early twentieth century, the curriculum included topics related to alcohol and ‘physical fitness, especially for boys’ (St Leger 2004, p. 405). St Leger (2004) explained that nurses or doctors were largely responsible for delivering the curriculum at this time.

From the 1950s, Mikhailovich, Louise and Morrison (2007, p. 6) described two subsequent phases ‘in efforts to improve health through schools in Australia’ in the twentieth century: (i) a focus on health education and (ii) an acknowledgment of the social determinants of health. First, the focus on health education occurred from the 1950s to the 1980s. In 1946, the World Conference on Public Education of the International Bureau of Education recommended that health be included in infant, primary and secondary schools, as well as teacher training (Turner 1966). The resultant programs focused on delivering information to students, with a prevailing premise that well-informed people would exhibit healthier behaviours (Mikhailovich, Louise & Morrison 2007; St Leger 2004). A lack of evidence that these instructional, knowledge-only programs resulted in positive behavioural changes resulted in a change in practice in the 1980s to include more skills-based content. However, the associated research indicated that, while including skills was achieving some modest changes in behaviours, these were not shown to have a long-term effect (Miller 2003). Thus, the need for a different approach became evident, and led to the more recent developments in health promotion and health education, and an articulation that health education is just one aspect of a multifaceted, whole-school approach that is more effective in improving health (Mikhailovich, Louise & Morrison 2007; Miller 2003; St Leger 2006).

Second, Mikhailovich, Louise and Morrison (2007) and Young (2005) described the next phase from the 1980s to the present day as involving a shift in thinking to recognise the social determinants of health, as well as advocating other organisations, institutions and individuals to share the responsibility of promoting health. Similarly, during the late 1970s and 1980s, contemporary health promotion practice was more clearly articulated, and social determinants of health were recognised as prerequisites

4 The social determinants of health are described by the WHO (2016) as ‘the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life’.
for health (Mikhailovich, Louise & Morrison 2007; St Leger 2004; Young 2005). It is interesting to note that similar discussions and recommendations had been identified years earlier. The WHO and United Nations Education, Scientific and Cultural Organization (UNESCO) facilitated many reports and discussions related to school health programs during the 1950s and 1960s (St Leger 1999; Turner 1966). These reports articulated aspects of a HPS, such as the need for schools to work with other sectors to deliver programs with a less didactic and more comprehensive approach (St Leger 1999). However, it was a number of years later that these concepts—significantly influenced by the Ottawa Charter for Health Promotion (WHO 1986)—were drawn together under the banners of HPS in Europe and Australasia, and CSH in America.

The Ottawa Charter for Health Promotion (WHO 1986) has been instrumental in the development of the HPS framework over the past 25 years. It identifies five strategic areas for action and categorises them according to policy, supportive environments, skills, community action and reorientation of health services. The IUHPE has adapted these components into the following essential elements of HPS (St Leger 2005): Healthy School Policies, the School’s Physical Environment, the School’s Social Environment, Individual Health Skills and Action Competencies, Community Links and Health Services.

The development of a broader approach to health in the school setting in the US and Canada had begun before the Ottawa Charter, with the term ‘comprehensive school health’ being realised in the early 1980s (Young 2005). The term was changed to ‘CSH’ in the late 1990s, although both terms are still often used interchangeably (Marx & Wooley 1998; Texas Department of State Health Services 2008). Interestingly, HPS, which was phrased in Europe and the UK in 1986, evolved independently of the US model with ‘only limited cross-fertilisation’ (Young 2005, p. 114). The models represent the shared perspective that a whole-school approach is necessary to effect change in health and learning. Conceptual differences between the two include a greater focus on student participation, equity and democracy in the HPS model; however, it is the similarities of a multifaceted approach that have led to the progression of new models of health in schools (Young 2005).

The Ottawa Charter facilitated a change from a focus on disease, morbidity, mortality and risk factors in health education and health promotion to building positive health
attributes and shaping environments that support health (St Leger 2004). The term ‘behaviour’ was also redefined as a result of the Ottawa Charter. As explained by St Leger (1999), ‘behaviour’ expanded from being focused on each individual’s personal health behaviours to a term that included ‘advocacy, empowerment and support’:

- **Advocacy**—to heighten public awareness and interest to impel societal forces that influence public policy and resources to support health.
- **Empowerment**—to help people develop knowledge and skills to make positive health choices and the ability to act individually and collectively to improve health.
- **Support**—to foster healthful social norms, alliances and systems that are sensitive and responsive to the health needs and conscience of the people (WHO 1986 cited in St Leger 1999, p. 53).

A number of authors have reiterated this change, claiming that promoting health is not just about making healthy choices—effective programs need to empower students to effect change on those factors affecting their own and others’ health (Donovan 2002; Gray, Young & Barnekow 2006).

The Ottawa Charter also stated that ‘health is created and lived by people within the settings of their everyday life: where they learn, work, play and love’ (WHO 1986), which led to the settings approach to health promotion in the 1990s. This holistic approach to health in schools, which aims to effect change in the setting itself, considers the complex nature of health promotion and contributes to the move away from a disease model to a focus on the potentials in a setting to effect change on health (Dooris 2009). The focus away from individual behaviours to the social-emotional context of the setting has been referred to as ‘a social ecological model of health promotion’ (Miller 2003, p. 14). This important ecological settings model is discussed in more detail later in this chapter.

### 4.3 Contemporary Developments in School Health

While the necessary inclusion of the health curriculum in a broader program was identified, the important role of the curriculum in the classroom as a component of this whole-school approach was (and still is) clearly articulated in the research literature and public policy (Department of Education 2003; Joint Committee on National Education Standards 2007; St Leger 2004; Young 2005).
St Leger (2006) recommended 40 to 50 hours of dedicated health curriculum time per year. Within the National Health Education Standards (NHES) (Joint Committee on National Education Standards 2007), the optimal time for attitude and behavioural change is proposed to occur after approximately 60 hours of instruction in a given year, with 45 to 50 hours shown to begin to cause changes. The recommendations from the Health Framework for California Public Schools (HFCPS) (Department of Education 2003, p. 49) are as follows:

Health education should begin before kindergarten and be continued yearly from kindergarten through grade twelve. Several national research studies suggest that significant changes in knowledge about health and attitudes toward health seem to occur after 50 hours of classroom instruction per school year or about one and one-half hours per week. This framework recommends that the kindergarten through grade twelve course of study in health be anchored by a full year’s work at the middle school level and a second full year’s work at the high school level.

The NHES (Joint Committee on National Education Standards 2007, p. 53) clearly outlined the need for health education to be made available to all students and to ‘not be sacrificed to other educational variables, nor should it be provided in a way that reduces its value’. Some authors have identified that health is already sacrificed to other variables. For example, Kolbe (2005, p. 226) referred to the ‘long-neglected school health programs’, while describing these programs as an effective means to improve both the health and educational status of children.

Echoing the philosophy of the Ottawa Charter, the NHES and HFCPS directed changes to the traditional risk-focused, classroom-based approaches of the past, highlighting that health knowledge itself is insufficient to effect change in behaviours and health outcomes (Department of Education 2003; Donovan 2002; Gray, Young & Barnekow 2006; Joint Committee on National Education Standards 2007; Kolbe 2002; Sawyer 2004). The NHES (2007) presents 14 specific characteristics of effective school health education, including addressing values, norms, protective factors, social pressures and influences, knowledge and skills, and presenting material in a personalised way that engages students. This need to include a greater focus on positive skills and protective factors, rather than negative risk factors, was recommended throughout the literature and is briefly examined below (Department of Education 2003; Joint Committee on National Education Standards 2007; Kolbe 2002; Sawyer 2004).
The 40 Developmental Assets created by the Search Institute (cited in HFCPS 2003) illustrate the correlation between developmental assets and healthy choices, including the avoidance of high-risk behaviours. The assets are divided into external assets (including support, empowerment, boundaries, expectations and constructive use of time) and internal assets (including commitment to learning, positive values, social competencies and positive identity). In conducting their analyses, Hanson and Austin (2003) found that both internal and external assets in young people were positively connected to healthier behaviours and promoting resilience.

In the area of psychosocial development, Schwartz et al. (2007) called for new models that address the overlap between protective factors and developmental assets in regard to both the risk-protection and developmental approaches. Further, Guerra and Bradshaw (2008, p. 3) advocated for addressing ‘common causal pathways’ and developing core competencies, rather than separate risk factors or topics. Weare (2000, p. 62) discussed the development of competencies, rather than just skills and behaviours, as a means of helping people develop ‘sound and lasting attitudes and values’. Focusing on positive skills and protective factors, rather than negative risk factors, was proposed earlier in the salutogenic model of health by Antonovsky (1996). In Australia, the National Curriculum for Health and Physical Education (HPE) illustrates how these contemporary developments have influenced health curriculum in this country (Australian Curriculum Assessment and Reporting Authority 2012).

This new Australian curriculum is grounded by five propositions, including a move to a strength-based approach (away from a risk-based model); building health literacy; a focus on educative outcomes; a critical enquiry approach; and value learning in, about and through movement (Macdonald 2013; McCuaig, Quennerstedt & Macdonald 2013). As described by McCuaig, Quennerstedt and Macdonald (2013, p. 110), the move to a strength-based approach in ‘the new Australian HPE Curriculum brings a shift in emphasis that builds strongly on influences from salutogenic health theory, positive psychology, health promotion and an assets model of health’. McCuaig, Quennerstedt and Macdonald proposed that operationalising the new health curriculum will involve health being regarded a resource for living well, rather than an end point in itself, and more than the absence of illness or disease.
Focusing on educative outcomes is a further proposition presented by Macdonald (2013) as focusing on knowledge, skills and understanding that provide the foundation for students to apply throughout life and enhance their own health, as well as the health of others (Macdonald 2013; Thompson 2013). This is presented as a change to those who view the school health curriculum as the vehicle to address non-educative, unrealistic outcomes, such as national health priorities, to become a curriculum that articulates achievable learning outcomes.

4.4 The Connection between Health and Learning

The work of St Leger (2004) emphasised the necessity for those working in HPS to realise that the fundamental concern of schools is the educational outcomes of the students, and that, for schools to embrace the HPS concept, they will need to see how it will enhance their core business of learning. Thus, in considering the appropriateness of the HPS approach as the content for change, it is important to make the connection between health and learning. The literature provides many opportunities to make this connection clear.

4.4.1 Protective Factors

The California Department of Education commissioned research to analyse the link between annual academic progress and student health risks and resilience. The survey they developed incorporated internal and external assets (Hanson & Austin 2003). The results reported by Hanson and Austin (2003, p. X) described the factors important for addressing students’ developmental needs and learning as providing students with many opportunities to:

1. have supportive, caring connections to adults at the school who model and support healthy development and wellbeing
2. receive clear and consistent messages that they can and will succeed at high levels
3. collaborate in pursuit of common academic and social goals
4. provide meaningful help to others and receiving help when needed.

The outcome of the research provided evidence of the link between eating nutritiously, exercising, having caring relationships and having high expectations at school with
achieving better academic test scores (Hanson & Austin 2003, p. vi). In the current study, the change message delivered to the LT employed the above evidence in conjunction with the following literature that addresses social/emotional skills, sleep and physical activity.

4.4.2 School Connectedness and Social and Emotional Skills

Research and policy addressing the social context of the school and discussing school connectedness as a protective factor demonstrate that, when students feel more connected to the school, they perform better academically and exhibit healthier behaviours (Blum 2005; Centres for Disease Control and Prevention 2009a; Chapman et al. 2013; McNeely 2013). School connectedness was defined by Blum (2005, p. 1) as ‘the belief by students that adults in the school care about their learning and about them as individuals’. However, Chapman et al. (2013) identified discrepancies in the definition and approaches used to measure connectedness, and concluded that there is evidence that building connectedness contributes to positive adolescent development and reduces risk-taking behaviour. Additionally, they stressed the need to more fully understand how connectedness is built in school settings. They identified the following contributing factors: high academic expectations, and a safe and supportive environment that develops social, emotional and academic skills and uses effective and fair classroom management practices. Involving parents and students in the school also contributes to developing connectedness, including involving them in decision-making processes and facilitating participation in extracurricular activities (McNeely 2013). As aforementioned, caring relationships between students and teachers, and a positive peer group, are also important—as Blum (2005, p. 2) stated, ‘ensure every student feels close to at least one supportive adult at school’. Thus, by increasing school connectedness, there is the potential to improve both health and educational outcomes.

There is also evidence that improving social and emotional competencies and functioning can improve academic performance (Clarke, O’Sullivan & Barry 2010; Durlak et al. 2011) and positive peer interactions.

4.4.3 Sleep

Sleep is another area providing evidence of the link between health and academic performance. Research indicates that children between ages 10 and 17 require
approximately nine hours of sleep for their biological needs and, with less sleep, their academic performance is negatively affected (Wolfson 2007; Wolfson & Carskadon 2003). Wolfson (2007) described parent education and subsequent involvement in changing bedtime routines, maintaining consistent sleep schedules and restricting television viewing close to bedtime as effective strategies for improving teenage sleep. Wolfson also described school start times and sleep education programs as strategies aimed at narrowing the gap between research and practice. Thus, changing these sleep practices would require partnerships with families, consideration of school policy, and education—a multifaceted approach.

4.4.4 Physical Activity

The link between physical activity and academic performance has also been clearly established (Ayan 2010; McDowell & Tomporowski 2011). Improvements in aerobic capacity have been correlated with better scores on mathematics tests, standardised testing and school performance, as well as facilitating connections in the brain. In addition, brief periods of exercise can improve concentration (Ayan 2010; McDowell & Tomporowski 2011).

4.5 Comprehensive Approaches to Health in School

What is considered best practice for health education in schools? The current focus on a strength-based curriculum in the new HPE Australian curriculum could be considered best practice in the taught curriculum (Australian Curriculum Assessment and Reporting Authority 2012). However, embedding the taught curriculum in a whole-school or comprehensive approach has been argued as best practice in relation to school health (Joint Committee on National Education Standards 2007). Variations of this can be found in North American, European and Australian approaches to whole-school approaches to health, relevant to this research.

4.5.1 North American Health Education and CSH

The detailed schematic presented in the NHES (Joint Committee on National Education Standards 2007, p. 17) from North America shows how health education fits into a much broader program—referred to as a CSH program—which is a multifaceted program that comprises eight areas that together aim to help students adopt and
maintain healthy behaviours (see Appendix 13). These behaviours are specifically referred to as ‘a student’s ability to successfully practice behaviours that protect and promote health and avoid or reduce health risks’ (Joint Committee on National Education Standards 2007, p. 5).

The NHES are the framework for the health education component of this schematic, and subsequently represent just one aspect of a much larger program. The standards are not a complete curriculum, but are designed as scaffolding to enable curriculum to be built that is tailored to the specific needs of the students. The HFCPS is a state-level framework that provides more guidance on specific grade-level topics than the national standards. These topics have been informed by research conducted in California and are subsequently tailored to the needs of the state of California. The HFCPS also introduces the need for health education to be supported by a comprehensive school-wide program, maintaining this as a central factor to a new approach to health education.

The placement of coordinated, comprehensive approaches to school health in curriculum documents—as a central component to the delivery of effective health education—clearly places HPS in the educational setting. Additionally, it identifies health as an essential part of achieving educational objectives, as shown in this statement ‘Health and learning are interdependent, and a quality health education curriculum imbedded in a coordinated school health program is essential for the accomplishment of all the goals of education’ (HFCPS 2003, p. 4). The standards go on to describe a collaborative approach between key stakeholders, as represented in the framework below.
4.5.2 The HPS Framework

Throughout Europe, Hong Kong and Singapore, comprehensive approaches are referred to as ‘HPS’ and, more recently in Australia, as a ‘whole-school approach’. The HPS framework was described by Stewart-Brown (2006, p. 4) as ‘a multifactorial approach that covers teaching health knowledge and skills in the classroom, changing the social and physical environment of the school, and creating links with the wider community’. In 2005, the UK made it a requirement for schools to work towards a National Healthy School Status, which includes the need for schools to demonstrate that a whole-school approach is being used to implement key areas (Department of Health 2005, p. 78).
In describing the HPS models developed in 10 countries throughout Europe and the UK, Jensen and Simovska (2002, p. 78) ‘emphasized the entire organization of the school’ in developing an appropriate social model for health. As stated by Sawyer (2004, p. 113), ‘a synthesis of research related to delivery of effective school health education would suggest the most effective way to deliver programming is within the context of a comprehensive school health program’. However, there remains a lack of evidence of the application and success of the model in its entirety (Stewart-Brown 2006). A number of different models and terms have been adopted throughout the world. The Australian HPS model in Figure 5 illustrates a more integrated schematic than the North American model.

![Figure 5: The Australian HPS Model (Australian Health Promoting School Association, 2009)](image)

A variation to the HPS model has been developed in South Australia—the Department of Education and Children’s Services (DECS) Learner Wellbeing Framework, as shown in Figure 6.
Collaboration, social justice and democracy are identified as important principles in adopting a HPS approach (MacDonald & Green 2001; St Leger 2005). It could be argued that they represent the desired ethos of a HPS culture. This research found no previous studies that compared or contrasted the different models. This may be indicative of the challenges of implementing and researching these approaches in their entirety.

4.5.2.1 Incentives for Adopting a Comprehensive Approach

In 2004, the US passed the *Child Nutrition and WIC Reauthorization Act of 2004* (US Government 2004) (Public Law 108-265), which ‘requires each local educational
agency that receives funding for US Department of Agriculture (USDA) Child Nutrition Programs (CNP) to establish a local school wellness policy no later than July 1, 2006. One could argue that this law recognises the importance of the school as a setting for addressing present and emerging health issues, and acknowledges the importance of a broad, coordinated approach in addressing the established priorities. In Hong Kong and Singapore, awards have been used to implement HPS programs. The Chinese University of Hong Kong launched the Hong Kong Healthy School Awards in 2001 (Lee, St Leger & Cheng 2007) and Singapore launched the Championing Efforts Resulting in Improved School Health (Cherish) Award in August 2000 (Singapore Health Promotion Board 2009).

More recently, the Victorian Government in Australia launched the Healthy Together Victoria Achievement Program (Victorian Government 2015b) in response to the Victorian Public Health and Wellbeing Plan 2011–2015 (Victorian Government 2011). This plan and program guide actions towards implementing a health promotion school framework across Victorian schools by providing support, recognition and awards. They also articulate specific benchmarks across key priority areas.

4.5.3 Effectiveness and Spread of the HPS and CSH Frameworks

The Stellenbosch consensus statement on HPS endorses the WHO goal to increase the number of schools using the HPS approach worldwide, citing an existing evidence base of positive results (Macnab 2013). However, the statement separates single-topic targeted programs as health promotion in schools, and HPS as a settings approach. Other literature identifies comprehensively implemented single-topic approaches as still adopting a HPS approach. While the Stellenbosch consensus statement acknowledges positive results in both of these approaches, it raises the issue of the need for a clearer definition of what constitutes evidence of a HPS approach.

5 The Stellenbosch consensus statement was a result of a colloquium held at Stellenbosch University in 2011 with 40 people from five continents to discuss their experience of using a HPS model. The title for the discussions was ‘Many Voices, One Song. Health-promoting Schools: Evidence, Strategies, Challenges, and Prospects’ and was sponsored by the Peter Wall Institute for Advanced Studies at the University of British Columbia Vancouver, Canada. The statement provides a current benchmark for HPS as well as discusses the future direction of the model (Macnab, 2013).
As indicated by the Stellenbosch consensus statement, there is a growing body of evidence that demonstrates the success of broad-based, multifaceted approaches in addressing students’ health in schools, especially in topics such as mental health, physical activity, healthy eating, hygiene, sexual health and relationships (Greenberg, Domitrovich & Bumbarger 2001; Macnab, Stewart & Gagnon 2014; Naylor & McKay 2009; Ollis, Harrison & Maharaj 2013; Stewart-Brown 2006; St Leger et al. 2010). St Leger et al. (2010) claimed that, when using such topic approaches to HPS, it is important that they are presented in a comprehensive manner and make the necessary links across the curriculum to show how the social and emotional dimensions affect all areas of health. This was also evident in the meta-analysis conducted by Stewart-Brown (2006), which examined the effectiveness of school health programs and illustrated how important it is to understand the complex factors affecting behaviours. In regard to substance use, Stewart-Brown (2006, p. 17) observed:

> It can be argued, on the basis of evidence, that mental health should be a feature of all school health promotion initiatives and that effective mental-health promotion is likely to reduce substance use and improve other aspects of health-related lifestyles that may be driven by emotional distress.

Results from the Icelandic Model (Sigfusdottir et al. 2009) illustrated another side to the substance use picture, with research indicating a reduction in use over a 10-year period that was positively correlated with improving protective factors in the school, the community and parenting, including the time children spent with parents, and parents knowing with whom their children were spending time. This further supports a whole-school, assets-based approach.

There have been recent reports of success using a HPS approach to effect change in socio-emotional factors and strengthen protective factors among students in Africa (Macnab, Stewart & Gagnon 2014). In reporting on the effectiveness of the Hong Kong Healthy School Award scheme, Lee (2014) identified that schools using the HPS framework to focus on specific health issues have found it beneficial. However, it was unclear whether the benefits reported were also measured with the indicators used in the associated accreditation system of the scheme, which would arguably provide stronger evidence of success.
Some authors have claimed that the spread of HPS has been slower than expected (Keshavarz et al. 2010). On closer examination of the literature, there has been much progress made in developing frameworks, guides and policies related to HPS. However, the translation of these frameworks and policies into school-owned change has been less evident (Bruun Jensen & Simovska 2002; Kann, Brener & Wechsler 2007; Marshall et al. 2000; St Leger 2006). In 2006, 43 countries were participating in the European Network of Health Promoting Schools (Stewart-Brown 2006). The US CDC reports that, in April 2011, 22 state education agencies and one tribal government received funding to implement a CHS approach (Centres for Disease Control and Prevention 2011a). The data from the 2006 CDC School Health Policies and Program Study (SHPPS) identified that 67.8% of districts had someone who oversaw or CSH; however, only 20.7% had received any training for their role and ‘nationwide, 60.8% of schools had someone at the school to oversee or coordinate school health (e.g., a school health coordinator)’ (Centres for Disease Control and Prevention 2011b). The comparison made from the 2000 SHPPS study showed increases in action among all areas covered, with the exception of staff health (Kann, Brener & Wechsler 2007); however, there was no evidence that schools were implementing all areas of the CSH model. This mirrors Stewart-Brown’s (2006) findings of a lack of evidence supporting the implementation of the HPS in its entirety.

4.5.4 Challenges Implementing HPS

While the theory, frameworks and models for HPS are well documented, a number of authors have acknowledged that the theory is ahead of the practice, and that there is a lack of evidence of how best to implement such a broad approach at the school level (Bond et al. 2001; Deschesnes, Martin & Hill 2003; Dooris 2006; Glasgow, Lichtenstein & Marcus 2003; Johnstone et al. 2006; Lynagh et al. 1999; Mohammadi, Rowling & Nutbeam 2010; Rowling & Samdal 2011; Samdal & Rowling 2011; Stewart-Brown 2006). Deschesnes (2003, p. 391) discussed the complexity and relative novelty of the approach as presenting two possible reasons for this lack of evidence. The specific aspects of this complexity and novelty that are cited as barriers to broader uptake include the lack of awareness, knowledge and skills of teachers and administrators in regard to health promotion; competing programs; and the lack of funding and staffing required (Deschesnes, Trudeau & Kebe 2010; Johnstone et al. 2006; Lee, Cheng & St Leger 2005; McBride 2000; Rissel & Rowling 2000; St Leger
2006). In his articles for school leaders, Buchanan (2009a, 2009b, 2009c) acknowledged the challenge of finding time and resources for health, while the Joint Committee on National Education Standards (2007) stressed the importance of allowing adequate instructional time for health education.

Where programs have been implemented, other problematic issues have arisen. Bond et al. (2001, p. 369) described the ‘piecemeal’ approach of many programs that are ‘considered extraneous to the core business of schools and core curriculum’ as a flaw of implementing this approach. This ambiguity about how HPS contributes to the educational goals of the school may also inhibit initial uptake and investment in a HPS approach (St Leger 2004, 2005). It is suggested that the lack of awareness has resulted from HPS research not finding its way to the educational sector (St Leger & Nutbeam 2000).

Additionally, where aspects of the model have been implemented, they have been largely driven by the health sector, which tends to use language that is unfamiliar or misinterpreted in the educational setting; often employ a risk-reduction approach; and result in many fragmented programs being offered (McCuaig 2006; St Leger 2004, 2005, 2006; Young 2005). Additionally, it has been reported that the health sector advocates a fast-paced timeline, in contrast to the slower rate of change typical in the school setting (Deschesnes et al. 2010). The complexity of evaluation and the fragmented approach to topic-related programs have contributed to the difficulties of evaluating the HPS approach in its entirety and in a manner that reflects educational needs (Rowling & Jeffreys 2006; Stewart-Brown 2006; St Leger 2006) (Deschesnes et al. 2010; Ollis, Harrison & Richards 2012). Thus, it is important to consider what has been learnt thus far about implementing HPS, and what is suggested as a way forward (St Leger 2004, 2005, 2006, 2010; Young 2005).

4.5.5 Facilitating the Implementation of HPS

There are a number of factors discussed in the literature as necessary for implementing a HPS approach, which contributed to the approach adopted to develop readiness for change in this research. The IUHPE (2009) document, *Achieving Health Promoting Schools: Guidelines for Promoting Health in Schools*, describes nine elements necessary to start a HPS. Rowling and Samdal (2011) identified eight factors in regard
to implementing a HPS approach, and Hoyle, Samek and Valois (2008) described five areas necessary to build the capacity for HPS. Hoyle, Samek and Valois (2008, p. 1) described capacity as a school’s ‘potential ability to sustain itself at a high level of performance’, and it could be argued that the five areas of capacity building that they identified are all represented in the literature on implementing HPS. Building a sustainable model for HPS is an important goal in its implementation (Rowling & Samdal 2011); as such, this overlap is possibly not surprising between schools with the capacity to implement a HPS approach and sustain it once it is introduced. Thus, the conditions of capacity described by Hoyle, Samek and Valois (2008) are summarised below, alongside those presented in the literature regarding supporting the implementation of HPS. These are discussed under the following headings: (i) effective leadership, (ii) institutional anchoring, (iii) allocation of resources and PD and (iv) building partnerships (Deschesnes, Trudeau & Kebe 2010; Hoyle, Samek & Valois 2008; Rowling & Samdal 2011; Young 2005).

4.5.5.1 Effective Leadership

Hoyle, Samek and Valois (2008) and Rowling and Samdal (2011) discussed the need for leadership to be shared and built across many levels, both internally and externally to the school. Hoyle, Samek and Valois (2008) described the important responsibilities of leadership as articulating the vision, mobilising people who share the vision, empowering others and facilitating collaborative action. In this manner, shared ownership of the program can be fostered (Macnab 2013).

The IUHPE guidelines identify the key roles of senior management in the school, and a broad coordinating group with representatives from staff, students and parents. The Stellenbosch consensus statement also identifies the key role of teachers and learners, and indicates government ministries (specifically, health and education) as other key stakeholders (Macnab 2013). Stoll (2009, p. 122) identified student leadership as ‘the most fundamental shift in developing leadership capacity’, while the IUHPE (2009) guide acknowledges the importance of gaining senior management support and commitment. Arguably, this is displayed through institutional anchoring and policy development, as well as adequate resource allocation. Thus, leading change to a HPS approach needs to acknowledge and involve a broad cross-section of stakeholders in the school.
4.5.5.2 **Institutional Anchoring**

Policies from government and district levels can show a degree of commitment to and support for the HPS approach. Similarly, school-wide policies, missions and charters allow a level of support and commitment to be demonstrated by the administrators and leaders of the school (Hoyle, Samek & Valois 2008; IUHPE 2009; Rowling & Samdal 2011). Samdal and Rowling (2011) claimed that committing stakeholders to anchoring a HPS approach to school policies makes health an ongoing priority, and helps commit resources and new staff to build a sustainable approach to HPS. However, it is unclear how to engage leaders and motivate them to change policies and adopt a HPS approach, which is a key focus of the current research.

4.5.5.3 **Allocation of Resources and PD**

The implementation of plans needs to be supported by the human and financial resources required to achieve sustainable change (Deschesnes et al. 2010; St Leger 2006). Hoyle, Samek and Valois (2008) argued that the greatest resource in the process of capacity building is human resources. Buying the time necessary to enable gradual change (over a number of years) requires sustained funding (Buchanan 2009c; Deschesnes, Martin & Hill 2003; St Leger et al. 2007). The time to learn new skills, collaborate, plan, and assess priorities and program effectiveness needs to be adequately reimbursed. In schools, the time in which new knowledge and practices are discussed, acquired, analysed and critically reviewed is referred to as PD (Deschesnes et al., 2014). Deschesnes et al. (2015) described multiple layers of stakeholders involved in PD, including teachers, health promotion coordinators, administrators, board members and local health service providers.

For those people coordinating HPS, Deschesnes et al. (2015) identified leadership, management, planning and evaluation as necessary skills, and found that knowledge relating to HPS priorities and actions builds confidence and ownership in the participants (Deschesnes et al. 2015). However, Deschesnes reported that one principal of the school was not engaged and chose not to attend the PD. This again raises the need to build motivation in school leaders and other potential change leaders in schools by bringing the research to their attention. Priorities identified in this international school research included highlighting what a comprehensive approach to health entails, why a
comprehensive approach indicates best practice, and how health links to learning and quality of life for students and teachers. Thus, for PD efforts related to HPS to be valued and well attended, and for schools to make PD available in the first place, motivation must be built. Sharing information and local data are proposed as important strategies to build this motivation. However, time and financial resources are not always available; thus, as Buchanan (2009b, 2009c) suggested, it may be necessary to seek external funds.

Therefore, the provision of trained staff with adequate time is an important aspect to the implementation of HPS (Deschesnes, Martin & Hill 2003; IUHPE 2009). Deschesnes et al. (2014) examined the interrelatedness of PD to other contextual factors, and found that PD (with time for reflection) in conjunction with receptive leadership and a learning and supportive culture in the school enhanced the absorption of HPS recommendations. To develop leadership and capacity at many levels, it is claimed by a number of authors that PD should include knowledge and skills in health promotion, including the philosophy of a comprehensive approach, planning, evaluation, and how to build mutual understanding (Australian Health Promoting School Association 1997; Deschesnes, Martin & Hill 2003; Rowling & Samdal 2011). As discussed in Chapter 2, this was a challenge in the context of the school in the current research.

4.5.5.4 Building Partnerships

Hoyle, Samek and Valois (2008) argued that schools cannot be expected to achieve their missions in isolation, and that building the required capacity to implement HPS requires a collaborative, interagency approach with hierarchical support developed within the school and between agencies. Calls for greater collaboration are made throughout the literature (Joint Committee on National Education Standards 2007; Kolbe 2002; St Leger et al. 2007; Tang et al. 2009; WHO 2008). External support for HPS can encompass a broad array of areas, and the literature has described the various roles of government and non-government organisations (Department of Education 2003; Joint Committee on National Education Standards 2007; Kolbe 2002). These roles include providing administrative leadership, policy and curriculum development, PD, and data collection and analyses (including identifying health priorities). Additional support includes appointing health education leadership positions and ensuring adequate budgets, staffing, class sizes.
St Leger (2007) and others (Hoyle, Samek & Valois 2008; Rowling & Jeffreys, 2006; Tang et al. 2009) have called for greater collaboration between health and education in the planning, implementation and evaluation of school health promotion. Shared expertise, resources and information have been instrumental to the effectiveness of programs and have facilitated tailoring programs to the needs of the regions where the program is to be implemented (Bruun Jensen & Simovska 2002; Deschesnes, Martin & Hill 2003; Stewart-Brown 2006). In North America, a new model called the ‘Whole School, Whole Community, Whole Child Conceptual Model’ has been proposed to help facilitate greater collaboration between the health and education sectors (Lewallen et al. 2015) (see Appendix 14). In Quebec, Canada, the healthy schools approach was launched in 2004 and represents a collaborative initiative between education and health sectors aimed at enhancing educational outcomes by making health central to the work of schools (Deschesnes et al. 2014). Similarly, in North America a new model called the Whole School, Whole Community, Whole Child Conceptual Model has been proposed to help facilitate greater collaboration between health and education sectors (Lewallen et al. 2015) (see Appendix 14).

More recently, Lee (2014) reported success when partnerships are fostered between school and universities, and when using an award scheme with systems of self-evaluation and accreditation. He claimed that this facilitated capacity building in HPS and provided a mechanism for maintaining consistency and quality. Additionally, having an academic institution involved with the scheme also helped via conducting research and training teachers in HPS. Teachers then have the skills to effect change at both an organisational level through policies and procedures, and at individual level among students by teaching knowledge and skills (Lee 2014).

In the international school environment, these types of localised structures and supports may not be available, which may explain why there has been a lack of visionary leadership and program development in international schools generally. In cases where a passionate ‘champion’ may successfully initiate some programs, it is suggested that, without coordinating teams and supportive infrastructure in place, the program will be unlikely to survive once the ‘champion’ leaves (Buchanan 2009c; Clarke, O’Sullivan & Barry 2010; Macnab, Gagnon & Stewart 2014).
4.5.6 The Way Forward for HPS

The solutions suggested to overcome previously cited barriers include educational institutions that develop health-related policies and plans with clear outcomes, realistic timeframes and alignment with the school’s mission and strategic plans (Deschesnes et al. 2010; Mohammadi, Rowling & Nutbeam 2010; St Leger 2006). The need for schools to own and drive the program is essential to build sustainable change (Macnab, Gagnon & Stewart 2014; McCuaig 2006; Ollis, Harrison & Richards 2012). As Young (2005, p. 114) noted, ‘if schools are merely perceived as a convenient setting on which to impose a health promoting school model from the outside, then this is a limited and unsustainable approach in the longer term’. Fullan (cited in St Leger 2006, p. 29) concurred that this type of approach is not amenable to successful change in schools:

[It is] probably closer to the truth to say that the main problem in public education is not resistance to change, but the presence of too many innovations, mandated or adopted uncritically and superficially on an ad hoc fragmented basis.

Additionally, being flexible and adapting the HPS model to the context of the school is important in ensuring the program is relevant and feasible in the already pressured school environment (Deschesnes, Trudeau & Kebe 2010; MacDonald & Green 2001; Mohammadi, Rowling & Nutbeam 2010; St Leger 2004; Whitelaw et al. 2001; Whitelaw et al. 2006). An issue to be mindful of during the process of adaptation is the need to maintain the comprehensive, integrated approach and thus the integrity of the HPS model, without diluting it (Deschesnes, Martin & Hill 2003; St Leger et al. 2007).

Sawyer (2004) identified the complex position of school health education as a combination of health education being typically viewed as a peripheral subject, while being held to a higher standard than other subjects, with the outcomes focused on changing behaviours. Helping leaders to view health as complementary, rather than peripheral, to the academic objectives of schools is an area requiring continued effort that needs to be supported by ensuring school leaders and administrators can access the evidence and literature related to HPS (St Leger et al. 2007). Weare (2000, p. 5) concurred and discussed the effect of standardised tests and public examination results, the resulting pressures on teachers, and the correlated growing exclusion and neglect of some students who do not meet the grade. As Weare argued, it is important that the
efforts of health promotion are viewed as complementary to the efforts aimed at improving academic performance.

To enhance the effectiveness and sustainability of HPS, Deschesnes, Trudeau and Kebe (2010) recommended that the health sector move closer to the education sector, that adjustments be made to the model to suit the context, and that efforts be made to increase schools’ capacity for HPS ‘that will support the organizational change necessary to incorporate it within schools’ (Deschesnes, Trudeau & Kebe 2010, p. 447).

St Leger (2007, p. 118) argued that ‘more evidence needs to be established about the most effective ways of integrating school health programs into the regular routines of schools, school boards and education missions’. This adds to St Leger’s calls in 2000 to find ways to introduce the concept to schools. Whitelaw et al. (2006, p. 142) provided further support to these claims, citing the need for ‘integrating the work into existing structures and procedures’.

This research focused on this gap, and sought to enhance the evidence base for a HPS approach by exploring ways to introduce and integrate the approach into existing structures and regular routines, and subsequently build sustainable change. This research was concerned with understanding the ‘how’ of implementation—how to achieve management support, how to integrate HPS into existing structures, and how to anchor a HPS approach to the school’s mission and collaborate with key stakeholders. This research also focused on understanding how the international school context influenced this process and the final model.

Another gap addressed by this research was identifying potential avenues for disseminating future research, so that research has a greater chance of being read by educational leaders. As outlined in Chapter 3, this research also explored the change process that occurred as this international school adopted a HPS approach, via the recommendations espoused by IUHPE (2009) and the whole-system change model presented by Dooris et al. (2007).

4.5.7 IUHPE Guidelines for Establishing HPS

The Protocols and Guidelines for Health Promoting Schools (St Leger 2007) and version two of this same document, Achieving Health Promoting Schools: Guidelines for Promoting Health in Schools (IUHPE 2009), provide an evidence-based summary of
the significant factors that are recommended to guide the design, implementation, assessment and monitoring of effective health promotion initiatives in schools. The IUHPE (2009) document was developed to assist those implementing HPS to be more strategic and effective. Following an introduction to the principles and essential elements of a HPS approach, it provides a concise summary of suggested actions under the headings of ‘Establishing a Health Promoting School’, ‘Sustaining a Health Promoting School’, ‘Issues (Which May Inhibit HPS Development and Sustainability)’ and ‘What Works’ (IUHPE 2009).

The recommendations include developing a supportive government/local authority policy for HPS, and achieving administrative and senior management support. The recommendations then suggest creating a small group that is actively engaged in leading and coordinating actions. They suggest that this group include teachers, non-teaching staff, students, parents and community members. Goals and the strategies to achieve these goals should stem from the results of conducting an audit of current health promoting actions. Building capacity in key stakeholders through practical opportunities, alongside developing a HPS charter and celebrating milestones, are also suggested to establish a HPS. This study found no evidence comparing these guidelines to practice, or commenting on their adaptability across settings. This also became an area of interest in this research, and the process of change in the international school context was compared to these guidelines. A number of these steps were reinforced in this case study, and some alternate steps are proposed in Chapter 8.

4.5.8 SBA to Change

The concept of an SBA or whole-system approach to change recognises the central role that context plays as a determinant of health and a focus in the change process (Whitelaw et al. 2001). Dooris et al. (2007, p. 328) made the important distinction that settings be considered not merely as places to implement interventions—‘place and context are themselves important and modifiable determinants of health’. Green and Tones (2010) concurred and specified that an SBA considers how setting influences the health of everyone who interacts with the setting. Thus, the aim of such approaches has been to focus on the setting or places where people live their lives, rather than on risk factors and individuals (Barton 2014; Kokko, Green & Kannas 2014; Teutsch, Gugglberger & Dür 2015). However, in practice, there have been different types of
applications of an SBA. Whitelaw et al. (2001) described five variations used in health promotion, ranging from a passive model in which the setting is used as an avenue to implement individual-focused change in knowledge and behaviours, to a comprehensive or structural model in which outcomes are focused on policy and structural change. This research is focused on the school setting, the HPS model and the latter application aimed at structural change. Barton (2014, p. 6) identified the following features as consistently identified in using SBAs:

- ecological, holistic and whole-systems approach
- strong leadership and direction to manage and change culture
- importance of partnerships both inside and outside the setting
- working with individual skills and capabilities
- taking an empowering approach from the bottom-up to ensure participation and sustainability.

As can be seen, these features are consistent with the HPS approach and the recommendations for its implementation. This approach is also consistent with other whole school change approaches that are presented in educational management literature and focus on multiple layers and levels (Lee, 2004; Thompson, 2007).

There has also been discussion regarding merging settings into ‘super settings’ as a way of reaching all settings in which people live (Bloch et al. 2014). This concept recognises the multiple settings people encounter each day, potentially consecutively or concurrently (Dooris et al. 2007), which is arguably illustrated in the concept of healthy cities (WHO 2015). The HPS approach is multifaceted and, in its theoretical form, attempts to change the whole system or organisation. It can be considered as adopting an ecological approach or SBA to health promotion (Dooris 2009; Dooris et al. 2007; Kokko, Green & Kannas 2014; Miller 2003; Poland, Krupa & McCall 2009). This theoretical grounding in ecological approaches and the acknowledgement of the interrelationships between individuals and the complex settings in which they exist contribute to the challenges of implementing and assessing the HPS model in its totality. The challenge to provide evidence of program effectiveness has been felt in other SBA, such as cities (de Leeuw & Skovgaard 2005) and health services (Whitelaw et al. 2006). It has been described by Dooris (2006, 2009) and Dooris et al. (2007) in these and other settings, such as the workplace and universities. As identified by
Whitelaw et al. (2001), HPS-related research has often reported on individual interventions implemented within a school, rather than aiming to change the organisation as a whole.

In the HPS model, the goal is to cause systemic change that adds health to the core business of the school. Correspondingly, Dooris et al. (2007) identified whole-system organisational development and change focus as a key dimension of a settings approach, which is the concern of the current research. Making health an explicit part of the setting requires long-term processes and a broader scope of implementation into organisational goals, rather than being focused on one health issue (Whitelaw et al. 2001). As defined by Adelman and Taylor (2007, p. 57) ‘systemic change involves modifications that amount to a cultural shift in institutionalized values (i.e., reculturalization)’. Achieving this involves simultaneous top-down and bottom-up efforts to create systemic or whole-system change. Teutsch, Gugglberger and Dür (2015) described the challenge of achieving structural change in schools, and identified the need for more direction in how to manage this type of change. The current research sought to contribute to the evidence on how to achieve such structural change; thus, using a settings model to examine the findings may contribute to the dialogue on SBA in schools.

In adopting an SBA to school change, the model proposed by Dooris (2004) and later revised by Dooris et al. (2007) provides a basis for guidance and discussion. As can be seen below, the model ‘balances organizational development with high visibility projects, top-down commitment with bottom-up engagement and the health promotion agenda with core business concerns’ (Dooris et al. 2007, p. 332).
‘Whole-system’ Approach

<table>
<thead>
<tr>
<th>Organisational development and change management</th>
<th>Top-down political/managerial commitment</th>
<th>Institutional agenda and core business</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-visibility innovative projects</td>
<td>Bottom-up engagement and empowerment</td>
<td>Health promotion agenda</td>
</tr>
</tbody>
</table>

Methods
e.g., Policy, environmental modification, social marketing, peer education, impact assessment

Values
e.g., Participation, equity, partnership, empowerment, sustainability

Figure 7: A Model for Conceptualising and Operationalising the Healthy Settings Approach

Specifically, organisation development is concerned with how health can enhance the performance of the organisation or system, and how it can be embedded in the existing structures (Dooris et al. 1998). The link to high-visibility projects could be argued as being an example of how change can be integrated into the setting’s existing structures and culture. Dooris (2004, p. 55) did acknowledge the challenges of implementing such a complex model: ‘To use the rhetoric of organizational development and change management is one thing, but there may often be very real constraints to implementation’. A lack of evidence of use may be indicative of these challenges in implementing and evaluating complex change. As discussed previously, these evaluation struggles have also been a challenge in providing an evidence base for HPS. This case study used simultaneous top-down and bottom-up processes, and was led internally from a bottom-up position. This complex process is examined in Chapter 8 using Dooris’s table above to examine the SBA or whole-system approach that was evident in creating readiness in this research.
4.5.8.1 Methods for a Whole-system Approach

The key elements of a whole-system approach are engaging multiple stakeholders across the organisation, creating an environment conducive to health by integrating health into daily routines, and engaging the wider community (Dooris 2004; Green & Tones 2010). An important consideration in managing whole-system change involves understanding the various motivations and perspectives of the stakeholders, and identifying how HPS is compatible with the setting (Green & Tones 2010). As can be seen in the model in Figure 8, the underpinning values include participation, equity, partnership, empowerment and sustainability. Various methods are suggested (although not prescribed) by Dooris et al. (2007) such as policy, environmental modification and peer education. However, Armenakis and Harris (2009) identify specific strategies including with persuasive communication, active participation and managing internal and external information.

This research addresses a number of key gaps in the literature—namely, the feasibility of the HPS approach in an international school, including how a model was adapted to the unique setting, and how the approach was anchored to the mission and integrated into the existing structures. Additionally, this research fills an identified gap in the literature by examining how to engage key stakeholders, and identifying avenues to introduce the approach and share literature with educational leaders. Other outcomes of the research include extending the evidence for HPS by examining the IUHPE guidelines and the SBA to change in practice. The readiness for change theory provided the framework to explore these issues in depth and determine the reasons that leaders support HPS. The following chapter presents a critical review of organisational change theory, with a specific focus on creating readiness for change.
Chapter 5: Exploring Readiness for HPS

5.1 Introduction

Two important aims of this research included understanding the factors that engage school leaders in adopting a comprehensive or whole-school approach to health (referred to in this study as HPS) and examining the feasibility of the HPS approach in an international school. Adopting a HPS approach is essentially asking schools to change the way they organise and implement their health-related programs. Thus, the literature on organisational change was relevant and provided theoretical frameworks to explore how to facilitate the adoption of a HPS approach. This discussion begins with an overview of the literature on organisational change, and then explores school change in more depth. Following this is a critique of the literature examining readiness for change. The chapter concludes by examining the literature specifically related to creating readiness to adopt a HPS framework.

5.2 Organisational Change

There is increasing pressure on organisations to be able to adapt to the constantly changing world in which they operate, with technological advances and an increasingly global marketplace just two of the pressures they face to remain effective (Stevens 2013). Rafferty, Jimmieson and Armenakis (2013) claimed that organisations now commonly make changes in response to such pressures every four to five years, with limited success reported. Organisational change is often described as occurring in phases, such as in Lewin’s (1951 cited in Burnes 2004) three-phase model, which involves ‘unfreezing’ the present way of operating, ‘moving’ to the new way of operating, and ‘re-freezing’ (or institutionalising) the change. Armenakis (1993) also proposed a three-phase model incorporating readiness for change, adaptation and institutionalisation. Adelman and Taylor (2007, p. 57) described the phases associated with systemic change as (i) creating readiness, (ii) initial implementation, (iii) institutionalisation and (iv) ongoing evolution and creative renewal. Critical reviews of the models of organisational change have highlighted the sometimes conflicting perspectives and concerning lack of empirical evidence supporting some of the theories, as discussed in related seminal work (Todnem 2005; Weiner, Amick & Lee 2008).
However, as Whelan-Berry (2003, p. 188) summarised, the change models share a number of important ideas, including the ‘importance of identifying the need or reason for change, creating a related sense of urgency and communicating the vision’. Whelan-Berry added that sustaining momentum and motivation are both important during all phases of the change process. These ideas are also reflected in successful school change.

5.3 School Change over Time

The process of change in schools is complex, and the effectiveness of the change is largely reliant on the specific schooling context in which it is delivered, and the capacity of the school to successfully implement the change (Armenakis, Harris & Mossholder 1993; Clarke, O’Sullivan & Barry 2010; Stoll 2009). Examining the history of school change will provide some insight to the drivers of change in schools, and how these may affect the uptake of HPS in this research.

The history of large-scale school change in the US and Britain described by Hargreaves and Shirley (2008) indicated that a number of different approaches have yielded various results. For example, the ‘welfare state’ approach of the 1960s granted freedom to teachers and administrators, and resulted in wide variation in the quality of schooling (Hargreaves & Shirley 2008, p. 57). The ensuing move to greater regulation reduced teacher motivation and enhanced educational leaders’ vulnerability due to the pressure to achieve standardised, top-down performance targets. Over the past decade, large-scale reform has continued, with testing and standardisation driving educational agendas (Hargreaves 2009; Hargreaves & Shirley 2008). While this most recent phase has seen more PD and networking between schools, the ‘tested basics still drive the hurried interactions of data-driven professional learning communities’ (Hargreaves & Shirley 2008, p. 58), with the downside being a focus on data, rather than on students and the community. The reforms in the US and UK have left both countries at the bottom of the scale of children’s wellbeing in wealthy countries, as measured by UNICEF (2007). Where small pockets of success have been noted, the general benefits have not been considered widespread or sustainable and have resulted in calls for new ways to create change in schools (Adelman & Taylor 2007; Fullan 2005, 2009; Hargreaves & Shirley 2008). The school examined in the current research is aligned to the US curriculum, with data-driven reform processes evident (see Chapter 6).
Hargreaves & Goodson (2006, p. 97) called for a new approach to educational change that will address the challenges of this time by encouraging creativity and innovation through the use of ‘networks, relationships and interaction’. By observing the nations where schools are performing well—such as Finland, Singapore and Russia—Hargreaves predicted that the most successful schools are those that work with and affect the community in which they operate. The curriculum in Finland is refined in municipalities by teachers, and focuses on the needs of the students (Hargreaves & Shirley 2008). This New Way of educational change proposed by Hargreaves will develop skills and knowledge more suited to the twenty-first century, such as creativity, problem solving, inclusiveness, emotional development and community building (Hargreaves 2009; Hargreaves & Shirley 2008). If the changes that Hargreaves (2009) espoused eventuate, then the time may have arrived for the HPS approach to be more widely adopted. One of the greatest challenges Hargreaves and Shirley (2008, p. 60) identified in the process of change is how to ‘make it spread’—clearly, this has been a challenge in the HPS movement.

The various waves of change discussed above can be described in a number of different ways: ‘top-down versus bottom-up’, ‘short-term versus long-term results’, ‘centralisation versus decentralisation’, ‘informed prescription versus informed professional judgement’, ‘transactional versus transformative leadership’ and ‘excellence versus equity’ (Fullan 2005, p. ix), as well as ‘mandated versus self-initiated’ and ‘inclusive versus exclusive’ (Hargreaves 2004). Rather than examine the differences in these approaches, the purpose here is to examine what is proposed as the preferred way forward to initiate change in schools, and to explore how the HPS model fits with this new paradigm. The following section examines which methods the literature supports as most effective in building sustainable change in the school setting.

5.3.1 Successful School Change

The literature has various notions about what constitutes successful school change. As outlined above, in the long term, improvement in educational outcomes could be considered the focus. In contrast, in the short term, successful change could be considered the adoption and institutionalisation of a change initiative. This research was concerned with the latter focus on creating change.
In discussing change specifically in school settings, Fullan (2006) identified motivation as the single most important criteria in creating change. To build this motivation, Fullan (2005, p. 55) referred to the need to establish a moral purpose—a ‘process of engaging educators, community leaders and society as a whole’. Hargreaves (2008, p. 60) also described the need for coherence—for diverse people to work towards a shared vision. He argued that achieving this includes the process of ‘building from the bottom, steering from the top’ (Hargreaves 2008, p. 60). He also described the need for sufficient flexibility in mandated change to allow teachers to be involved in necessary modifications that will engage them in the change process. Magaña (2014) also described successful change as bringing together key stakeholders to work towards a shared vision.

Hall and Hord (2001) earlier described a shift in the perspective of the drivers of change to what they termed a ‘horizontal approach’. This approach requires all participants in the change process to see themselves on the same plane—that they are members of one system—which supports the concept of the need for coherence. In leading such change, Glaze (2013) identified the importance of building capacity by investing in people and supporting them in the change process. In this manner, ‘trusting professional relationships with the individuals who are expected to do the daily work’ can be nurtured (Glaze 2013, p. 44). Fink (2014) discussed the need to balance trust between policymakers and those implementing policy, with verification of the importance of the proposed change with data and researched practices. Similarly, Glaze (2013) highlighted that researching best practices and using local, school-based data were important in focusing change efforts and stimulating collaborative discussions.

Thus, building a shared vision among diverse groups by using local data and researched practices, while providing opportunities for collaborative input, are suggested by the research on school change as effective strategies to lead change. Using the stakeholder input to adapt the HPS framework to the specific context then helps to build the necessary motivation to change. These factors were incorporated into the change process in the current study. It is suggested that using these strategies will also help build trusting relationships between the change agent and change recipients (Fink 2014).
5.3.2 Barriers to Successful School Change

A number of the barriers to school change echo those identified in Chapter 4 as influencing the uptake of HPS, such as inadequate capacity, schools not institutionalising the change, and a lack of time and attention devoted to creating readiness to change (Adelman & Taylor 2007; Fullan 2009; Stoll 2009). Senge et al. (2007) concurred and discussed other barriers, including the change being perceived as not relevant, and a perceived discrepancy between the espoused values and actions—particularly among the leaders of the change.

Previous research claims that past attempts to change schools were largely lacking an appreciation of the complexity of the process of reform (Fullan 2009) and how pivotal context is during the process of change (Clarke, O'Sullivan & Barry 2010; Stoll 2009). Creating lasting and sustainable change involves ‘re-culturating’ or ‘changing what people in the organization value and how they work together to accomplish it’ (Fullan 2002a, p. 18). Senge et al. (2007, p. 33) described a similar outcome: ‘give people the opportunity to change the way they think and interact’. A goal of the current research was to achieve just that—to change the way the leaders and key stakeholders thought and acted.

Additionally, this research was concerned with identifying which factors are important in initiating change—or, more specifically, in creating support for change. Thus, this research closely examined the first phase of change—presented previously as ‘unfreezing’, or building readiness for change. Neglecting this first phase has been identified as a reason for the failure of some change efforts (Adelman & Taylor 2007; Kirch et al. 2005; Kotter 1996; Reeves 2009; Stoll 2009; Todnem 2005). Kotter (cited in Weiner, Amick & Lee 2008) claimed that over half of all failed attempts of organisational change can be attributed to a lack of readiness. The following section examines the concept of creating readiness, and how this relates to adopting a HPS approach.

5.3.3 Creating Readiness for Change

Adelman and Taylor (2007, p. 61) argued that the process of creating readiness for change involves ‘increasing a climate/culture for change through enhancing the motivation and capability of a critical mass of stakeholders’. Holt et al. (2007, p. 235)
specifically described readiness as a construct that ‘collectively reflects that extent to
which an individual or individuals are cognitively and emotionally inclined to accept,
embrace, and adopt a particular plan to purposefully alter the status quo’. This
specifically addresses a crucial aspect of this research in understanding the underlying
reasons that a comprehensive school health program may or may not be embraced by
the stakeholders.

However, there have been criticisms about the differences in how readiness is
conceptualised in the literature, and the limitations in the dominant theories of creating
readiness (Stevens 2013). Stevens (2013) argued that confusion stems from
understanding whether readiness is a belief, attitude or intention, and whether it fits
cleanly in the proposed stages of change or (as he proposed) fits better in a process
model that is more fluid between stages. This concept has arguably been raised before
by Adelman and Taylor (2007), when they identified overlaps between the phases of
creating readiness and implementation. Thus, it was important that the current research
be extended to capture data during what was considered the first year of
implementation.

Armenakis (1993, p. 681) defined readiness as ‘the cognitive precursor to the behaviors
of either resistance to, or support for, a change effort’. The readiness for change theory
presented by Armenakis, Harris and Mossholder (1993) is acknowledged as one of the
most comprehensive (Stevens 2013). Like Lewin (1951), the theory represents a
proactive model of how to create readiness (or unfreezing), as opposed to other theories
that are focused on reducing resistance to change (Self & Schraeder 2009; Van Dam,
Oreg & Schyns 2008). This proactive focus, alongside the specific strategies that
Armenakis (2009) proposed to create readiness, was particularly relevant for
illuminating how to build support for a HPS approach.

Armenakis’s (2009) model focused on building five key beliefs in change recipients,
and this provided a specific focus to capture data from the LT in the current study.
However, this individual focus has been criticised as a limitation of the theory, with
other authors claiming that individual readiness does not necessarily indicate group or
organisational readiness, and instead proposing a multilevel approach to readiness
(Rafferty, Jimmieson & Armenakis 2013; Stevens 2013). This is pertinent to this
research, as the change message is focused on different levels in the organisation, while
aiming to build readiness among the school leaders. Thus, support from the leaders may not necessarily indicate that readiness has been established in the whole school. Additionally, it is claimed by Rafferty, Jimmieson, and Armenakis (2013) that while the cognitive factors identified by Armenakis, Harris, and Mossholder (1993) are generally supported, potential affective elements influencing change readiness have not been adequately examined and were not examined in this research. There was no literature found using Armenakis’s (2009) theory in a school setting.

The readiness for change theoretical framework proposed by Armenakis and colleagues (Armenakis & Bernerth 2007; Armenakis et al. 2007; Armenakis & Harris 2002, 2009; Armenakis, Harris & Mossholder 1993; Holt et al. 2007) was selected because it provided a strong theoretical basis to guide the development and delivery of a change message, as well as a structure to explore how the change message was being received. Armenakis and Harris (2002) claimed that the five key beliefs required to develop motivation are appropriate for all models of change and any stage in the change process. Trying to build these beliefs in change recipients helps focus change messages and create readiness for change. These five beliefs were described by Armenakis (2009, p. 129) as:

**Discrepancy:** A belief that a change is needed—that there is a significant gap between the current state of the organisation and what it should be.

**Appropriateness:** The belief that a specific change designed to address a discrepancy is the correct change for the situation.

**Efficacy:** The belief that the change recipient and organisation can successfully implement the change.

**Principal support:** The belief that the formal leaders in an organisation are committed to the success of the change.

**Valence:** The belief that the change is beneficial to the change recipient.

Armenakis (2009) suggested that some key beliefs may be more influential than others in certain change endeavours. The findings in this research that examined the initial adoption phase may have reflected this.
Armenakis (1993) claimed that the attributes of the change agent work in conjunction with the interpersonal and social dynamics in the organisation to affect the change message and ultimately affect system readiness. To enhance a positive social climate to create readiness, Armenakis (2009) described persuasive communication, active participation and managing external sources of information as key strategies. These will be discussed later in this chapter under the heading of ‘Process’. The readiness model shown in Figure 8 illustrates how the strategies and change message are influenced by the internal and external context, change agent and change recipients. The message is targeted at creating readiness. In this research, rather than system readiness, readiness was aimed at key stakeholders—the primary target being the leaders of the school.

![The Readiness Model](image)

**Figure 8: The Readiness Model (Armenakis & Harris 2009, p. 133)**

Three factors are proposed to be common to all change efforts and to influence the success of change: content, context and process (Armenakis & Bedeian 1999). Additionally, Armenakis and Bernerth (2007) raised the need to consider the individual differences among both change agents and change recipients.

### 5.4 Content

Content issues were defined by Armenakis and Bernerth (2007, p. 762) as referring ‘to the change being implemented’. Content refers to the appropriateness of the proposed
change to address the identified discrepancy that exists in the organisation (Armenakis & Harris 2009)—that is, whether the change is appropriate to meet the school’s needs. The content of the proposed change in this research was a move to a comprehensive approach to health, or, more specifically, adopting a HPS approach.

Content issues were conceptualised by Armenakis and Bernerth as fundamental or incremental changes. Fundamental changes are described as being responsive to outside pressures that result in significant change to the organisation’s character, while incremental change is defined as gradual movement ‘toward an organizational ideal’ (Armenakis & Bernerth 2007, p. 762). The process of change that was studied in this research can be considered incremental change, as the school fine-tuned its existing structures and processes to incorporate a HPS approach and became responsible for the health of the community it serves. It is proposed that, by studying the effect of content on the process of creating readiness for change, it is possible to examine the appropriateness of the HPS framework in moving the school from the present state to the desired state.

5.5 Context

Context can be considered as comprising ‘the pre-existing forces in an organization’s external and internal environment’ (Walker, Armenakis & Bernerth 2007, p. 763). It indicates whether an organisation has the capacity to implement the change (Hoyle, Samek & Valois 2008; Walker, Armenakis & Bernerth 2007). Thus, available capacity may influence the belief of efficacy (Hoyle, Samek & Valois 2008). Weiner (2009) proposed that capacity may indicate a structural readiness for change, which may not necessarily indicate a collective psychological readiness for change. Weiner also suggested that organisational culture, policies and procedures; past experience of change; and organisational resources and structure are the contextual factors that may influence readiness. Contextual factors can act as supports or barriers to successful change (Clarke, O’Sullivan & Barry 2010), and understanding the influence of context is necessary to know how to systematically and gradually guide the process of creating organisational readiness. All the key beliefs of appropriateness, discrepancy, efficacy, principal support and valence examined in this research have the potential to be influenced by the context (Clark, O’Sullivan and Barry 2010; Lindahl 2006; Rowling & Jeffreys 2006; Stoll 2009). Thus, Armenakis and Harris (2009) discussed the
importance of a thorough organisational diagnosis, especially in regard to identifying the discrepancy and developing an appropriate solution.

The effect of context on creating readiness is concerned with where the changes are occurring in the organisation. There needs to be a recognised need (or discrepancy) in that setting, and there also needs to be a belief that the organisation can effectively implement the proposed change—thus the belief of efficacy. Therefore, discrepancy and efficacy are proposed to be associated with context.

5.5.1 Individual Attributes

Individual attributes refer to how key stakeholders’ personalities, dispositions, values and past experiences affect the collective reaction to change. Having tolerance for ambiguity, openness to experiences and a high level of self-monitoring are qualities presented as being more conducive to supporting organisational change (Armenakis & Bernerth 2007, p. 764). Holt et al. (2007a) identified that past experience and success with change is a precursor to being more open to change, and an individual’s response to change will be influenced by the specific nature of the change itself—that is, if the individual feels that the change is needed and will be rewarding. Walker, Armenakis and Bernerth (2007) proposed that employee cynicism may be present because of previous negative experiences with change, and may result in a lower level of motivation to embrace change initiatives.

In the current study, individual attributes were not measured. The researcher felt that examining the personal attributes of the leaders was potentially too invasive—especially because these leaders were in supervisory positions to the researcher. While it is acknowledged that these attributes could play an important role in influencing change, this research did not plan to include individual attributes in the process of developing and delivering the change message.

5.6 Process

The third influencing factor is process, which was described by Armenakis and Bernerth (2007, p. 762) as referring to ‘the actions taken by change agents during the introduction and implementation of the proposed change’. This research focused on the process of change in a school (Hall & Hord 2001, p. 6), and Armenakis and Bedian
claim that ‘the process used to plan and enact an organizational change is as important as the state of existing content and contextual factors’.

5.6.1 Qualities of Effective Change Agents

During the process of creating readiness for change, the change message(s) and change agent(s) are critical. Change agents are those people transmitting the change message (Armenakis et al. 2007). They may be internal or external to the organisation, leaders or respected peers, and local (line) or global (organisational) managers. The change recipient refers to the person to whom the change message is directed, or, as described by Armenakis et al., (2007, p. 483), ‘the potential adopters’. In the current case study, the researcher was the change agent, who worked from a bottom-up position.

Armenakis (1993, p. 682) claimed that ‘the energy, inspiration and support necessary to create readiness must come from within the organisation and recognizes expertise, credibility, trustworthiness and sincerity as important attributes for change agents’. Additionally, change agents need to identify key stakeholders, listen to and understand their priorities and concerns, and empower them to be positive advocates and leaders in the change process (Adelman & Taylor 2007; Hargreaves & Shirley 2008; Roffey 2007). Overall, one of the key elements in the change agent may be having patience and a ‘high degree of commitment and relentless effort’ (Adelman & Taylor 2007, p. 68).

As stated by Hoerr (cited in Roffey 2007, p. 18):

A leader sets the vision but doesn’t stop there. A leader listens, understands, motivates, reinforces and makes tough decisions. A leader passes out praise when things go well and takes responsibility and picks up the pieces when things fall apart. Leadership is about relationships.

5.6.2 Leading Change in Schools

These same characteristics for leading change have been mirrored in the school context, with Kotter (1996) stressing the need for leadership, rather than management. The distinction he made is that leaders have a clear vision that can be articulated in a way that motivates people, and that leaders are not bound by linear models, but able to capitalise on the dynamic conditions influencing the multiple projects at various stages. Fullan (2002a, 2005) described the need to develop cohesiveness and motivation by empowering others and connecting the right people. He also claimed that building
sustainable change involves cultivating leadership throughout the organisation. Teachers and staff are recognised as important change agents, while students, parents and the community are described as important partners in change (Clarke, O’Sullivan & Barry 2010; Hargreaves & Shirley 2008; Stoll 2009).

St Leger (2006, p. 29) identified the potential of leading change from a bottom-up position: ‘There is a strong suggestion that successful change in complex areas is more bottom-up, where teachers and schools have considerable ownership and freedom in shaping the change’. For change in teachers and schools to occur, the change needs to be owned and driven by teachers (St Leger 2006, p. 29). Other authors have highlighted the important role that teachers play in successful change (Frost & Durrant 2002; Lukacs & Galluzzo 2014; van der Heijden et al. 2015). Teachers as change agents have been described as a ‘future model’ (Lukacs & Galluzzo 2014, p. 103) in which teachers move beyond leading visions created by others to actively shaping the strategic direction of a school. This is discussed more in Chapter 9. Conveying the change message is arguably the key role of change agents (Armenakis & Bernerth 2007).

5.6.3 Conveying the Change Message

The change message is the content delivered to the change recipients, including what they hear, see and experience. The aim of the change message is to develop positive attitudes towards the change before the change is implemented (Jones, Jimmieson & Griffiths 2005; McKay, Kuntz & Naswall 2013). The three strategies proposed by Armenakis (1993, 2009) to convey the change message were all influential in the current case study—active participation, persuasive communication and management of internal and external information.

Persuasive communication includes oral and written communication that primarily addresses discrepancy, including the aims and projected outcomes of the change (McKay, Kuntz & Naswall 2013), as well as the efficacy or ability of the organisation to implement the change. The delivery may take the form of speeches, presentations, meetings, reports, newsletters or memos prepared within the organisation (Armenakis, Harris & Mossholder 1993). Jones, Jimmieson and Griffiths (2005) recognised the role played by informal communication in an organisation, and its influence on change
readiness. These informal interactions between coworkers at various levels in an organisation can influence the substance and effect of a change message.

Managing internal and external information—such as sharing research articles, best practice models and involving guest speakers or external consultants—reinforces the change message (Armenakis & Harris 2002). Information from a number of sources—especially sources that are external to the organisation—plays an important role in creating readiness for change. The management of external information is particularly important in regard to adopting a HPS approach, as stated by St Leger et al. (2007, p. 117):

If more schools are to embrace a HPS/CSH framework to school health, then it is vital that they [school administrators] are informed about the benefits of HPS/CSH, particularly those related to educational outcomes. School administrators and teachers rarely, if ever, read the research and evaluation literature on school health.

Developing this understanding among all key stakeholders is an important step in the process of creating readiness for change (Mohammadi, Rowling & Nutbeam 2010), and was reinforced in the current research.

Active participation was described by Armenakis (1993, 2002) as a process of self-discovery that is achieved by providing opportunities for change recipients to be involved in activities that relate to the change message. There are three types of active participation described by Armenakis (1993, 2002): (i) enactive mastery, which involves taking small steps and slowly developing efficacy and confidence; (ii) vicarious learning, which involves developing confidence by seeing others successfully apply the change; and (iii) participation in decision making, such as strategic planning processes. Another salient point regarding determining which conveying strategy is most appropriate is the level of urgency of the change and existing readiness. For example, in situations where urgency and readiness are both high, persuasive communication alone might be the chosen strategy. Alternatively, if readiness and urgency are low, multiple strategies will most likely be needed to create readiness (Armenakis, Harris & Mossholder 1993).

This theoretical base, with specific reference to the key beliefs and conveying strategies, was used to identify the factors that influenced the leaders’ decision in regard to
adopting a HPS approach. Some previous research has sought to examine readiness for HPS, as follows.

5.7 Readiness for Change in HPS

Two main studies were found related to readiness for change in HPS—the work of MacDonald and Green (2001) and Deschesnes, Trudeau and Kebe (2010). MacDonald and Green (2001) identified several features as determinants of a school’s readiness for a health prevention project, and found that the presence of these items affected the success of the program initiation. The second study by Deschesnes, Trudeau and Kebe (2010) reported on the factors that affected the adoption of a HPS approach. The findings from these and other related studies are explored below under the topics of context, content and process.

5.7.1 Contextual Factors and Adopting a HPS Approach

These previous studies found that schools that supported comprehensive school health, had personnel that ‘understood and valued the meaning of prevention’ (MacDonald & Green 2001, p. 756) or had an existing commitment to health promotion (Deschesnes, Trudeau & Kebe 2010) were more ready and likely to adopt the approach. Both previous studies on this topic found that adequate resources were factors in creating successful readiness and adoption. As described by MacDonald and Green (2001, p. 756), ‘the school’s commitment to implement the project was reflected in the allocation of resources for implementation’. Previous research has also reported that parents that have a higher level of education and are more likely to be involved in their children’s education, and schools that experience a strong sense of community, are contextual factors that may influence readiness for change for health promotion activities (Clarke, O’Sullivan & Barry 2010; Ollis, Harrison & Richards 2012). Deschesnes, Trudeau and Kebe (2010) also identified that belief in the school’s efficacy or ability to implement the change influenced readiness for the adoption of a HPS approach, which was mediated by existing receptivity for a HPS approach.

As argued by Clarke, O’Sullivan and Barry (2010, p. 275), ‘the whole school context includes the school’s environment and ethos, organization, management structures, relationships with parents and the wider community as well as the taught curriculum and the pedagogic practice’ (Hoyle, Samek & Valois 2008). It is alleged that different
contexts require differentiated approaches to capacity building (Bond et al. 2001; Stoll 2009). As termed by Stoll (2009, pp. 118–119), ‘contextual capacity building’ is a differentiated approach to building capacity that considers the unique internal and external contextual factors affecting school improvement initiatives. Stoll (2009, p. 118) acknowledged that, without necessary capacity, the school’s readiness to take on change ‘just isn’t there’—a view shared by Clarke, O’Sullivan and Barry (2010). Chapter 2 described the context of the school in detail, while Chapter 4 examined the factors associated with building capacity for HPS. The international school context provides other challenges to consider prior to undertaking change initiatives.

5.7.1.1 The International School Context

Many international schools have varied health services and programs that are already in place, such as onsite counsellors and psychologists, nursing and related health services, and varied activities programs; however, their involvement in whole-school, comprehensive approaches is low (Curless & Burns 2003). The key issue in regard to a comprehensive approach is the term ‘coordinated’. As defined by Deschesnes (2003, p. 392), ‘it is important that the intervention focus simultaneously on children, school environment and school/family/community links using strategies to address multiple objectives’. This is arguably more challenging when there is a wide age range of students and multiple administrative offices in one school.

5.7.1.1.1 Differentiating HPS for ES and HS

As previously outlined, the international school involved in this study has the ES, MS and HS on the same campus, with three separate principals and deputy principals. Previous research has claimed that primary (elementary) schools are more open to the HPS concept and ready to embrace the change (Australian Health Promoting School Association 1997) and that HSs are generally more challenging to engage in school improvement (Stoll 2009). The reasons given for this are the seemingly closer interaction between primary schools and parents, the local community and service groups. In the Australian experience, the subject-based HS curriculum—rather than a more integrated curriculum—is also seen as a potential barrier for the ready engagement of HPS. In addition, research has observed that, as students grow older, they feel less
connected to school, which may also affect their receptiveness to HPS endeavours in higher grades (McNeely, Nonnemaker & Blum 2002).

As students mature and become more independent, the potential risks associated with substance use and sexual activity become more direct; thus, the messages and strategies to address the risks also need to be differentiated. Therefore, the approaches adopted across a pre-kindergarten to Grade 12 school (as in this research) need to be differentiated to be most effective in the different contexts of each school, with specific strategies employed to address the different health targets, engage the different age groups and encourage students to be advocates for health.

Another challenge relevant to HPS that surfaced through the curriculum review was identifying which health priorities to address. Identifying local needs and priorities has previously been identified as an important motivating factor in supporting the uptake of HPS (Glaze 2013; Mohammadi, Rowling & Nutbeam 2010).

5.7.1.1.2 Health Needs in the International School Community

As shown in Chapter 2, the school involved in this case study has a high percentage of expatriate students. There is a large body of research devoted to studying expatriate students who have spent a significant portion of their developmental years in a culture different to their parents, and are described as ‘third-culture kids’ (TCKs) (Pollock & Van Reken 2001). Research has well documented how this experience affects their lives, describing both positive and negative outcomes and great variation in the extent to which individuals are affected. Some of the reported patterns in TCKs’ behaviours include unresolved grief, personal identity issues, different relational patterns, uneven maturity, depression, and feelings of isolation and loneliness (McLachlan 2007; Pollock & Van Reken 2001; Zilber 2009). Programs aimed at providing support for TCKs may also need to assess these factors as part of establishing priorities and understanding the needs of families in transition, and how to best help in the process of building a sense of connectedness. The HS and MS students’ health needs were explored via a Wellness Survey (see Appendix 2 and 3) and the results from these surveys are discussed in section 7.2.4.

The parents of TCKs have also expressed a wide variety of feelings associated with transitions, such as guilt in relocating the family, a loss of a sense of self and social
support (especially if they are the accompanying spouse), and leaving jobs and family and friends behind (Copeland & Norell 2002; Ezra 2003; McLachlan 2007; Zilber 2009). The literature has indicated that the expatriate spouse, often the mother, has the greatest influence on the success of the families’ adjustment, including the psychological wellbeing of the child and the productivity of the working spouse (Ali, Van Der Zee & Sanders 2003; Reeves 2006; Zilber 2009). In turn, the support from the sponsoring organisation—both prior to and during the relocation—plays an important role in the successful adjustment of the spouse. International schools need to consider this from the perspective of the employer, and the adjustment of their staff and families, as well as support to the families of transitioning students (Ali, Van Der Zee & Sanders 2003). Thus, clarifying the needs of TCKs and their families, and the role health plays in addressing these needs, is another area for consideration. The concern is not just the initial clarification of needs, but also—as called for by Reeves (2006)—the long-term monitoring of the emotional and educational progress of the students and (one could argue) the emotional and social progress of the accompanying spouse.

5.7.2 Content Factors in Creating Readiness for HPS

The content in creating readiness is the HPS framework and its flexibility in the international school context is a key area that was examined. The essence of this aspect of the research is reflected in the following statement by Deschesnes et al. (2010, p. 8):

> It is important that research study the tension created by the inevitable adaptation of an innovation to its context, on the one hand, and compliance with its essential components, which are the foundations known for its potential effectiveness, on the other hand.

As aforementioned, the complexity of the HPS approach means that implementing the framework with all its essential components in a setting is a challenge that has not been supported by evidence. Thus, this study had to consider whether a program could be developed for the school that did retain the essential components of a HPS approach. Additionally, this study had to consider whether the leaders of the school would support the adoption and integration of the approach into the existing school framework.
MacDonald and Green (2001) reported that a clear understanding of and support for the expectations of HPS programs (among teachers and administrators) were found to influence readiness and adoption. They also described the need to match the project to the school’s philosophy, vision and goals, and to identify how the project would help address an acknowledged problem—that is, to identify where a discrepancy exists and how HPS will help address this discrepancy. Lee (2014, p. 233) argued that local student health data provide ‘strong evidence of the validity and need for the adoption of the HPS model’. He explained that the student health data and ‘trained and committed educators have been key driving forces for change’ (Lee 2014, p. 233).

In summary, the literature indicates that, for change to be successful, time must be invested in creating readiness. The unique context of the school must be carefully considered, and the proposed content of the change must be developed to appropriately fit the identified discrepancy or need. Armenakis (2009) argued that the change message needs to address the five key beliefs of discrepancy, appropriateness, efficacy, principal support and valence. In situations in which urgency and need are perceived as low, all the conveying strategies of persuasive communication, managing internal and external information, and active participation are required.

The vision for change must be shared by stakeholders, and people must be empowered and included in the process of change (Hall & Hord 2001; Hargreaves & Shirley 2008). Identifying strengths and possible barriers in the school’s capacity to implement the change, as well as identifying ways to overcome these barriers, help enable successful change. In regard to adopting HPS, these contextual supports include leadership support, educated and involved parents, and a strong sense of community. The barriers can be summarised as a lack of awareness, knowledge and skills in health promotion in the school; competing priorities; and a lack of funding and staffing. Other barriers to the way HPS is implemented include not clarifying how HPS contributes to educational goals, approaching planning in a piecemeal manner, and HPS research not being read by school leaders.

Change agents can plan to reduce these barriers and build relationships that lead to a cohesive approach, in which leadership and responsibility is shared. This enables the re-
culturating of the school, which (as shown in the previous chapter) is the ultimate objective of the HPS approach (Adelman & Taylor 2007; Dooris 2009; Miller 2003). Thus, the role of the change agent in leading change involves understanding the context, developing appropriate content, and then motivating others to support the change through a flexible, collaborative process. In the initial phase of creating readiness, the change agent needs to build a critical mass of support and sufficient capacity for the change to be considered feasible.

The readiness for change theory provided a framework to understand the leaders’ decision and indicated the influence of discrepancy, appropriateness, efficacy, principal support and valence. This research also closely examined the actions taken by the change agent to provide the much-needed detail on how to create readiness and initiate the adoption of a HPS approach. Additionally, examining readiness for HPS using the theoretical framework proposed by Armenakis and colleagues contributes to the evidence of this approach in a new setting, and revealed some beliefs as being more critical in the adoption of a HPS approach in this case.

The following chapter is a thick description of the process of change, outlining the specific actions taken by the change agent to develop the support of key stakeholders that led to adopting a HPS approach.
Chapter 6: Steering from the Top, Building from the Bottom

Kotter (1996, pp. 24–25) emphasised that, ‘most major change initiatives are made up of a number of smaller projects that also tend to go through the multistep process’ and ‘because we are talking about multiple steps and multiple projects the end result is often complex, dynamic, messy and scary’. This was certainly the case in this research. In the dynamic school environment, while leading from a bottom-up, insider position, there were many challenges in leading change and capturing and explaining the data. The research phase began in February 2009 and remained focused until the change to the school mission in February 2012. However, to contextualise the research thoroughly, it is necessary to refer to events and activities conducted at the school both prior to and following the research period.

This chapter is concerned with a thick description of the process of establishing a HPS in the international school setting, and is structured into top-down and bottom-up approaches, which often occurred simultaneously. It details the actions taken by the change agent to facilitate the adoption of a HPS approach. However, as the analysis of the findings in this research included examining multiple theories, the discussion of the findings related to the readiness for change theory, SBA theory and IUHPE guidelines is presented in the three chapters to follow. Thus, this chapter is primarily an exploration of the intervention or process of creating readiness for change, and reflects only on the general literature related to implementation and capacity building for HPS, as presented in Chapter 4, including effective leadership, institutional anchoring, allocation of resources and PD, and building partnerships.

To more fully understand the processes being described in this chapter, the participants’ perspectives are provided. Data are presented directly from each of the stakeholder groups through surveys and interviews, with the exception of students whose direct participation was not sought due to ethical concerns and conflicting roles as teacher and researcher. Students’ input to planning was facilitated in their health classes. Document analysis, interview responses and the researcher’s journal are referenced throughout this chapter. The contextual factors outlined in Chapter 2 are briefly examined as potential supports or barriers to change.
6.1 Potential Supports or Barriers to Change

The important events prior to the start of the official research in 2009 were introducing the HPS approach, developing a mechanism (student survey) to identify health priorities, and beginning the process of building awareness and support for HPS in colleagues. The contextual factors presented in Chapter 2 can be considered potential supports or barriers to creating readiness for change, as shown in Figure 9 below.

![Figure 9: Existing Contextual Factors with the Potential to Influence the Adoption of a HPS Approach](image)

The change agent used her existing contextual understanding, including the potential supports and barriers, to plan the change process. The key stakeholder groups were recognised from a management, top-down perspective as the BOT and LT with three levels—senior, middle and low. The key stakeholder groups identified in the bottom-up perspective encompassed the teachers and other support staff (including counsellors, psychologists, intensive study support staff and curriculum staff), parents and students. The BOT were identified as having the responsibility of ensuring the mission was being achieved by the LT; thus, the BOT were also considered stakeholders. The school’s strategic plan was identified as the driver of school improvement initiatives, and the mission and vision as the point of accountability of the LT. The formal research phase then began in February 2009.
6.1.1 Where to Begin the Process of Change?

The change agent examined the literature’s suggested processes of creating readiness and implementing the HPS approach. The initial tasks undertaken were defining the key stakeholder groups and summarising the suggested processes in the literature.

6.2 Top-down Processes

The top-down processes included those directed at the LT and BOT. The LT were the key participants in this research as leaders of the strategic direction of the school.

6.2.1 Achieving Administrative and Senior Management Support

6.2.1.1 Identifying a Need or Discrepancy

At the conclusion of the health review, discrepancies emerged between the school’s current state and preferred end state. The evidence for this was that the health curriculum was not following a best practice model of being embedded in a comprehensive framework (Joint Committee on National Education Standards 2007), and there were no data to determine priorities and focus the curriculum. Examining the link between HPS and the health curriculum in the school was an initial strategy to view HPS from an educational lens, as advocated by Deschesnes (2010). The next strategy involved examining the school’s mission and vision.

6.2.1.2 Linking to the School’s Mission, Vision and Strategic Plan

When this research began, the school’s mission, definition of learning, vision and guiding principles (mission and vision) were written in a six-page description. Most relevant to the research were the following statements from the mission and vision (School Document, Self Study for WASC 2007, p. 51):

We offer a balanced program focusing on the whole student.

Learning is the primary focus of our school.

Vision for Learning and Schoolwide Learning Results

The school will be a recognized leader in educating international children for success in the world community. Our students will receive an extraordinary
education that includes transportable gifts of intellectual development and cross-cultural understanding. [The school’s] students will:

1. Reach their academic, recognizable potential
2. Acquire an international education that inspires understanding and enthusiasm for world citizenship and service to others
3. Become experts in understanding and guiding their own learning

The school students will accomplish this by:

4. Experiencing outstanding teaching, based on best practice and research, supported by meaningful data
5. Learning in a nurturing and supportive environment.

There were no specific statements relating to the role health plays in achieving academic potential, or to health or wellness being a specific learning outcome of the school. Understanding the mission and vision, how the HPS framework aligned to the mission, and the guiding principles for the school’s mission (such as best practice, research and data) were all important in creating the change message and reducing the risk of HPS being viewed as peripheral to the school’s core priorities, as described by Sawyer (2004). They were also important in building the key beliefs in the LT, as will be shown in Chapter 7.

The school’s mission statement did refer to ‘the development of the whole student’ and, while the school exhibited many efforts to address student health, a formal comprehensive framework did not exist. This can be considered a gap in meeting a best practice model for school health (Joint Committee on National Education Standards 2007). The guiding principles of a HPS and the guiding principles of the school from 2009 were closely aligned, as can be seen in Appendix 15.

While there were many common themes, the change agent looked for a specific, overarching link that was part of the accountability processes in the school. The overall link chosen by the change agent between the existing vision and HPS approach was Statement 5 in the mission above—to provide a supportive and nurturing environment for learning—because this seemed the most directly related to health. That is, a HPS approach could support the school in achieving a supportive and nurturing environment,
as described in the school’s vision and mission. This was the main strategy to achieve institutional anchoring of the HPS approach (Rowling & Samdal 2011).

As a result of the findings of the health review and the identified discrepancies, the change agent was asked to prepare a plan under the headings of:

1. Current Environment: Where are we now?
2. Desired Environment: Where do we want to be?
3. Process: How do we get there?
4. Program Assessment: How will we know we have been successful?

The plan was developed with input from a member of the LT (Lower LT) who had been at the HPS conference six months prior and was a key advocate for change. This plan was presented to a Senior LT member in October 2009 (see Appendix 16). There was verbal support given for the plan during the meeting. However, as will be shown, the mission and vision and planning process were to be revised and rewritten, which had important implications for the proposed change to a HPS approach.

In response to recommendations from the WASC Visiting Committee Report (School Document 2007), the wording of the school’s mission and vision changed to focus more on the students’ learning outcomes. While the words changed and the document was streamlined to make it more easily understood, the essence of the mission and vision remained intact. By 2010, the school had restructured the mission as follows (School Document, WASC Mid-Term Progress Report 2011):

Through outstanding teaching in a nurturing environment, the school inspires students to:

- achieve their academic potential
- be passionate, reflective learners
- become caring global citizens.

The term ‘nurturing environment’ was still included, and this term continued to be the anchor for the proposed change to a HPS approach. However, this also eventually changed. At some point between June and August 2010, during an LT meeting, it was discussed that health and wellness was not represented explicitly enough in the new mission. One of the new Lower LT members responsible for athletics recalled the
discussion: ‘the point I remember was the LT meeting. The question was, “well, how can you justify this being part of the Strategic Learning Plan when it’s not even in the school’s vision or mission?”’. When questioned about the link to the supportive and nurturing aspect of the mission, the response from the same new LT member was as follows:

Well, I think they actually removed the supportive and nurturing environment from the main mission vision and definition of learning, which is obviously like a big chain that goes now the vision or mission of the school was all about learning and that’s that. So we were missing that chain. The conversation I think was, ‘How does this match the mission and vision thing?’ Our comments were that it didn’t. So therefore are we missing the key point, which justifies all our credit programs, our PE courses, our health and wellness courses? There was no justification based on our mission. So, at any point, all that funding could be axed (Lower LT.6).

Thus, the reference to a ‘nurturing environment’ to introduce the bullet points was not discussed as the anchor for HPS; instead, the need for a new bullet point was identified. While this extended the timeframe and may be indicative of the slow process of change in school, as described by Deschesnes et al. (2010), it was ultimately important in building sustainable change and raising the profile of health, as it would now be one of the four key bullet points directing the school’s strategic direction.

As will be shown, it took considerable time for the fourth bullet point to be added to the mission. Meanwhile, there was a flow-on effect from the new three-bullet mission that had been adopted. As stated in the March 2011 WASC Mid-Term Progress Report (School Document, 2011, p. 17):

After refining and articulating our vision of successful student learning, we recognized that our current Strategic Plan was insufficiently linked to our Mission and Definition of Learning and that it lacked goals framed as measurable student learning targets. We therefore decided to write a completely new four-year Strategic Learning Plan.

Therefore, the initial plan presented to the LT needed to be reviewed, as well as a new bullet point added to the mission to reflect health in a measurable learning outcome.
6.2.1.3 Strategic Learning Plan

The initial planning document (Appendix 16) was translated into the school’s Strategic Learning Plan (SLP) through a collaborative process that is known to be an important element in establishing HPS (IUHPE 2009). As the overall coordinator of wellness in the school, the change agent was asked to provide input to this process on two occasions—once in October 2010, before the LT met, to edit the SLP, and again in November at one of the LT meetings to continue to develop the document that had been prepared. The final document was developed in February 2011 (see Appendix 17).

As stated by a Senior LT member, the SLP ‘is the way that we are accountable to our mission’ (2012, email, 9 February, Senior LT.2). When examining the final plan, it was apparent that each point on the plan was linked to a number of criteria called the ‘Strategic Planning Preamble’, including the WASC recommendations—see Figure 10 below.

<table>
<thead>
<tr>
<th>Strategic Planning Preamble</th>
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<tbody>
<tr>
<td>We will have a successful learning-focused four year plan if:</td>
</tr>
<tr>
<td>1. Its primary focus is on learning rather than supports systems such as facilities, HR or communication</td>
</tr>
<tr>
<td>2. Its results in intended learning improvements</td>
</tr>
<tr>
<td>3. It is aligned with our Mission, Vision and Definition of Learning</td>
</tr>
<tr>
<td>4. It Utilizes WASC recommendations aligned with our Mission, Vision and Definition of Learning</td>
</tr>
<tr>
<td>5. Wherever possible, it works toward measurable learning results rather than activities and processes</td>
</tr>
<tr>
<td>6. It is simple and clear enough that any faculty member can explain its themes and his or her role in executing it</td>
</tr>
<tr>
<td>7. It incorporates IT Literacy and Global Citizenship learning frameworks</td>
</tr>
<tr>
<td>8. It allows adaptive changes in actions as we as an organisation learn more effective approaches to improving learning</td>
</tr>
<tr>
<td>9. It ensures that the energies of the school are focused on improved student learning</td>
</tr>
</tbody>
</table>

Figure 10: The Strategic Planning Preamble Used to Guide the SLP

The focus on learning is apparent in these points, and the LT had aligned the plan for health and wellness with the first WASC (School Document, WASC Visiting Committee Report 2007) recommendation of:

essential purpose, vision and guiding principles should be further refined and articulated in order to identify what successful student learning results will look like, thus providing a foundation, direction, and a vivid picture of school improvement targets.
The SLP was then further worked into an SLP by year, which governed the health promotion programs over the following years. From this document, specific action plans were developed to achieve the SLP objectives for the year, including nutrition, increasing physical activity and staff wellness. It was intended to also develop a plan for connectedness; however, due to a lack of time, this did not eventuate (see Appendices 18 to 20 for copies of these plans). These specific action plans guided the wellness initiatives over the following three years from 2009 to 2012. While there was much overlap between the timeframe of the action plans, they can be broadly summarised, with the first year focusing on physical activity, the second focusing on food, and the third focusing on staff wellness. These programs will be discussed in detail in the bottom-up initiatives. The plans were written to align with the school’s mission and to have clear outcomes and realistic timeframes, as advocated by St Leger (2006) and Deschesnes et al. (2010).

An interesting part of this process is that the final version of the SLP was not forwarded to the change agent until February 2012, prior to the BOT presentation, although this did not seem to interfere with implementing the SLP. It may indicate that, as a bottom-up change agent, it is difficult to be fully informed of all aspects involved in top-down processes. Chapter 9 explores the change agent’s role in relation to the literature.

6.2.1.4 Presentations to the LT

The change agent gave a total of four presentations to the LT during the research phase. Another LT member presented one other presentation regarding the proposal for staff physical activity during the school day as the change agent was unavailable. These presentations were a key time when discussions resulted in agreed goals and strategies. While they facilitated collaboration and shared ownership, they also provided the change agent with time to develop awareness and skills in health promotion, which was described by St Leger (2006) as a potential barrier for the uptake of HPS. The first presentation to the LT was in March 2010, and focused on the initial planning document (Appendix 16) transcribed into a PowerPoint presentation. The presentation expanded on the plan and gave more detail about the HPS approach and how it linked to other school initiatives. During this presentation, feedback from counsellors (shown in the quotations below) was included to indicate that other staff supported the proposed
change and that a collaborative process was being used, in alignment with the WASC recommendations to consult teachers (Slide 3 LT Presentation, 24 March 2010):

I think that you are right on track and working well toward a comprehensive and articulated K-12 Health Proposal!

The Framework offers a good visual as well as substantive picture of the systems needed to support our students.

Additionally, a model that was presented by a school psychologist was used in this presentation to demonstrate how a HPS approach would support the initiative proposed by the psychologist. The change agent used the same language that the psychologist had used to reduce language disparities and build a cohesive vision. Thus, this first presentation was focused on how a HPS approach would help the school meet the mission, linked to other strategies, and was supported by other staff members. During this presentation, one of the Senior LT members (Senior LT.1) commented that the school had a ‘moral obligation’ to address health, that health would be included in the strategic plan, and that there was a need to explore staffing and budget for this area. This was an early and clear message of support. Other questions and comments from the LT included:

explain again what multifaceted is (Senior LT.1).

is there comparable data from other schools [regarding survey results]? (Lower LT.5).

just what we need (Lower LT.1).

During subsequent LT meetings, the progression of the final SLP was the focus. The LT members were involved in the wellness aspect of the SLP in various ways. LT members were asked for feedback, asked questions during LT meetings and consulted when strategies were being planned and implemented in each of the schools (HS, MS and ES). The principals and deputy principals were involved during initial planning at their respective school levels, and the curriculum and technology staff were involved as necessary to support the activities taking place.

In essence, implementing the SLP demonstrated to the LT how a comprehensive approach to health or wellness could work in the school, which subsequently helped develop efficacy. The process employed actively involved the LT members in decisions
and in celebrating successes that were occurring. The presentations to the LT (of approximately 30 minutes in length) were carefully planned, and reinforced earlier messages. Each presentation revisited the overall model and reinforced the concept of a comprehensive approach, and thus was also PD of the LT. The presentations showed the progress being made in a structured, focused manner, rather than the ad-hoc approach previously used. The LT recalled these presentations in the following ways:

She has always been really well prepared, had a PowerPoint, had clearly a starting point and an ending point that she wanted to move people to, to build the understanding (Middle LT.1).

Her communication to leadership team and her presentations have always been well thought out and to the point, and she’s also been very available for questions (Lower LT.3).

These are the steps in her plan of action … where are we in this plan of action, how far have we come, where have we—it’s not been quite as fast as we thought—why is that? It was always very, very clearly articulated how they’re moving forward, why and where they were on that road (Lower LT.4).

This could be representative of one of the responsibilities of effective leadership described by Hoyle, Samek and Valois (2008) as articulating the vision, as well as facilitating collaborative action.

6.2.2 Building the Comprehensive Model

As aforementioned, during the health curriculum review, the need to support the taught curriculum in a broad comprehensive approach was presented to the LT and BOT. Once Senior LT members supported the concept of a comprehensive approach, it was necessary to choose the right model or make modifications so a model would suit the school. This process occurred early in the change process and primarily involved the change agent and one Senior LT member. During a meeting in October 2010, the five key points of the Ottawa Charter for Health Promotion were introduced as well as the Australian Health Promoting Schools Framework (see Chapter 4). The Senior LT member liked the Australian model; however, the change agent felt that a more appropriate model for the school could be developed to align more closely with the school’s mission and strategic priorities. Thus, the change agent wanted the final model
chosen to be a guide for planning—one that clearly reinforced the various dimensions of the Ottawa Charter and included the school’s key areas of data and academic potential. Adapting a model to the context of the school is deemed important (Mohammadi, Rowling & Nutbeam 2010; Whitelaw et al. 2006) and the change agent chose a model that she felt would best fit the context and provide a strong link to the strategic planning process. The model chosen was the DECS Learner Wellbeing Model (Figure 6). The original, modified version of this model initially developed for the school was more detailed than the final version. The detail in this first version was completed in an attempt to show how responsibility could be shared among existing staffing and organisational structures—see Figure 11 below:

![Figure 11: Initial HPS Model Presented to the LT](image)

As shown in Figure 11, specific data tools were identified in the ‘Data’ box, while specific staff groups were identified under the ‘Physical’ and ‘Social and Emotional’ boxes. Further, the coloured logo in ‘Community Action and Partnerships’ related to the parent committee that had been established, while the shaded area in ‘Curriculum and Pedagogy’ linked to the curriculum office. By presenting the model in this way, the
change agent was demonstrating how the HPS approach could link to existing structures, and that the overall responsibility was shared throughout the school. The final, more simplified model (Figure 12) was revisited in all the LT presentations.

![Action Plan Diagram]

**Figure 12: The Final Comprehensive Model Chosen for the School**

As shown in Figure 12, this model incorporated two key areas the school used to guide the strategic planning, that is, the plan being informed by data with the overall goal of students reaching their academic potential. It also reinforced the key areas for planning—that is, policy, curriculum, the learning environment, community and partners. Health services were addressed in the learning environment. Addressing these elements is considered an essential part of a HPS approach (IUHPE 2009). A questionnaire was used to examine whether members of the LT felt that the final model retained the integrity of the HPS. These findings are presented in Chapter 8.
6.2.3 Building Sustainability and Commitment by Changing the Mission

As introduced above, the need to anchor the HPS approach to a new fourth bullet in the school’s mission was determined during an LT meeting at which the change agent was not present. It was articulated in August 2010 in the following email from a Senior LT member asking for input:

At the Board retreat Friday next week, I will be proposing that the school mission statement be modified to include language related to a health promoting school. Of course the language needs to be in the style of the mission statement, eg learning outcomes for the students … I think the Board will be fully supportive of this. Then we can add health promoting school initiative to the Strategic Learning Plan and really get cracking. With these two pieces in place, money and position will not be issues (2010, email, 8 August, Senior LT.1).

This email indicated that the senior members of the LT were ready to commit more formally to making health a recognised priority, and that after this process of institutional anchoring, resources would be available. This reinforced the findings of Samdal and Rowling (2011) that anchoring HPS to school policies helps gain resource commitment.

Without the background or clarity of the wording of the new mission, it was difficult for the change agent to respond to the Senior LT’s request for suggestions to the mission. In September, the change agent met with both of the Senior LT members to clarify this point and develop some suggestions on how to better represent health and wellbeing in the new mission statement. Some of the words considered at this meeting included ‘healthy’, ‘resilient’ and ‘well balanced’. It was also suggested that the school add the word ‘healthy’ to the existing mission point of ‘caring global citizens’. During this meeting, both of the Senior LTs shared the overall priorities they had for wellness in the school. The first priority agreed upon by both leaders was students’ learning about leading a healthy life and the cognitive aspects of wellness. The second priority focused on participating in regular physical activity.

One of these Senior LT members proposed the wording of ‘lead healthy, active, fulfilling lives’ as the new fourth bullet. This was presented to the Staff Wellness Committee, LT and Parent Committee. In May 2011, the same Senior LT member
proposed this new bullet point to the BOT during a BOT retreat; however, it was not supported. The comments made in the above email about the board being ‘fully supportive’ and of funds being made available were not representative of how things proceeded. Individual differences, power and politics slowed processes and, in some cases, were barriers to change and growth. One of the Middle LT members alluded to these struggles, commenting that there were many different personalities that had to be managed effectively to build support for the change.

In August 2010, the change agent was offered a .1 position, equivalent to a half day per week, to plan for the implementation of the SLP. In the bottom-up discussion to follow, some of the struggles associated with funding and support from one particular member of the LT are presented. The focus now moves to the BOT, who make the final decisions about any changes to the school’s mission. In the roles and responsibilities of the BOT, the BOT are described as the ‘guardians of the school’s mission’ who are involved in policies and strategic direction (School Document, Board of Trustees Announcement, School Website November, 2012). Thus, any change to the school mission is an important decision for the BOT, and, in this case, a decision that was not made quickly.

6.3 The School Board

Understanding the BOT representatives involved in the decision to ratify the change to the mission is an important start to comprehending some of the challenges that were faced. Among the 15 BOT members at the time, their main occupations were business professionals, engineers or lawyers, while their main qualifications were bachelor degrees or higher (such as a Master of Business Administration). Some BOT members were from government offices, such as the American Embassy, US Agency for International Development and Thai Government. Three members were non-working, professional spouses who were very active in school activities, including the PTA and Parent Wellness Committee. The representative from the Parent Wellness Committee was a nutritionist who joined the BOT in August 2010. Earlier in the year, she had discussed the idea of joining the board as a way of further supporting the wellness initiatives in the school. Her election to the BOT further strengthened the top-down processes and helped articulate some of the challenges to adding health in the mission. In November 2011, this BOT member asked to meet to discuss frustrations she was
feeling within the BOT in relation to adopting the fourth bullet point (Researcher’s Journal, 29 November 2011). In particular, she was frustrated with resistance and narrow-minded thinking in the BOT regarding food choices and measuring outcomes. The following entry in the researcher’s journal (29 November, 2011) captures the feelings of frustration from the change agent after this meeting:

It felt like the program needed to be defended—I needed to equip the BOT member with the data to defend it. It is tough still needing to do this. Maybe the BOT education could have occurred earlier?

A lack of HPS knowledge in the BOT was identified as a potential barrier; thus, the change agent’s reflections may indicate that the BOT was overlooked when other stakeholders’ knowledge was being developed. Thus, the importance of PD was reinforced, and the need to include all stakeholders was highlighted (Deschesnes, Martin & Hill 2003; Hoyle, Samek & Valois 2008). However, the meeting described above illuminated the barriers that needed to be addressed. The discussion revealed three important areas the BOT needed to understand if change was to occur: (i) the dimensions of health (not just food and exercise and that the dimensions need to be balanced), (ii) the link between learning and health, and (iii) the school’s needs indicated in the Student Wellness Survey (Researcher’s Journal, 29 November 2011). This knowledge was instrumental in planning the next BOT presentation.

In January 2012 (School Documents; email, 12 January), the same BOT member sent this more positive message:

Committee on Trustees had a good conversation about the health bullet for the mission statement. Here are some ideas we came up with …

Through outstanding teaching in a nurturing environment, the school inspires students to:

• acquire lifelong habits of fitness and health.
• lead healthy, active, balanced lives.

The following week, the LT met to discuss the wording. The following was recorded in the minutes (School Documents, LT Minutes, 18 January, 2012):
4th Bullet Point: ‘to lead healthy, active, balanced lives’ (committee will look again next week); in principal [sic] they are supportive

The final wording agreed upon was: ‘Lead healthy, active, balanced lives’. At this point, in January 2012, the final wording had been agreed upon—some 17 months after the need to change the wording was identified in August 2010. It had been a collaborative process involving the Staff Wellness Committee, LT and BOT. However, the wording still needed to be ratified by the BOT, and there were still concerns expressed by certain BOT members that again related to a lack of awareness and understanding of a HPS approach among the BOT members. These concerns may also indicate that other Senior LT and the BOT nutritionist were struggling to articulate what HPS was and was not.

Another non-working BOT and PTA representative was actively involved in fundraising activities in the school, including hot dog sales, while a BOT member was involved in managing a number of American fast food outlets in Thailand, such as pizza, burger and ice-cream franchises. Another BOT member reported that these two members particularly raised concerns about the effect of food-related messages and choices if the new bullet point was added, such as restricting hot dog sales and other less healthy food on campus (Researcher’s Journal, 29 November 2011).

Members of the BOT recalled the issues in the 2012 Bot survey as follows:

The Board wants this bullet point to be about children making healthy choices, not as a preamble for starting to introduce restrictive measures [eliminating food from the cafeteria]. (BOT member 1)

Some board members feel that some health-related decisions were the responsibility of parents, not the school (BOT and LWLW Committee member).

One challenge was that, at the beginning, people were only concentrating on nutrition (hotdogs in the cafeteria etc). As discussion progressed, it became apparent that several components, such as curriculum, environment, adequate nutrition, should also be evaluated (BOT member 2).

As indicated earlier, the other area that needed resolving related to measuring the mission:
How will you measure success? If only through surveys, the data might still be somewhat subjective (BOT member 1).

A big concern was to ensure that the statement was measurable in terms of results that it seeks to achieve. How are we sure that the knowledge and abilities re. health promotion are effectively instilled in the children? (BOT member 2).

It was this issue of measurability as to why the word ‘fulfilling’ was not supported earlier as BOT members felt it was too difficult to measure fulfilling. However, determining how to measure HPS learning-related outcomes became a challenge in later years during discussions in the BOT and in the first year of implementation for the Learning Evidence Team. This was indicative of the challenges of measurement in HPS. Inchley, Muldoon and Currie (2006) discussed these challenges as the difficulty of measuring long-term behavioural change, and proposed that schools track the way they are changing their practices as an alternative to measure the success of HPS. However, measuring such process factors did not align with the school’s procedures in this case, hence the difficulty encountered. Lee (2014) addressed these challenges by developing a model that involved academic institutions and an award scheme to help facilitate the measurement of HPS (see Appendix 25). Lee (2014) incorporated student health data, a school self-evaluation, and a School Health Profile Report as mechanisms for measuring HPS. Although it is unclear which items in these mechanisms are related to process or learning, the ultimate objectives are optimal health status, positive mental health, life satisfaction and academic achievement. Thus, it would appear that schools in Hong Kong that are part of the Hong Kong Healthy School Award Scheme are supported by external academic institutions to gather data related to HPS, which includes indicators of academic achievement. It could be argued that schools need support in regard to measuring HPS.

6.3.1 Ratification of the New Mission

In February 2012, the change agent was given a 30-minute time slot in the BOT meeting to propose the addition of the new bullet point to the mission. This was the first presentation to the BOT by the change agent since the start of the research. A Senior LT member had previously presented and was unsuccessful, and there was still some resistance within the BOT. To review, the points identified above as important to address with the BOT included the dimensions of health, link between health and
learning, and results from the students’ survey. The presentation began with the findings from the health curriculum review and explained the process that had resulted in the proposed HPS approach and associated fourth bullet point. The other key areas—aimed at developing understanding of health and health promotion—were woven throughout the presentation. The Prezi platform was used to develop the presentation and engage the BOT with a visual presentation, and to take them on a journey of the process.

Eleven BOT members attended the presentation, while apologies for not attending were received from other members, including the member associated with the food outlets. Questions from the BOT and the replies given included the following (Researcher’s Journal, 14 February, 2012):

1. What other schools have had success with this model?

   The response was that there is lots of evidence of success of implementing individual, topic-specific programs; however, there is less evidence of implementing programs on a whole-school basis.

2. Would this be about controlling and restricting food choices?

   The response explained that the other dimensions of health are important, and that the issue was much larger than just food. Overall, ‘no’, it would not necessarily mean food restrictions.

As the minutes from this meeting show (see Appendix 21), the bullet point was ratified. The presentation was an example of persuasive communication that was structured around conveying the process and developing awareness of health promotion. This is discussed further in the following chapter on creating readiness, and the process used.

The ratification of the fourth bullet point became a hurdle that consumed more time and energy than anticipated. However, as shown in the next chapter, it was seen as critical to achieving sustainable change. One of the LT members reflected that they had also tried to change the mission:

   I know personally to get something in there, it’s difficult. I tried to get something about our kids developing IT skills for the twenty-first century and I couldn’t get that in (Lower LT.5).
6.4 Reflecting on the Process

During the interviews, after the fourth bullet point had been ratified, the change agent learnt of the original conversation in the LT identifying the need to include health more specifically in the mission. It appeared from the LT member’s response, quoted above (section 6.2.1.20, that a number of programs—such as athletics and the PE and health curriculum—would all be legitimised by this new bullet point. While a HPS approach covered all these areas in the school, the change agent did not make the link explicit in regard to the new bullet point. It was interesting that this link was not the main focus of conversations between the LT and BOT. Adding a fourth bullet was included in the SLP relating to HPS, and, as such, the justification for the change was focused on the change to a HPS approach. Perhaps the fourth bullet would have been ratified more quickly if it had been linked to the existing programs, such as health/PE and athletics, rather than HPS. If these other areas had been included in the initial conversations, perhaps the change would have been met with less resistance. This confusion may be representative of bottom-up led change, in which it is difficult to keep abreast of all the strategic conversations in an organisation. This is explored further in Chapter 9.

This confusion may also be indicative of the dynamic and messy nature of the change process, which involves competing priorities and personal and political agendas. For example, why had food become such a contentious issue? Some of the earlier interactions between the Senior LT/PTA representative and LT member who attended the Australian HPS conference had been focused on the hotdog fundraiser. There had been some negative messages sent from the LT member regarding unhealthy food, including hotdogs, which may have contributed some negativity and sensitivity regarding the things that might change if a HPS approach was adopted and the fourth bullet point added. The following entries were made in the researcher’s journal:

There are times his messages of ‘stop eating that crap’ worry me that it is putting some people off (29 September 2009).

Some people had voiced that they were annoyed by being told they were doing the wrong thing (having hot dogs taken out of hands and thrown away, cigarettes screwed up and thrown away) (5 June 2010).
However, when this LT member left in June 2010, the change agent did feel like she had lost an important link to the LT and support for the process of change. This highlights the importance of champions and the hole that can be left when they leave (Buchanan 2009c; Clarke, O’Sullivan & Barry 2010; Macnab, Gagnon & Stewart 2014). Even though this LT member had left, the nutritionist on the BOT may have had discussions regarding the effect of the fourth bullet point on food choices to which the change agent was not privy. When this BOT/Parent Wellness Committee member left with her family, she was recognised for her contribution to the fourth bullet point in the following way:

The BOT member who is a nutritionist by profession, was one of the driving forces behind introducing the 4th bullet, to ‘lead healthy, active and balanced lives’, in the school’s mission (Board Chair Letter, 7 December, 2012).

It would appear that, from the BOT’s perspective, this member played an important part in the change to the mission, which again highlights the importance of champions (Buchanan 2009c).

The BOT survey conducted in 2012 identified the following reasons for their support of the change:

This is a transportable gift that children will make use of for the rest of their lives (BOT member 1).

I believe that a healthier school environment and culture will result in increased academic success; more balanced students and increased likelihood of students respecting the importance of health and wellness (BOT and LWLW Committee member).

The health component completes the mission of the school—it promotes the whole development of the child, not only focusing on academics but their physical well being as well (BOT member 2).

As outlined above, throughout the top-down strategies, the communication to the school leaders (both the LT and BOT) included details of the process and who had been consulted. A Senior LT member present at the BOT meeting made the following comment:
She did a board presentation last week, it was just spot on, one of the best that I’ve seen from the point of view of being useful to board members, engaging them in conversation (Senior LT.1).

The changes to the mission and vision, choosing the priorities and developing the SLP were led by the LT, while the plans for implementing school-wide health promotion pilot programs were led by the staff and parent committees. Grade 10 students were consulted in health classes for input to these plans, and their voice was arguably also represented in the survey results. This thesis now turns its attention to the effect of the bottom-up strategies used in this study.

**6.5 Bottom-up**

Using a collaborative process with key stakeholders to lead change is a common factor identified in the literature on organisational change and implementing HPS approaches (Hoyle, Samek & Valois 2008; Rowling & Samdal 2011; Weiner 2009). The HPS guidelines advocate for a small group with representatives from teaching and non-teaching staff, students, parents and community members. In this research, with three schools (ES, MS and HS) on the campus, such a cross-section of representatives would have resulted in a large group, and finding meeting times would have been very difficult (Researcher’s Journal, 30 October 2009). Thus, two committees were established—one with primarily parent representatives and the other with certified staff, including teaching and non-teaching staff. The plans (see Appendices 18 to 20) were coordinated by the change agent, with the parent committee primarily involved in the implementation and the Staff Committee providing the link to existing school processes and activities, and guiding the plan addressing staff wellness. These committees provided input to the planning and implementation process, and their input was fed back to the LT during the presentations. This indicated that a collaborative process had been used and that support existed from both parents and staff for the strategies being proposed, thereby recognising two important stakeholder groups in the school (IUHPE 2009; Macnab 2013). Additionally, the staff and parents who were involved in the committee showed their support to the LT through their attendance, as well as through direct communication with the LT. Thus, they played a role in developing leadership support. The activities of the parent committee will be discussed first.
6.5.1 Parents: The Live Well Learn Well Committee

The parent representatives who had been on the Student Wellness Survey Committee agreed to be part of the proposed parent committee. A staff member in charge of learning spaces for the school (who was studying marketing) encouraged the committee to develop a logo for the health promotion programs to create more of a profile. The following logo was developed, and this committee was known as the Live Well Learn Well (LWLW) Committee.

![LWLW Logo](image)

**Figure 13: LWLW Logo**

In February 2010, a flyer was distributed through email to the school community during the weekly communications to introduce the committee and ask volunteers to join. See Appendix 22 for this flyer, which also outlined the backgrounds of the original members (names have been withheld for confidentiality purposes), promoted the newsletters that were to be developed by the committee, and explained the relevance of the colours in the logo. The colours represented the different dimensions of health; thus, ensuring that members of the community understood the relevance of the colours was aimed at building awareness and knowledge of a holistic concept of health.

6.5.1.1 High-visibility, Innovative Health Promotion Projects

The health promotion programs were initiated to show the community how a HPS approach could operate at the school. This was highly effective because the active

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6 The school’s acronym has been removed from the figure to maintain confidentiality
participation provided an avenue to build capacity and the belief of efficacy—that is, the belief that the school could implement a HPS approach. Once the SLP was finalised, it directed the health promotion activities in the school.

6.5.1.1.1 Magnets and Newsletters

To further promote the LWLW logo and health at the school, fridge magnets of the logo and a ‘to-do list’ (including information on recommended levels of sleep, exercise and fruit and vegetable intake) were sent home in the Friday folders of the ES students. One of the parent LWLW Committee members was a substitute teacher at the school and sent this email:

I have been subbing in the elementary school and have to comment that every classroom has the logo present, via the delivery of the magnets in the Friday packets. One teacher has the daily checklist pinned next to the desk. One of the students has a sticker of the logo ON his desk. It is exciting to know that what was once a passing conversation has developed into an agenda within the Long Term Plan (LWLW Committee member, email, 26 November 2010).

As aforementioned, the LWLW Committee was primarily responsible for helping implement the action plans generated from the SLP. Some areas—such as the taught curriculum—were guided by teaching staff in collaboration with the principals/deputy principals and curriculum office, and were not managed by this committee.

In total, this committee wrote and distributed six newsletters on the following topics:

- Breakfast Eaters Learn Better: February 2010
- Snacks and Healthy Hydration: March 2010
- Food—The Big Picture: April 2010
- The Newzzz on Sleep: November 2010
- Physical Activity and the Brain: January 2012
- Balance Your Food: January 2013.

In response to parent feedback and requests, as shown below, a LWLW site was added to the parent portal on the school website in November 2010, with links to the newsletters/articles that had been developed by the committee:
The sleep article was excellent! I will share it with my son. How can I get the earlier articles mentioned in the newsletter? I would like to read them all (Parent, email, 8 November 2010).

Thanks very much for the informative Newsletter on Sleep. The LWLW is doing an excellent job in helping students and parents make healthy choices. As a parent I appreciate the work your committee is doing (Parent and BOT member, email, 5 November 2010).

These positive responses were evidence to the LT that the community was valuing the program, and provided an opportunity to celebrate progress and ‘to affirm the concept of HPS’ in the LT, which is advocated in the guidelines for establishing HPS (IUHPE 2009, p. 3).

The LWLW access point on the web was identified with the logo and the following sentences:

Live Well Learn Well @ … is a health promotion program aimed at providing evidence-based information regarding issues that affect the health and learning of the community.

Here you can find an archive of all the Live Well Learn Well articles.

6.5.1.1.2 Plates and Posters

An example of another innovative project was introducing new plates to the ES cafeteria, and a new large banner/poster at the entrance to the ES cafeteria. See Appendices 23 and 24 for the newsletter introducing the plates, and a copy of the banner.

A PTA newsletter also featured an article on the LWLW program and the new plates, which the PTA helped to fund. This funding from the PTA could be considered an example of accessing external funds, as described by Buchanan (2009b, 2009c), when funds were not made available by the school’s chief financial officer (CFO). It also highlighted the importance of the support of parents in the process of school change (IUHPE 2009).
6.5.1.1.3 Health and Fitness Week

The LWLW Committee also helped with a Health and Fitness Week in September 2010. The main person driving this activity was the LT/LWLW member who attended the HPS conference. There were a number of activities aimed at healthy behaviours, eating and physical activity conducted throughout the week, which culminated in a fair on the Thursday. The week also supported the environmental activities of the school by linking choices that were healthy for the body with choices that were healthy for the planet, such as riding or walking to school, rather than using a motor vehicle; eating a plant-based diet, rather than meat; and choosing organic produce, rather than produce treated with chemicals. This was another way of linking to existing programs.

The following year, when the LT/LWLW staff member who led the initial Health Week had left the school, the Health Week was run again—this time led by the other staff members who had attended the HPS conference. The LWLW Committee continued to provide support.

An innovative activity at the Health Week fair was having the Grade 10 health classes run short sessions educating ES students on topics such as food, sleep and handwashing. After the second fair in September 2011, the following email was received from a staff member:

I loved the interaction of the HS with ES students. Please congratulate your health classes for me; they did a terrific job. We need to do more of this! Once again thanks for all the time you put into this event. This was a great example of how collaboration (teachers, parents and students) can make for powerful learning! (Staff member, email, 16 September 2011)

The Health and Fitness Week was not run again due to the amount of work necessary to plan and implement it. The event had been largely driven by the LT member who had left, and adding it as a regular fixture on an already busy calendar was not seen as sustainable. This evidenced Buchanan’s (2009c) claim that activities heavily reliant on champions are not sustainable. The week did provide an opportunity for interaction between the HS and ES students, and this experience motivated a Grade 11 student to establish another innovative project—the Student Health Ambassadors. This will be discussed later in this chapter.
6.5.1.1.4 Nursing Review

As stated earlier, health services were included as part of the ‘supportive environments’ in the planning model. Two of the parent LWLW representatives with nursing backgrounds were integral in conducting an audit of the health services. The audit and report were not a part of the SLP; thus, the report was done on a voluntary basis. It is worth noting that these parent representatives felt that the LWLW banner was an avenue to raise awareness of the changes necessary in the nursing office, and advocating for the Thai nurses who ran the office to be recognised as needing staffing and other support, which ultimately affected the health of students. Funding to implement the plan was not forthcoming until 2013, and this was a frustrating process for the two parents involved, as shown by the following comment:

I feel that nursing and health are an unknown entity in a school setting and we got a lot of push back. We developed an action plan and professional document and had several meetings but very little change has taken place. There is one person who seems to be the primary decision maker, who is not a part of the process, and this area is not being supported or a priority. Lack of professional support and respect for how important this is (LWLW Committee and nurse).

This comment refers to the imbalance of power regarding decisions in the school and funding made available by one particular administrator, who was not present at many discussions. The change agent experienced similar frustrations, which are discussed further in Chapter 9.

6.5.2 Building Staff Support for HPS

Certified staff who were not on the LT were also key to building support for change, as well as building capacity to implement change. Staff were involved in the change process in many ways, including participating in the Staff Wellness Committee and later in a Learning Evidence Team. This team provided input during department meetings, helped implement curriculum-related aspects of the plans, participated in the Health Week and attended the fair, shared information and made personal healthy changes as a result of the health promotion programs. The targeted strategies used to collaborate with staff are examined below, starting with the counselling and psychology staff members.
6.5.2.1 Counselling and Psychology Services

At the time of the research, the school employed two clinical psychologists—one focusing on ES and the other on MS and HS students. The school website defined their role as follows:

School psychologists help children and youth succeed academically, socially and emotionally. They collaborate with educators, parents and other professionals to create safe, healthy, and supportive learning environments for all students that strengthen connections between home and school.

As can be seen, this brief is consistent with many facets of a HPS, such as social, emotional and academic success; collaborating with the community; and providing a safe, healthy and supportive environment. However, it could be argued that their time was focused on supporting individual students with specific learning or behavioural needs, rather than undertaking health promotion aimed at all students. Along with the breakfast survey discussed in Chapter 2, the HS psychologist developed and maintained a register of health professionals in Bangkok. Access to specialist health professionals for referral of students is an external capacity building area identified by Hoyle, Samek and Valois (2008).

In addition to the psychologists, two counsellors in the ES, three counsellors in the MS and six counsellors in the HS further supported students and staff. The counsellors’ role included helping students to transition; providing learning support to students, staff and parents; small group and individual counselling; and parent presentations and workshops. The HS counsellors also provided students with career and college application support. The counsellors and psychologists worked together to support the social, emotional and academic development of students. With such a strong link to student wellbeing and providing a supportive environment, engaging this team of 13 certified non-teaching staff was an early goal of the change process.

In November 2009, the change agent met with the psychologists to discuss the results of the students’ social-emotional wellbeing and the Social-Emotional Wellbeing Survey from the Australian Council for Educational Research. The ES psychologist shared a three-tiered Response to Intervention (RTI) model that was related closely to a tiered primary, secondary and tertiary concept of health promotion. The change agent noted
the need to follow-up with the psychologist to discuss the link between a HPS approach and the RTI model. As a result of two more meetings with this psychologist to discuss the similarities between the two proposed approaches, the change agent chose to show how the RTI model and HPS were complimentary. The change agent used language consistent with both concepts during the presentation to the LT in March 2010. After this presentation, one of the Middle LT members acknowledged that they had just seen the RTI model and that the HPS presentation was good timing (Researcher’s Journal, 24 March 2010). The link was a conceptual one that showed how HPS was supportive of other proposed initiatives in the school, which further helped link HPS to the school’s core business (Macnab 2013).

In March 2010, the change agent again approached the psychologist to discuss the assessment of the social/emotional wellbeing of the students. The psychologist was supportive of the idea, and a subsequent meeting was organised with representatives from the counselling staff of each school to discuss the implementation further. At this point, due to the implications of more work and meetings without compensation, the idea was not supported. Thus, including the social/emotional component of a HPS into the existing social/emotional support structure of the school was unsuccessful without time being compensated. Limited time and competing demands were barriers in this aspect of the change process, as also reported by St Leger (2006) and Deschesnes et al. (2010).

6.5.2.2 Staff Wellness Committee: Guiding Coalition

In November 2010, staff were asked to volunteer for the Staff Wellness Committee, which was referred to as the Staff Guiding Coalition. Representatives from the HS and MS included the HS psychologist, one counsellor, the Head of Athletics, the Head of PE, a teacher with an interest in staff health, and a Global Citizen coordinator. Representatives from the MS included one PE teacher and a teacher who also conducted the MS Student Wellness Survey and joined the LWLW Committee. No representatives came forward from the ES. In January 2011, a second call was put out to the ES, specifically to the PE department and counselling department—again with no volunteers. The ES administrators were approached and one teacher representative was identified to represent the ES. This ES staff representative was passionate about wellness and had previous experience in the US seeing a CSH approach implemented.
He proved to be a valuable and supportive representative. Unfortunately, he coached after school and was unable to attend a number of meetings. The nurses were invited to attend; however, they were too busy during the meeting times after school. Regular attendance was problematic for some staff and presented a challenge in developing cohesive plans. A number of staff commented on competing demands and a lack of time:

sometimes I couldn’t make it and I felt a bit guilty (Staff committee. 4).

I was frustrated at the lack of time to be more actively involved in a message that is so important (Staff committee.2).

Thus, the appropriate climate for PD that Deschesnes et al. (2014) described, with time to plan and learn new skills, was not evident and could be a barrier for building wider capacity and readiness later (Hoyle, Samek & Valois 2008).

The first meeting in February 2011 was an introduction to the HPS approach and the SLP. Ten staff attended and apologies came from three other MS staff who had conflicting demands. The room was set up with three stationary bikes at the back to reinforce the idea of supportive environments, and staff were encouraged to cycle while the meeting was being conducted. Three staff members used the bikes. Some of the issues raised by staff at this meeting included the level of administrative support, the amount of curriculum time that would be devoted to health, the meaning of ‘sustainability’ in this context, and the role of nurses. These were key issues that could be representative of questions relating to principal support and efficacy from readiness theory (Armenakis and Harris 2009). These questions ultimately needed answers from the LT.

There were a number of informal discussions after this meeting, including discussing why senior administrators were not present, the ways in which some members were unclear about the role of the committee, and the belief that representatives from the curriculum office should be on the committee. There were other conversations of which the change agent was not a part, including the MS teacher talking to a senior administrator and suggesting they attend to show support. This administrator did attend the next meeting, which examined the student data. While he had seen these data before, he was impressed with the data and thought they should be shared with the LT. It was
useful having him present at the meeting to answer questions related to the LT’s support for the approach, and it was fortuitous that the staff member had pushed him to attend (Researcher’s Journal, 10 March, 2011).

This committee was structured with a five-month plan to meet once a month and guide the implementation of the SLP by linking it to existing structures, and to assess and plan for staff health. To make this task manageable, subgroups were established, which included a social/emotional group with counsellors and a psychologist, a physical health group with PE and athletics representatives, and a staff health group with two HS staff leading the process and reporting back to the committee. The change agent and two other committee members were tasked with overseeing activities in each school. Thus, this was a collaborative process to build shared ownership (Hoyle, Samek & Valois 2008; Rowling & Samdal 2011).

Some staff present at the first meeting did not attend future meetings, citing conflicting demands. The subgroups were committed and found time to meet as needed, and reported back to the Staff Committee during the monthly meetings. The counselling/psychology team was asked to consider assessing the social/emotional needs of the students to see if they would now take responsibility for this aspect of health promotion in the school. The reply from the HS counsellor representative that ‘if it ain’t broken, why fix it’ (Researcher’s Journal 2011, February) suggested that there was further work to be done to establish a discrepancy to indicate the need for change. The psychologist did not attend any other committee meetings, and the counsellor focused on the Staff Wellness Survey. The physical health subgroup was the link to curriculum of the Physical Activity and Nutrition Plan for the HS and MS. In the ES, the teacher representative helped facilitate the curriculum-related aspects to the SLP in the ES.

The Staff Wellness Survey was completed and, in May 2011, a report was distributed to the certified faculty (see Appendix 27) and a draft plan developed (see Appendix 28). As demonstrated in this report, staff nominated the following priorities: planning for retirement, physical activity and managing stress.
6.5.2.3 Innovative Outcome: Staff Physical Activity Release Time

In response to the staff priorities identified in the Staff Wellness Survey report, it was decided by the committee that allowing staff to undertake physical activity during the school day could improve fitness and help alleviate stress. Thus, after a collaborative process between the committee and LT, a statement of support for staff physical activity during the day was written as follows:

Staff have the full support of the LT to participate in physical and stress-reducing activities during the school day, and within the school grounds, when time permits.

While not all staff felt that this statement suited their own circumstances (as not all wished to exercise on the school grounds during the school day), it arguably helped build support from the teachers and ensured the program was also focused on staff health, which is considered an important part of a comprehensive approach (IUHPE 2009).

6.5.2.4 Embedded into Existing Structures: Learning Evidence Team

After the ratification of the fourth bullet point, and the associated accountability of the LT to strategically address the mission, a new Healthy, Active, Balanced Lives (HABL) Learning Evidence Team (LET) was established. It should be noted that integrating HPS into ‘existing structures’ did require a specific LET be established to focus on this new strategic component. Therefore, the existing structures needed to be expanded to accommodate the change. The curriculum office, in consultation with senior administrators, led this team. The curriculum director was a new member of staff in August 2012, as was the deputy superintendent. Having two new members on the LT requiring PD in HPS was challenging because they already had much to learn about their new positions, staff and community.

Staff who were members of the Staff Wellness Committee and joined the HABL LET included the HS counsellor, MS teacher and LWLW member, ES teacher and change agent. This provided consistency in the change process. It was pleasing to see that counsellors from the ES and MS committed to this group, as did two ES teachers and a HS subject coordinator (Researcher’s Journal 2013). The change to the mission may have demonstrated that the school was committed to the change, which may have
motivated others to be involved. The HABL LET group met five times between November 2012 and May 2013. The school had established an LET for each of the bullet points in the school’s mission, with the purpose being to ‘figure out how to measure what we value and to look for ways to gather and analyse evidence’ (meeting minutes 2012, 5 November). The first part of this process was to define the bullet point. The following statement was developed by the committee to define the bullet point ‘Lead healthy, active, balanced lives’:

Healthy, active, balanced learners are empowered to meet their needs, engage fully in their learning, and cope with challenges

• Health is a state of physical, social, and emotional well-being.
• Physically active learners participate in the recommended daily levels of physical activity.
• A balanced person manages time for rest, work, play and passions and time for self and others.

Current sources of data were examined and gaps identified, including social/emotional skills, ES students’ data and assessing balance. To fill these gaps, the committee decided to add 10 questions to the ES Grade 5 end-of-year survey and to interview six to 10 students across Grades 3 to 11 during lunchtime focus groups.

As recorded in the researcher’s journal, the change agent felt that the sample for the focus groups was too small to draw conclusions, and this concern was shared by another HS representative (Researcher’s Journal, 10 May 2013). Additionally, the findings from the survey had not been considered. This is discussed further in Chapter 9. As the change agent was leaving the school in June, and had been the change driver, the committee concluded with the following recommendations:

What should we continue with next year?

• If no one is appointed to spearhead this … revisit the action plan and appoint different staff to lead individual action steps
• Continue to administer the student survey with support from MS teacher (keep data connected to student learning and available to staff at all different levels so they can share with their colleagues)
• Unpack the action plan to determine what committees need to be formed/resurrected

Strategies to consider:

• Continue with HABL staff committee to promote health and wellness to examine … What is the policy for staff during work hours to exercise? How can we promote more HABL behaviors? What facilities can staff access for health promoting activities?
• HABL LET to continue to gather and analyse evidence related to how well students are realizing the mission
• Follow a Focus Groups of students and work with them over the year
• Develop full representation on given committees to include students, teachers, parents
• Getting student council involved with HABL.

6.5.3 Student Involvement

In terms of student input to the process of creating readiness, students were only involved as participants and not as part of the decision-making process. Their input was facilitated through the student survey. In Grade 9, 177 (94%) students participated; in Grade 10, 143 (75%) students participated; and, in Grade 12, 151 (91%) students participated. The change agent was teaching approximately half of the Grade 10 cohort and developed classroom activities associated with identifying strategies to realise the SLP. As the students had not consented to be involved in the research, these discussions were not formally recorded. From the change agent’s perspective as a teacher, the students were engaged in these activities, and many of the strategies were well considered; thus, Stoll’s (2009) suggestion of the potential of students to be advocates and leaders of change was apparent.

Other ways the students were involved as participants was in new curriculum activities in the plans (Appendices 18 and 19), such as students keeping an activity log to measure physical activity, and participating in the health fair. In the LET, involving students through the student council was discussed as a way of facilitating student leadership during the next phase of implementation.
6.5.3.1 Student-led Innovation: Student Health Ambassadors

In March 2013, a Grade 11 student developed the concept of having Student Health Ambassadors to work with the MS and ES students. She proposed this as part of the International Baccalaureate (IB) CAS (creativity, action, service) requirement. The student had participated in the HS-led sessions during the health fair while in her Grade 10 health class. Appendix 25 presents the proposal she developed to support the Student Health Ambassador idea. In May, following discussions with the ES administrators and ES staff, the following email was sent from a Grade 4 teacher:

   This project would connect really well to our Influence unit in Social Studies that we’re beginning the year with next year, and it would set up the norms in our classes really well. We would really like to invite the Health Ambassadors to work with Grade 4 at the beginning of next year (Grade 4 teacher, email, 15 May 2013).

A trial of the Student Health Ambassadors was conducted in May 2013, and, in the 2013/14 school year, the program was implemented. Given that the change agent left the school in June 2013, the outcome of this new program was not witnessed. As noted in the researcher’s journal (2 May 2013): ‘It is such a shame I am leaving I would have liked to be involved in this. It is a great, student-led evolution of the activities we developed for the Health Fair’. Thus, the potential of student leadership was again demonstrated, as was the ability of students to be advocates for change and health (Macnab 2013; Stoll 2009). This program also demonstrated how the curriculum (the IB in this case) has the potential to be a catalyst for change.

Kotter’s (1996) description of change processes as dynamic, complex and messy was true in this research. Of the potential supports identified, those that were arguably influential in this study were health promotion experience in the school, educated and involved parents, support from leaders in the school for health education and health promotion, and previous health promotion activities. A lack of HPS knowledge in the BOT was found to slow the process of change. Additionally, the health curriculum was seen to be an important driver of change.

The four areas described in Chapter 4 that needed to be addressed to implement HPS included (i) effective leadership, (ii) institutional anchoring, (iii) allocation of resources and PD and (iv) building partnerships. These were realised to different extents in this
Effective leadership was primarily the responsibility of the change agent, who worked to build a model of shared leadership across many levels in the school, including the administrators, staff and parents (Hoyle, Samek & Valois 2008; Macnab 2013; Samdal & Rowling 2011). Internally, three staff members who had been given the time for PD at the Australian conference became the key initiators of change and represented the levels of LT, head of department and teacher. Additionally, support from the HoS and deputy HoS was obtained early. As described by Kotter (1996, p. 6):

> in the most successful cases, the coalition is always powerful—in terms of formal titles, information and expertise, reputations and relationships, and the capacity for leadership. Individuals alone, no matter how competent or charismatic, never have all the assets needed to overcome tradition and inertia except in very small organisations.

While students were not included, the influence they had on the adoption of HPS in this setting was not considered significant by the change agent, as past experience had shown strategic direction being governed by the LT and BOT. However, in moving to implementation, the need for students’ input was stressed by the change agent and acknowledged by the LET.

Much effort was taken to anchor HPS to the school’s mission to facilitate sustainable change (Rowling & Samdal 2011). The allocation of financial resources and time for PD was important, yet difficult to attain. While financial resources were available, the CFO made the process for accessing them difficult; thus, external sources were sought from the PTA. As such, rather than financial resources, internal personalities could be considered a barrier in this study, which supports Armenakis’s (2009) claim that individual differences influence change processes. Similarly, a shortage of time in the curriculum and for the PD of staff was a barrier (Deschesnes, Martin & Hill 2003; Hoyle, Samek & Valois 2008).

Building partnerships was difficult in this setting due to the autonomous nature of the school and the lack of available HPS support for international schools. Established partnerships with local hospitals were used for health promotion activities. The need for avenues to build partnerships for HPS initiatives in international schools was indicated.
The following chapters identify the specific factors that influenced the change process, alongside discussion of how these findings link to the theory and practice of implementing HPS in the international school setting.
Chapter 7: Enabling the Adoption of HPS

7.1 Introduction

A key aim of this research was to identify factors that influenced the leaders of the school to either support or reject the proposed change to include a comprehensive approach to health—referred to as a HPS approach. Identifying these factors involved examining which aspects of the change message delivered to the leaders of a large international school had most influence on the leaders’ support for the change.

The theoretical framework that guided this research was overwhelmingly the theory of creating readiness for change, used extensively by Armenakis (1993) and Holt et al. (2007a), who focused on what change recipients consider when supporting or rejecting change, and how to frame an effective change message. They proposed that effective change messages need to address the five key beliefs of discrepancy, appropriateness, efficacy, principal support and valence, using the conveying strategies of persuasive communication, information sharing and active participation (Armenakis 2007).

Developing a change message involves carefully considering the context, content and process of the change. This chapter argues that, in this case study, discrepancy, efficacy and valence can be classified as aspects of the context; appropriateness is representative of content; and leadership support is linked to the process necessary to create readiness.

7.2 Findings

This examination of the factors influencing the school’s readiness for change begins by examining the conveying strategies employed to deliver the change message. As outlined in Chapter 3, the urgency and existing state of readiness can indicate which conveying strategies are most appropriate. In this research, the change agent perceived a low level of urgency in regard to readiness for change to a comprehensive approach to health, and subsequently incorporated all suggested conveying strategies. During the LT interviews, a Middle LT participant commented that a comprehensive approach ‘wasn’t on our radar screens’, which confirmed the low urgency and readiness. Had there been a high level of urgency and readiness, persuasive communication alone may have been
enough to build readiness. The following sections discuss how the conveying strategies were used in this research.

7.2.1 Persuasive Communication

Persuasive communication is concerned with the direct message given by a change agent. This typically occurs verbally through presentations and meetings, or through written avenues, such as reports and newsletters. Chapter 6 detailed how the communication from the change agent occurred in a variety of ways to key stakeholder groups. Presentations were used to communicate to the BOT, LT and staff groups. Meetings were held with staff, LT members and parent representatives. HS students were involved in discussions in their health class. Newsletters were used with the wider community. The presentations were structured based on the process that had been used to develop the plans and proposed changes.

7.2.2 Active Participation

Self-discovery involved in active participation is proposed to occur through taking small steps to learn the new approach, learning through witnessing others using the new approach, or being involved in decision-making processes (Armenakis & Harris 2002). Chapter 6 described the processes that illustrated how all three of these strategies were used. For example, the committees and presentations to the LT provided stakeholders with an opportunity to be involved in decision making, while the health promotion pilot programs provided members of the community with opportunities to learn by being involved in the program or vicariously learn by seeing others implement new programs. The LT recalled aspects of this active participation in the following way:

There’s a group of parents out there who are not working, spouses with incredible talents. She basically found all the people, bought them together and started creating health newsletters and those different pieces (Lower LT.6).

A number of other LT participants referred to the health promotion programs and consultative processes that were employed.

Armenakis (2002) identified this strategy as potentially having the greatest effect on creating readiness, as change recipients build their own knowledge through experience. It could also be argued that the change agent builds knowledge to help plan via this
engagement with the stakeholders and setting. The change agent viewed the pilot programs as a way of building both knowledge and skills in the school, as well as the belief of efficacy that the school was able to implement the proposed change. Armenakis’s (1993, 2002) description of active participation seems more associated with individual PD, rather than building the belief of organisational efficacy.

### 7.2.3 The Management of External and Internal Sources of Information

Sharing supportive evidence or information can enhance readiness for change and contribute to the PD of stakeholders. Gist (cited in Armenakis and Harris 2002, p. 172) identified that such information is more believable when the message is ‘generated by more than one source, especially if the source is external to the organisation’. The first information shared in this case study was from the change agent to the HoS when the HoS requested information on HPS. The documents shared included the *Australian National Framework for HPS* (1997), *Developing a Health Promoting School* (Gray, Young & Barnekow 2006) and *National Healthy School Status: A Guide for Schools from the United Kingdom* (Department of Health 2005). An external consultant shared curriculum documents from England on personal, social and health education (Department for Education 2009) with the change agent and some members of the LT.

Other information shared by the change agent with the LT included research exploring the link between health and academic performance (Durlak et al. 2011; Hanson & Austin 2003; McDowell & Tomporowski 2011; Wolfson & Carskadon 2003) and that embedding health curriculum in a comprehensive approach is considered best practice for schools (Joint Committee on National Education Standards 2007). In this case, the information was predominantly shared by internal sources. As the following participants’ comments acknowledged, access to research as part of this process had an enabling influence on building support:

> We were reading a lot of research on how important that is to learning. So it became—that’s our business, so that’s why we needed to do something (Lower LT.3).

> you provided tons of evidence about the impact of health on learning and on the importance of kids learning healthy habits when they’re younger. I won’t say to a boring degree, but persistent side of information, drip, drip, drip (Senior LT.1).
she sent us written stuff, she gave us presentations and she’d give us copies of those presentations. She shared what she’d shared with other people. She had lots of different communications. There are newsletters as well that we got shared with (Lower LT. 4).

also had a lot of sort of current research to back things up (Senior LT.2).

there was research presented on sleep and diet and the way it impacts the adolescent mind in learning. That was all important (Middle LT.1).

Other LT members shared TED (Technology, Entertainment, Design) talks on food (such as Jamie Oliver’s ‘Teach Every Child About Food’ and William Li’s ‘Can we eat to starve Cancer’); links to the benefits of 30 minutes of exercise; and the effect of exercise, sleep and food on the brain and learning. The information came from within the LT, staff and parents. As stated by a Lower LT, motivation to share these types of articles gathered momentum during the change process:

I think people have been more willing to share articles, research, talk about these kinds of things in terms of learning, because this benefits us all in learning, whatever it is, it’s there (Lower LT.1).

Thus, this information sharing was from internal sources and could potentially also be considered as overlapping active participation—that is, the LT were actively engaged and contributing to this conveying strategy. It is unknown whether the combination of active participation and information sharing has been observed in other research associated with creating readiness. Similarly, the presentations and newsletters were an avenue to share information. In the wider community, the newsletters provided a focus on the link between health and learning and the student survey results (see the newsletter in Appendix 23):

Every time we’ve had a meeting she’s come forth with information for us to consider, information in terms of looking ahead, models that she had. Then in terms of information that’s gone out to the community, that she’s worked with parent groups and teacher groups about educating, trying to bring information in terms of healthy lives to parents and students (Lower LT.2).

By sharing the information to key stakeholder groups, a broad cross-section of heightened awareness and PD could be facilitated and, as articulated by a Lower LT:
‘Once you’ve reached a certain awareness, in terms of the whole community, then it’s a lot easier to make change happen’. Thus, primarily internal sources were sharing the externally generated research. This may be representative of the lack of external people discussing health with leaders of schools. During the interviews, the LT were asked which publications they regularly accessed and read. The findings revealed that the LT were frequent readers of publications from educational journals and websites, including Educational Leadership, Education Week, The International Educator, Principals Training Centre and The Marshal Memo.

As shown above, all the conveying strategies were used to build readiness for change. It was through these conveying strategies, that beliefs were established and change readiness enhanced.

7.2.4 Understanding Context and Identifying the Need for Change

A number of discrepancies—that is, a clear difference between the existing state and the proposed state—were identified throughout the process of change and discussed in Chapter 6. At the beginning of the process, the discrepancies included not following a best practice model for health education and not having access to health-related data. At the conclusion of the interviews with the LT, the main gaps or discrepancies were identified as enhancing educational outcomes by addressing health priorities, and not having a coordinated program. This is shown in Table 7 below. As shown in this table, four LT members discussed the lack of a coordinated program, and nine of the 11 LT members discussed student health needs.

<table>
<thead>
<tr>
<th>Node</th>
<th>Number of LT Discussing This</th>
<th>Number of Comments Made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated, focused</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Health needs from data</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Enhances educational outcomes</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

The change agent identified these two areas by examining previous health-related programs in the school and examining the results of the Student Wellness Surveys that were conducted in 2008 (Document Analysis 2009). The change agent found that an ad-
hoc, champion-driven approach to health-related issues was previously used, and the LT realised this was not the best approach:

it wasn’t in an organized fashion, haphazard (Lower LT.2).

we had no organized program to support this learning (Senior LT.1).

Additionally, there were specific student health needs—including reduced sleep and activity levels, and skipping breakfast—as well as lower parental and teacher support that had the potential to negatively influence academic achievements.

Chapter 6 discussed how these discrepancies were presented to the senior leaders in an initial planning document, which contributed to health being included in the strategic planning process. The message then spread to the middle and lower members of the LT through subsequent presentations and meetings. Selected results from the Student Wellness Survey on sleep, physical activity, breakfast consumption, handwashing and adult support (see Appendices 2 and 3 for the full HS and MS reports) helped identify a need and were presented to different stakeholder groups. The data were important to build the belief that a discrepancy existed and was closely related to professional learning in regard to the link between health and learning. As a Lower LT pointed out:

What comes to mind first of all is the surveys that you did and what we know impacts kids and their learning. I’m thinking about sleep, substance abuse and what not. Those surveys that you did, I mean it was so clearly a gap. That’s where I saw the discrepancy (Lower LT.4).

The data were also key to gaining support from the two Senior LT participants:

I think the data collection was really powerful because it showed that there were things to work on related to sleep, exercise, caring adults. I think that really showed there was a need (Senior LT.2).

we were not and are not providing kids with enough opportunities to be physically active. I mean that was my major concern and there was obviously a discrepancy there (Senior LT.2).

The strong influence of the data on identifying a discrepancy echoed the findings Lee (2014) reported—that assessing student health status was key in showing there was a
need to adopt a HPS model. In regard to educational outcomes, the responses from the LT could be broadly classified in two ways. The first way, health being a key to achieving the school’s mission and vision and the second as health being an important educational outcome in itself. These were key factors in building an appropriate model, and are discussed in the following section.

7.2.5 Adapting the Model and Building the Belief of Appropriateness

Building the key belief of ‘appropriateness’ entailed modifying a comprehensive model of HPS to the context of the school—that is, developing appropriate content. The need to make context specific modifications was acknowledged by an LT member:

A Health Promoting School can work at this school but you know you have to be able to make some tweaks for the different schools, for the size of the school, different make-up (Middle LT.1).

The model modified for the school was the DECS Student Wellbeing Framework (South Australian Government 2007). Adding data to the model was seen as important in this setting, and, as the findings show, was reinforced by members of the LT: ‘I think being data based is really important, especially in an international school like this … if it is based on data then that gives it some grounding (Lower LT participant)’. Similarly, having student learning as the ultimate output was also considered important by the change agent to align to the academic focus of the school (Researcher’s Journal, 11 October 2010), which was also identified by members of the LT:

I don’t believe that you can reach your academic potential—I don’t think that we can realize our mission or the vision without it (Lower LT.4).

The primary thing we would want is reaching their academic potentials in the mission and vision (Middle LT.3).

While the academic alignment was seen as appropriate, and health seen as supporting academic achievement, many of the LT saw value in health as a lifelong gift and an important goal in itself:

The real benefits you can gain from being healthy and teaching good life skills, those skills go on with the kids and one could argue it’s more valuable than the more academic skills that we put a lot of emphasis on (Lower LT.5).
I have two goals for the school. One is the kids will learn as much as they can, and the second is the kids’ experience at school will be as positive as possible, and I think they spend a lot of energy on the first part and not so much on the second one. This is a vehicle to pay more attention to the second one (Senior LT.1).

It was interesting to note that, although it was important to embed HPS in the factors guiding strategic planning, which included a strong link to academic potential, these leaders indicated that the outcomes were important in their own right—that is, a positive school experience versus reaching academic potential. The fact that both Senior LT members voiced this benefit of health as an independent goal may indicate that promoting both outcomes as being benefits of a HPS approach may help build the belief of appropriateness.

A number of members of the LT team clearly illustrated the importance of the HPS model bringing together all members of the community to address the previously ad-hoc approaches to perceived health needs:

   It pulls together all the different parts and … people can see how they fit together (Lower LT.2).

   it’s a really good way for us to organise our work (Senior LT.2).

   I think it’s the holistic nature of it. I think it’s the right model (Middle LT.3).

BOT members also expressed support for the holistic nature of the model:

   The holistic approach, focus on the learner (BOT member.1).

   Community action and partnerships: It’s important that the school maintains the capacity to provide an environment that supports health and learning and actively partners with families and community in achieving this goal (BOT member.3).

However, aspects of the HPS approach were potential barriers. A senior administrator commented that the HPS model was ‘just so broad and could take us in tangents we don’t want to go’. Identifying the health needs of the students helped focus the program and was a key factor in gaining this particular administrator’s support.
### 7.2.6 Understanding Context and Building the Belief of Efficacy

The ability of the organisation to implement the change—referred to as ‘efficacy’—was an area in which some tension emerged in the LT, particularly among the lower level administrators, who questioned the principal support of the Senior LT. Specifically, reservations were linked to the actual priority the program would be given by the senior administrators, with an already full curriculum and school calendar. This is illustrated in the following comment:

> but we only have limited resources with people and time. So how do we adjust things so that the moral purpose—this is a really big thing for us to do and we believe in it wholeheartedly, then how do we find that time from limited resources to invest in that? So I think it’s appropriate, it’s how do we then shift things so that it becomes a priority? (Lower LT.1).

BOT members also voiced concerns about how the change would be put into practice:

> It will be interesting to see what kind of priority this bullet point gets within the school. Would it be just as acceptable for a student to say that homework couldn’t be completed because of afternoon activities and a need for sleep, as it would be to cut out activities and miss precious hours of sleep to finish homework, or study for a test? How do you balance when there are only so many hours in a day? (BOT member.1).

> I hope policies will be put in place to support the fourth bullet (BOT and Parent Wellness Committee member).

The concerns were not strong enough to change the belief that the program was needed and that the proposed model was appropriate. The change to the mission statement indicated that the school had committed to implementing the program and addressing the identified need. As a participant pointed out: ‘this is here to stay’ (Middle LT.3). Another stated:

> once it becomes clearly a part of the school’s mission, then I think it will sustain the efforts. I think it would be incredibly difficult to be taken out of the school’s mission once it’s in (Senior LT.2).

The different responses from the Lower LT members may indicate that more attention is required to build the belief of efficacy in those who will implement the change.
7.2.7 Using Effective Process and Building the Belief of Principal Support

To review, ‘principal support’ refers to the belief that leaders in the school support the change. Armenakis and Harris (2009, p. 129) described principal support as potentially being expressed by formal leaders (vertical position in the organisation), as well as colleagues who are described as ‘opinion leaders who can serve as horizontal change agents’. In the LT, it could be argued that the most senior leaders are the principal support in this group, as they are the vertical, formal leaders. Other horizontal change agents were not identified in the group during the lead up to changing the mission. Support was gathered from the senior leaders of the school early in the process of change. A number of middle and lower level administrators identified how important it was to have the support of the senior administrators if any change was to occur: ‘If the head of school in any way doesn’t agree etcetera, then it’s not going to happen, so that’s the key person to get’ (Lower LT).

Sharing information with Senior LT members on comprehensive approaches, and presenting it as a best practice model, helped build this support. The student data and links to the school mission also contributed to gaining the Senior LT support. As mentioned in Chapter 6, at the first presentation to the LT, one of the senior administrators said that the school had a ‘moral obligation’ to ensure that the health of the students was addressed. In the interviews, members of the LT were questioned regarding this comment and one of the middle level administrators recalled: ‘I definitely remember the comment. It struck a chord, I think, with all of us, especially when [the HoS] stands up and says basically we can’t not do this’ (Lower LT).

The comments from the LT indicated that they understood the comment to mean that there was an ethical responsibility of the school to address health and an obligation to prepare students for learning and life. Thus, the LT present at that meeting was given a clear verbal indication of support from a senior leader in the school. However, there was still some tension and concern regarding the level of support and priority that the new mission point would be given. This may indicate a lack of perceived Senior LT support by some stakeholders in the community. Chapter 6 also indicated that the presence of LT members in committee meetings was another factor that demonstrated principal support for the change. A further indication that the level of principal support was questioned by some of the community was evident from feedback after a whole-school
presentation on the 2020 vision for the school by a Senior LT. An anonymous staff member stated the following:

It would appear that the 2020 vision … We are again adding to student’s life with more. Yet, we still add ‘healthy balance’ and ‘healthy lifestyle’ at the bottom of the 2020 goals and the overall school vision. We need to be honest and say that we are giving lip-service to this, hence why is it always at the bottom … what are we truly going to do about it? (School Documents 2013, May).

In Chapter 6, the frustrations voiced by the parents who had been involved in preparing a plan for the nurses’ office also indicated the lack of support and priority given to health.

Principal support was developed and displayed by the Senior LT and by the belief built in the remaining LT members. This key belief was seen to influence the support for adopting a HPS approach. However, in the next stage of implementation, it appeared that there was a need to build the belief throughout the community, and for the Senior LT to demonstrate their commitment by facilitating time and resources to the new mission. Thus, the findings may indicate that, in adopting the change, the more senior leaders were central to building the belief of principal support.

Another consideration in building support is the process used. Effective process relates to the actions taken by the change agent, and the way the conveying strategies are used. As detailed at the start of this chapter, all the conveying strategies were used in a way that built support for the proposed change. Thus, the attributes of the change agent and the way she used the available strategies also influenced the outcome of the efforts to create readiness. The role of the change agent is discussed in detail in Chapter 9.

Of particular note is the way process was used to build the presentations given to the stakeholders. That is, the presentations indicated the diagnosis and consultations that had led to the plans and proposed change. Armenakis and Harris (2002) argued that, ‘if the change agent cannot justify appropriateness with reference to the process used, then he or she must justify it based on other criteria that may be more suspect’. Using process in this case was arguably an effective way to help build the belief of appropriateness. Additionally, attention was given to the language chosen and, where possible, the language used in the school was adopted—such as with the psychologist’s
proposed model discussed in Chapter 6. The support expressed by staff and parents for the change was included in these messages to the LT. Thus, it could also be argued that the LT support for the change was influenced by the wider support displayed by the community.

7.2.8 Considering Valence

Building the belief of valence involves addressing the personal benefits the change recipients may experience if the change goes ahead. Armenakis et al. (2007) acknowledged that valence can be extrinsic or intrinsic. Extrinsic valence is described as focusing on rewards or benefits, while intrinsic valence includes factors such as greater autonomy in decision making or PD. The LT identified benefits for themselves and for students’ learning, and five LT members specified that the whole community would benefit from the change. The responses shown below are examples of how these benefits were described by the LT, a staff member and a parent.

7.2.8.1 Personal Benefits

A Lower LT member stated: ‘it’s been good just self-reflection for me, because I had a much healthier, much more balanced lifestyle before this. So I think that self-reflection piece has been good’.

7.2.8.2 Whole Community Benefits

A Lower LT member also stated:

The students will benefit, I think that’s very, very clear. But I think also all the adults in these students’ lives because that has a huge influence on everything they do. Also part of this community is the teachers—that’s a key, key factor because the sleep, homework, their own health, the home balance is massive.

The change agent did not focus the change message on potential personal benefits for the LT; thus, the questions in the interviews did not explore this concept well. Therefore, it may be beneficial to encourage dialogue in meetings regarding the potential personal benefits change recipients can see. In this way ideas are shared and potential personal benefits can be identified and the concept of valence defined. This was a limitation of this research. However, from the responses above, the LT did
identify intrinsic and extrinsic benefits of the change, which may indicate that a belief of valence was developed indirectly and positively influenced readiness. One of the Middle LT actually stated that valence ‘is almost the easiest part of this whole process, seeing that we’re going to be healthier, learn more efficiently’.

The other tool used to examine the LT’s beliefs was the Organizational Change Recipients’ Beliefs Scale (Appendix 9), as discussed in the following section.

### 7.2.9 The Organizational Change Recipients’ Beliefs Scale

The purpose of administering this scale was two-fold: (i) to help guide the change message and (ii) to provide quantitative data pertaining to developing the key beliefs in the LT. Table 8 below shows the results from the first (March 2010) and second (January 2012) occasions at which the scale was given to the LT. As the table shows, the first time the scale was administered, the averages (on a seven-point Likert scale, where 1 = strongly disagree and 7 = strongly agree) were 4.6 for valence, 5.5 for principal support, 6 for efficacy, 6.2 for discrepancy and 6.3 for appropriateness. Due to the small differences, the results did not inform any modifications to the change message. Discrepancy and appropriateness were scored slightly higher both times, while valance and principal support were the lowest on both occasions. There were minimal differences between the first and second administering of the scale.

Some of the questions were not consistently understood, which could indicate they were not well constructed. One of the Lower LT left Questions 21 and 22 blank, relating to the perceived support of their immediate manager. Another left Question 20 blank, and questioned what ‘our operations’ meant. They also commented on Question 10 about the meaning of the term ‘operate’. Another LT member pondered the possible improvements in operations, questioning the criteria that would be used to assess any improvements, and also left Question 20 blank. Another LT member clarified their view of valence by crossing out references to ‘me’ or ‘I’ in Questions 1 (‘This change will benefit me’) and 6 (‘I will experience more self-fulfilment’) and replacing it with ‘students and staff’. Thus, the results indicated that adapting the scale to this case study required more trialling of the questions in a pilot study, including providing clarity for terms such as ‘immediate manager’ and ‘operations’. Additionally, the belief of valence could be perceived as either a personal benefit or a whole community benefit from the
change. This needed to be clarified for consistency. However, the interviews provided the opportunity to explore which key beliefs had been established and resulted in support for the change.
Table 8: The LT’s Responses to the Organizational Change Recipients’ Beliefs Scale

<table>
<thead>
<tr>
<th></th>
<th>Discrepancy</th>
<th>Appropriateness</th>
<th>Efficacy</th>
<th>Principal Support</th>
<th>Valence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1st Scale</td>
<td>2nd Scale</td>
<td>1st Scale</td>
<td>2nd Scale</td>
<td>1st Scale</td>
</tr>
<tr>
<td><strong>Senior LT</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1</td>
<td>7</td>
<td>on leave</td>
<td>6.8</td>
<td>on leave</td>
<td>6.2</td>
</tr>
<tr>
<td>A2</td>
<td>5</td>
<td>6</td>
<td>5.8</td>
<td>6.6</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>Middle LT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B1.1</td>
<td>5.25</td>
<td>5.25</td>
<td>5.6</td>
<td>4.8</td>
<td>5.2</td>
</tr>
<tr>
<td>B2.1</td>
<td>5.75</td>
<td>6</td>
<td>5.6</td>
<td>5.8</td>
<td>5.8</td>
</tr>
<tr>
<td>B3.1</td>
<td>6</td>
<td>on leave</td>
<td>6</td>
<td>on leave</td>
<td>6.2</td>
</tr>
<tr>
<td>BC.1</td>
<td>6</td>
<td>6.75</td>
<td>7</td>
<td>7</td>
<td>6.4</td>
</tr>
<tr>
<td><strong>Lower LT</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>BE.1</td>
<td>5.75</td>
<td>5.75</td>
<td>6.4</td>
<td>6.2</td>
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<tr>
<td>B1.2</td>
<td>6.75</td>
<td>5.3</td>
<td>6.4</td>
<td>6</td>
<td>6.4</td>
</tr>
<tr>
<td>B2.2</td>
<td>7</td>
<td>7</td>
<td>6.4</td>
<td>6.8</td>
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<tr>
<td>B3.2</td>
<td>6.75</td>
<td>6.25</td>
<td>6.4</td>
<td>6</td>
<td>5.6</td>
</tr>
<tr>
<td>B3.3</td>
<td>6.75</td>
<td>6 NP</td>
<td>7</td>
<td>5.8NP</td>
<td>7</td>
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<tr>
<td>BC.2</td>
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<td>6.33</td>
<td>7</td>
<td>6.6</td>
<td>6.2</td>
</tr>
<tr>
<td><strong>Average All</strong></td>
<td>6.2</td>
<td>6.1</td>
<td>6.3</td>
<td>6.2</td>
<td>6</td>
</tr>
</tbody>
</table>

Key: 1 = strongly disagree, 7 = strongly agree. NP refers to a new person in the position.
### 7.3 Discussion

The findings suggested that, with careful consideration to context, content and process, a change message can be crafted that is tailored to the unique setting. Using appropriate conveying strategies to deliver the change message, consistent with Armenakis, Harris and Mossholder (1993), may provide the best opportunity for the change to be adopted. In this case study, discrepancy, appropriateness and principal support were the key beliefs that all leaders expressed most strongly as influencing their support for the change. Concerns were raised regarding efficacy and valence was not consistently addressed.

#### 7.3.1 Principal Support

Institutionalising change requires commitment and resources, and, when the formal leaders express their support, others feel more confident to support the change (Armenakis & Harris 2002). Consistent with Nutt (cited in Armenakis & Harris 2002), this research found that when this support was perceived early and continued, successful change was more likely. The need to gain principal or leadership support and to position health as complimentary to academic objectives, as discussed in the literature review, was evidenced in this research. Developing this support was achieved through a broad-reaching process that actively engaged key stakeholders—a process strongly supported by Armenakis and Harris (2009, p. 130), who suggested that without this collaborative process fostering ‘genuine buy in sustainable change is unlikely’. Sharing research on the link between health and academic performance, as well as research on successful outcomes using comprehensive approaches, also led to leadership support. Providing school-specific student health data further highlighted a need that the leaders felt a moral obligation to address. Thus, in addition to active participation, sharing information and persuasive communication were important conveying strategies, as outlined in the theory for creating readiness.

However, members of the community questioned the level of support that the school leaders would actually give to the new mission during implementation. Thus, during the process of adoption, the belief of principal support was developed to a degree in the LT. During the next phase of implementation, it may be necessary for greater attention to be devoted to building this belief.
7.3.2 Discrepancy

As the data showed, the lack of a comprehensive model and the identified student health needs were the key factors in building the belief that a discrepancy existed. In discussing readiness to adopt a HPS project, MacDonald and Green (2001) described the need to match the project to the school’s philosophy, vision and goals, and to identify how the project would help address an acknowledged problem. This was clearly the case in this research, as the LT acknowledged the need for change with a clear discrepancy and agreed that the HPS model was the right solution to address this discrepancy—that is, the belief of appropriateness.

7.3.3 Appropriateness

Proposing the right solution to address the identified discrepancy is how the belief of appropriateness is built, according to Armenakis and Harris (2002). In this case, it was found that the HPS model could be successfully adapted to this setting by modifying the model to emphasise the importance of student data and learning, without losing its comprehensive nature, which is argued by Deschesnes, Trudeau and Kebe (2010) to be the foundation of its success. However, the change agent became essential to this process in overseeing and ensuring that the new mission statement was grounded in a comprehensive approach. In the international school environment, where there is high staff and community turnover, there is a risk that the integrity of the model and program could be lost. Building capacity (Hoyle, Samek & Valois 2008) throughout the organisation is the strategy proposed to reduce this risk and to help institutionalise the change. This began by actively involving the LT, staff and parents.

The other two key beliefs to be addressed, efficacy and valence, were not established as strongly as discrepancy, principal support and appropriateness. In their reflections on their research and practice in organisational change, Armenakis and Harris (2009) reiterated the need to address all key beliefs in change messages. However, they also raised the potential that some key beliefs may be more important than others to change recipients, as seemed to be the case in the current research. They identified the need for more research in different contexts and with different variables to assess this fully.
7.3.4 Efficacy

The school involved in the research did have a history of some ad-hoc health promotion activities and access to resources, which were identified as supporting the uptake of the HPS model. However, the belief in the school’s efficacy was not universally expressed, with a lack of time and competing priorities being the most commonly stated concern—consistent with other research (Kearney et al. 2016). The concerns with efficacy were expressed more by middle and lower level members of the LT, which may be because they had less commitment to health promotion, but may also be because they were likely to be more involved in the implementation phase and were aware of the competing demands on time.

7.3.5 Valence

Valence, the belief that the change is beneficial to the change recipient, proved to be less important in this research due to the varied interpretation of its meaning; thus, the influence it had on building readiness for change was difficult to assess. The belief of valence was interpreted as personal health gains by some members of the LT, and as benefits to students and the school by others. Arguably, both of these outcomes could be used in a change message to build the belief of valence. Mohammadhi, Rowling & Nutbeam (2010) found that the benefits staff described of adopting a HPS were most often related to student health and learning, as well as engaging students in more activities and boosting students’ self-esteem. The benefits to staff included PD in health-related topics and a more positive working environment. In regard to the community, Mohammadhi et al. (2010) identified the benefits as more knowledge and support for health promotion at home, and the opportunity to be part of the school. Thus, these points could be included in messages to build the belief of valence.

As acknowledged by Armenakis (2009), it is important that change agents address the potential benefits for the change recipients, and this was not clearly targeted by the change agent in this research. It is suggested that further research of this construct in the decision-making process in schools is necessary to understand the best way to assess the influence of valence in the educational setting. The results indicated that it would be worthwhile exploring the construct of valence from multiple perspectives prior to
developing research instruments, and then structuring questions aligned to these various interpretations.

7.3.6 Content, Context and Process

As previously discussed, content, context and process have been identified as factors influencing change efforts (Armenakis & Bernerth 2007), and were found to be influential in this study. All three of these factors influenced the change message delivered to the LT. The change agent, who was leading health promotion activities, maintained that understanding the context proved to be important to be able to understand how a comprehensive health program could contribute to the school’s existing goals and mission. Similarly, the data showed that contextual understanding was necessary to determine what adjustments needed to be made to which model or framework in order to enable easy integration into the existing structures, and thus develop the right content. By using all the conveying strategies—that is, persuasive communication, active participation and sharing internal and external sources of information—the change agent was able to motivate the leaders to support the proposed change. A key point in regard to the persuasive communication was the way process was used to structure presentations. This supported Armenakis and Harris’s (2002) claim that explaining the process that resulted in the proposed change is the best way to communicate appropriateness.

There have been calls to find ways to introduce the HPS approach (St Leger 2006), and the conveying strategy of sharing and presenting information may provide some direction of how to achieve this. The findings revealed that the LT were frequent readers of publications from educational journals and websites. Thus, to increase the awareness of comprehensive approaches and introduce HPS to schools, it is suggested that some targeted publishing through these avenues could be beneficial. Further, creating readiness for HPS in the international school context necessitated some modifications to the processes proposed by the IUHPE for establishing a HPS. These are presented in the following chapter.

At the end of the research, it could be argued that readiness for change had been established in the LT and in some members of the BOT and other key stakeholder representatives in the community. There were still questions regarding efficacy and the
level of principal support linked to the next phase of implementation. Discrepancy, appropriateness and principal support were identified as potentially more influential in the initial stage of adopting the change to a HPS approach. However, valence had been developed, even though it was not clearly targeted by the change agent. Therefore, the findings suggest that, in the initial phase of adopting a HPS approach and the need to engage the senior leadership in the school, some key beliefs are more influential than others. This supported Stevens’s (2013) concept that readiness occurs in stages. It also indicated that the senior leaders of the school were critical to building the belief of principal support in the LT.

The following chapter examines the other outcomes that were achieved by the end of the change process. This chapter also explores the data related to an SBA to change, and the guidelines for establishing HPS.
Chapter 8: Establishing HPS in an International School Setting

It can be useful to examine data in different theoretical frameworks to attain different insights (Ringrose & Atta 2015). An SBA to change and Achieving Health Promoting Schools: Guidelines for Promoting Health in Schools (referred to as the IUHPE guidelines) were both used to explore the data (Dooris 2007; IUHPE 2009). Both the SBA and IUHPE guidelines share a common aim of affecting change among the whole school, and providing conceptual and practical direction for those involved in leading change. Similarly, the literature on organisational change makes a valuable contribution to understanding and analysing change initiatives. This chapter draws on these different theoretical and practical perspectives in an effort to provide direction for establishing HPS in the international setting, and to contribute to the evidence for increasing the uptake of comprehensive approaches to health in schools.

The questions discussed in the following paragraphs relate to the feasibility of the HPS approach in the setting, and the degree to which the final model retained the integrity of the HPS approach. This chapter also discusses the contribution of the readiness for change theory to guidelines for establishing HPS and SBA.

Data are presented from each of the stakeholder groups directly through surveys and interviews, with the exception of students, whose direct participation was not sought due to ethical concerns and conflicting roles as teacher and researcher. Students’ input to planning was facilitated in their health classes. Documents, interview responses and the researcher’s journal are referenced throughout this chapter. The specific guidelines for establishing HPS published by IUHPE (St Leger 2005) and the whole-system approach presented by Dooris (2007) guide the ensuing discussion in this chapter.

The overall goal of an SBA and adopting a HPS approach is to embed health into the existing structures of the school, and thereby facilitate a re-culturing of the organisation (Dooris 2007; Whitelaw et al. 2006). That is, it seeks to cause organisational change and not just use a setting, such as a school, to implement a health promotion intervention. It was a goal of the change process in this research to facilitate a re-culturing in the school and make health a priority. This chapter begins by exploring what evidence existed that
re-culturing had occurred, before examining the other outcomes of the change process. Following this, this chapter discusses the simultaneous top-down and bottom-up strategies presented in Chapter 6 in light of organisational change theories and establishing HPS, and finally through the lens of the whole-system approach presented by Dooris (2007). This chapter also discusses the challenge raised by Dooris in implementing this approach in the real world.

8.1 Outcomes of the Change Process

8.1.1 Change to the School’s Culture and Agenda

The combination of strategies presented in Chapter 6 was arguably successful in achieving a re-culturing—or, more explicitly, the school acknowledging health as something that is highly valued. Four members of the LT spoke of a cultural change that occurred in the school:

I don’t think this change initiative does reside within individuals. I think it’s gone beyond that. It’s soaked into the woodwork as it were, not just the people sitting on the seats (Middle LT.3).

I would say possibly the most effective changes are the ones, which are almost subliminal. So that speaks to a culture, I think. Be it the automated way we might think. If we’re changing the way we’re thinking, if people are—without almost realising it—thinking in a new way, that’s got to be success (Middle LT.3).

it does already feel like there’s a fibre ‘cause you can see the way people tend to eat or use things—I don’t know, you just see little—you’ve already seen change happening. It’s becoming part of the fibre of the school, I think (Lower LT.4).

It almost gives permission for people, that have been wanting to do some of these things, that this is supported by the school, it’s very clear. It’s great to go back and say now, when we have this as part of our mission, we can say this is who we are. So of course we’re going to have these healthy foods guidelines, of course we’re going to have activity logs and we’re going to talk about adult exercise, and as a faculty are we well, and promote time to that and give time to that, because it becomes who we are. So it’s changing the culture of who we are (Lower LT.1).
Building the belief of a discrepancy was instrumental in causing changes to the mission and including health in the SLP. As stated by a member of the LT: ‘The belief became, oh, in the end, it’s our job. I think that’s where there wasn’t a change in belief. It was just a change in purpose’ (Lower LT). As shown in Chapter 6, the change to the school’s mission was a significant part of the change process and as the mission is the point of accountability of the LT it was a key to building sustainable change. A number of LT members commented on the significance of this:

Getting the board to adopt that fourth bullet [on the mission statement] was what institutionalised it—that says the board says, ‘this is one of the four big things our school’s going to do’. That’s huge because then all the administrators are accountable to the board to track progress with that and pay attention to it (Senior LT.1).

I think once it becomes clearly a part of the school’s mission, then I think it will sustain the efforts (Senior LT.2).

Once it gets up there on the mission, it becomes part of what we will be talking about and addressing (Middle LT.2).

Through educating the key stakeholders of the link between health and learning and the benefits of a HPS approach, the congruence between health and educational outcomes could be seen and the value of health in the educational setting made clearer. It was suggested that this increased awareness and that discussions energised the community, and that there was a shift towards a healthy culture:

Sure, I mean, I think certainly in terms of awareness and commitment the school is poised now—understanding of the issues in terms of food, nutrition, the health office, the amount of efforts to increase physical activity amongst the middle and high school kids. I think the people who most care about this have been energised (Senior LT.2).

I think there’s an awareness within—there’s more of an awareness with the fact that it’s been talked about (Lower LT.6).

Yeah, I think in general the food—there’s been a conscious effort at both elementary and, as a parent of an elementary kid, I think there are conscious efforts to look at the nutritional value of the food and to not offer so much junk food and looking at the snacks that are offered and things like that (Lower LT.3).
### 8.1.2 Changes to the Environment

The change to ‘meatless Mondays’ was an initiative of the environmental group, and was supported during the Health and Fitness Week. Other specific changes in the cafeteria were not directly driven by the LWLW Committee. However, it was interesting to note two of the Lower LT members attributing the cafeteria changes to the HPS initiative. Arguably, the increased awareness and change in culture could have been influential in the cafeteria manager responding to this:

> For example, like the change in the cafeteria itself towards healthy food, I think, if you didn’t have awareness in the community, you would have more backlash. What are you doing, taking away like my sweets? But we haven’t had that backlash. Very few people have complained. I think it’s because of that awareness and people are—it makes sense. We have these changes in the cafeteria, the meatless Mondays, etcetera, etcetera. People are accepting and changes are happening (Lower LT.2).

> Another is that I think the food choices have become healthier and physical activity for students and teachers has been encouraged (LWLW parent.2).

Thus, a change in the school’s culture, agenda and environment and an increase in awareness were some of the changes identified by stakeholders, and may indicate that the change was focused on the whole setting.

### 8.1.3 Some Shared Ownership and Sense of Empowerment

Chapter 6 highlighted the extensive collaboration that occurred to build readiness for change. Engaging key stakeholders and giving them a true voice in the process was identified as important. As outlined in *Achieving Health Promoting Schools* (IUHPE 2009, p. 3):

> The HPS is a whole school approach and, as such, needs to have ongoing support and commitment from head-teachers or school directors/managers/administrators.

> It is essential to have a number of students and parents participating and that their ideas are respected.

A key aspect of involving stakeholders is ensuring their ideas are heard and respected, so they subsequently develop a sense of shared ownership and empowerment. The
responses indicated that, while some sense of empowerment was established, it was not consistent:

The committees do give a sense of empowerment and ownership, especially when the community are involved (Staff and LWLW Committee member).

[being on the committee] absolutely gave me ownership and a sense of empowerment (LWLW Committee.3).

Yes, absolutely, I think I am one of the few people that avails myself to do the staff physical activity. Increased awareness of the benefits of opportunity to take advantage of the facilities. Yes and part of the mission statement—input was well received (Staff Committee.3).

No, but I do hope my support for you enabled a ‘no give up’ approach for change (Staff Committee.2).

As my involvement increased, I did begin to feel empowered to effect change, but sadly that feeling went away as time passed and it has now started to seem like the wellness program is being less well received or supported by administration. That is, difficulty in purchasing plates for ES, difficulty in getting support for nurses’ office changes (LWLW parent committee and nurse).

Specific feedback from students was not sought. However, the student who conceptualised the Student Health Ambassador program was supported by teaching staff and LT members, which could indicate that this student’s voice was heard and respected: ‘Thanks so much for being supportive of this, I’m really excited to get started :)’ (Grade 11 student, email, 21 April 2013). The feedback from staff and parents regarding what they enjoyed about being on the committee focused on being with like-minded people:

I enjoyed the committee members, as they were often like-minded on these issues. I enjoyed making a difference and getting our school documents aligned with a wellness philosophy (Staff Committee.3).

Exciting to talk about something I’m passionate about and talk to like-minded people. I do see a goal to achieve Staff Committee.2).
8.2 Integrity of the Model

A key outcome of the change process was the integration of a comprehensive approach to health into the existing structures in the school, and the HPS approach was modified to fit the school. As highlighted by Deschesnes (2010), an important consideration in the process of modification is maintaining the integrity of the approach. Thus, an important question in this research was examining whether the final model did retain the integrity of a HPS—that is, whether the final model had the fundamental aspects that were instrumental for it to be successful. Table 9 presents the 10 responses collated from a checklist completed by the LT to rate the integrity of the HPS model.
Table 9: The LT’s Responses to the Integrity Checklist

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<thead>
<tr>
<th>The ISB HPS Model</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Promotes the health and wellbeing of students</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Upholds social justice and equity concepts</td>
<td>5</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>3. Involves student participation and empowerment</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Helps to provide a safe and supportive environment</td>
<td>9</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>5. Links health and education issues</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Addresses the health and wellbeing issues of staff</td>
<td>9</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7. Collaborates with the local community</td>
<td>6</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8. Integrates into the school’s ongoing activities</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Sets realistic goals</td>
<td>9</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10. Engages parents and families in health promotion</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following Essential Elements of a HPS are included in the model.

- **a) Healthy School Policies**: Such as policies or accepted practices that enable physical activity, healthy eating or prevent bullying
- **b) Individual Health Knowledge and Skills**: Including the curriculum and associated activities, such as the health fair and physical activity log, where students gain age-related knowledge and understanding
- **c) Community Links**: Connections between the school and the students’ families and other key local groups
- **d) The School’s Physical Environment**: Including facilities, shade provision, handwashing facilities, etc.
- **e) The School’s Social Environment**: Combination of the quality of the relationship among and between staff and students, which is influenced by the parents and the wider community
- **f) Health Services**: Including nursing, counselling and any other health services at school

There was unanimous agreement that the five essential elements of a HPS were included in the model. Regarding the principles of a HPS, respondents were unanimous that the model promoted the health and wellbeing of the students, involved student participation and empowerment, linked health and education issues, integrated into the school’s ongoing activities, and engaged parents and families. Nine of the staff agreed that the model helped provide a safe and supportive environment, addressed the health and wellbeing issues of staff, and set realistic goals. The two areas that were rated lower included ‘upholds social justice and equity concepts’ and ‘collaborates with the local community’. When these were discussed with the LT members, it became apparent that
there was a need to define these more clearly, specifically, what these principles were referring to and how they would appear in a HPS approach. Thus, operationalising the principles of a HPS approach was challenging and indicates a need to make them more practical and measurable. This may be an area of consideration in the HPS field, or specifically in the international context. Alternatively, it may have been a limitation in the process of implementation in this case.

Overall, it could be inferred from the responses that the final model, modified to the context, retained the integrity of the HPS approach defined by the Protocols and Guidelines for Health Promoting Schools (St Leger 2005). Thus, the HPS approach could be modified to the international school setting and retain the components that made it successful.

8.3 Establishing HPS and Organisational Change Theory

The literature on organisation change and creating readiness for change gave the change agent a direction to plan for change in the initial stages. Table 10 is a summary of the common tasks of leading change presented in Chapter 5 that were most relevant to creating readiness, with a comparison to the elements identified as necessary in starting a HPS proposed by the IUHPE (2009; St Leger 2005) (please note that the final element of allowing three of four years to complete specific goals was not included because it was not considered relevant to the specific readiness phase).
Table 10: Comparison of Change Literature on Guidelines for Establishing HPS

<table>
<thead>
<tr>
<th>Organisational Change Theories and Creating Readiness</th>
<th>Necessary Elements in Starting a HPS (IUHPE 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall governing structures not specified in change literature</td>
<td>Develop a supportive government/local authority policy for HPS</td>
</tr>
<tr>
<td>Gain leadership support</td>
<td>Achieve administrative and senior management support</td>
</tr>
<tr>
<td>Establish a clear need and sense of urgency</td>
<td>Could be argued that the audit would establish a clear need</td>
</tr>
<tr>
<td>Incorporate collaborative processes with staff, students, parents and community to develop a shared vision and create a guiding coalition</td>
<td>Create a small group who is actively engaged in leading and coordinating actions, including teachers, non-teaching staff, students, parents and community members</td>
</tr>
<tr>
<td>Use systems of data collection to focus on school-specific priorities</td>
<td>Conduct an audit of current health promoting actions according to the six essential elements</td>
</tr>
<tr>
<td>Develop vision and plan</td>
<td>Establish agreed goals and a strategy to achieve them</td>
</tr>
<tr>
<td>Communicate the change message with appropriate conveying strategies</td>
<td>Specific conveying strategies or specific message not suggested</td>
</tr>
<tr>
<td>Build internal capacity and empower broad-based action</td>
<td>Ensure appropriate staff and community partners undertake capacity building programs and have opportunities to put their skills into practice</td>
</tr>
<tr>
<td>Specific step not included</td>
<td>Develop a HPS charter</td>
</tr>
<tr>
<td>Generate short-term wins</td>
<td>Celebrate milestones</td>
</tr>
</tbody>
</table>

Note that the organisational change steps were compiled from multiple sources: Adelman and Taylor (2007); Armenakis and Bedeian (1999); Clarke, O’Sullivan and Barry (2010); Fullan (2005); Hoyle, Samek and Valois (2008); Kotter (1996); Lindahl (2006); Tjomsland et al. (2009) and Todnem (2005).

There are some subtle differences and unique steps advocated by the theory for creating readiness and HPS framework. Both the HPS guidelines and readiness theory advocate developing support with leaders and key stakeholders early in the change process, and creating either a small group (IUHPE guidelines) or collaborative processes with stakeholders (readiness). Readiness theory articulates an additional step of establishing a clear need and sense of urgency. Data are referred to in different ways. In readiness, they are related to accurate diagnosis of the problem and the root cause of the problem that the change will address (Armenakis & Harris 2009). In establishing a HPS, data are focused on conducting an audit of current health promotion activities. Next, developing a vision and plan (readiness) and agreed goals and strategies (IUHPE guidelines) is
recommended, followed by building capacity and recognising short-term wins (readiness) and milestones (IUHPE). The IUHPE guidelines specifically add developing a HPS charter to the steps of establishing a HPS.

Consistent with good change management practice (Armenakis & Harris 2009), this study undertook careful examination of the context prior to the start of the research, and examined the priorities and mission of the school. This study determined the contribution of a HPS approach to the school goals and mission, which provided an opening for discussions. The table presented above provided a guide for the steps in the change process. Some of these steps were reinforced in this case study, while some differences were noted. These will now be examined.

Some of the HPS recommendations observed in this case study included gaining administrative and leadership support, facilitating stakeholder input (although not through a small group), establishing agreed goals and celebrating milestones. Recommendations not observed included looking to a governing or local government policy as the first step, having a small group of stakeholders and developing a HPS charter. A more subtle change was seen in using local student data, rather than an audit, to identify priorities and implement innovative health promotion programs as a way of building capacity through active involvement.

8.3.1 Consistent Elements in Starting HPS

8.3.1.1 Gaining Administrative and Leadership Support

Leadership support was gained early in the change process by identifying a clear need and demonstrating how a HPS approach could address this need or discrepancy. Changing the school’s mission and then anchoring a HPS approach to the new mission institutionalised the change and facilitated the integration of a HPS approach into the existing structures in the school, such as the LET. By making the link to the mission, the change was made relevant to the school, which removed lack of relevance as a barrier. Another important aspect of gaining leadership and BOT support was establishing the concept of procedural justice by clearly explaining the process that had led to the SLP and the proposed change to the mission (Armenakis & Harris 2002).
8.3.1.2 Stakeholder Input and Agreed Goals

Collaboration with key stakeholders and engaging them in conversation, as advocated in the recommendations for establishing HPS, was an important aspect of the change process in this research. This was achieved in both top-down and bottom-up processes through different mechanisms, including presentations, meetings, committees and class time. Informal conversations and emails were also sources of input. The input guided the change to the mission and vision, and the plans and processes used.

Creating realistic goals, as advocated by IUHPE (2009), was important in developing the annual plans linked to the SLP. The results from the student survey identified a lack of sleep as an area that was potentially influencing academic performance. A solution that was discussed included making a later school start time (see Appendix 2: Student Wellness Report 2009). However, the need to bus students out of the city prior to peak hour was viewed as a factor that could not be changed; thus, sleep was only addressed in newsletters and presentations to the HS students. Therefore, realistic goals were included in the planning process.

8.3.1.3 Celebrating Milestones and Short-term Wins

The communication channels—including the LWLW newsletters and emails and PTA newsletters—were avenues used to share successes. Positive outcomes were shared to the LT and committees in presentations and emails. For example, positive comments received in response to the newsletters were collated and forwarded to the LT. Other wins—such as the physical activity release time and addition of the fourth bullet point—were communicated to all faculty members, with some positive responses:

Wow this so awesome. thanks so much for all the hard work you have put into this project (HS staff member).

Thank you for doing all this excellent work (MS staff member).

For some committee members, these short-term wins were an enjoyable part of their involvement in the committee: ‘Seeing the results such as children’s consciousness and awareness raised, better choices being made, it was a “glorious moment” when the 4th bullet was adopted’ (Parent, LWLW Committee).3)
8.3.2 Different Elements in Starting HPS

There were some differences to the suggested processes for establishing HPS in this setting, which the literature on organisational change was useful in identifying and explaining. This section examines the differences to the suggested HPS elements.

8.3.2.1 Identifying Accountability

In the absence of an external body or governing structure in the international school setting, identifying the point of accountability for the LT became an important focus, rather than seeking to develop a local government policy. As the change process unfolded, the importance of the WASC accreditation document and the associated accountability of the LT to this document (and, more specifically, the mission and vision) became obvious. This knowledge was gained by examining documents and attending meetings and discussions with members of the LT and BOT. The school’s mission and vision was identified as the key point of accountability. Thus, reviewing accreditation documents and identifying the point of accountability for the school’s LT could be considered an important first step in planning for change in the international school environment.

8.3.2.2 Collaborative Processes

One small committee was not deemed feasible to create readiness in this setting; thus, two committees were established—a Parent and Staff Committee. Members of the LT were invited to participate in both these committees, and their involvement tended to be of an ad-hoc nature. Students were not involved in either of these committees. Discussion in the LET included facilitating student involvement through the student council in the next phase. These committees were established with short-term goals focused on creating readiness; thus, it is unknown how collaboration will continue and whether the staff-based LET committee will be the chosen avenue for collaboration in the future.

8.3.2.3 A Change to the Mission

A change to the school mission, as opposed to developing a HPS charter, was considered critical to building sustainable change. The purpose of a HPS charter is to demonstrate the school’s commitment to the HPS approach, and to show how local
policies and principles are tied to the HPS framework. In this research, the change to the school’s mission and integration into existing structures arguably fulfilled these functions.

8.3.2.4 Identify Local Needs

Using local school-based data, rather than conducting a health audit assessing specific criteria, created the potential for local issues to emerge and was critical in building support for the adoption of HPS. Lee (2014) also found student health status was a motivator for adopting HPS. Using local, school-based data stimulated discussions and focused change efforts, which supports the observations of Glaze (2013) that efforts need to be targeted on key areas of need to improve student achievement. Additionally, using school data also enabled the SLP to be linked to clearly articulated outcomes, which further supports successful change initiatives in schools. The LET was grappling with the ongoing data sources and priorities as the program was implemented into existing processes. Questions were also added to the annual survey processes to monitor progress towards priority areas, rather than conducting independent student health and wellness surveys. The process of identifying needs in this case pointed to a larger survey or tool to develop a baseline of health data from which priorities were identified. These specific priorities were then included in existing annual data collection.

8.3.2.5 Implement Innovative Health Promotion Programs to Build Capacity

A lack of HPS supports in this setting—and a subsequent lack of opportunities for PD—was identified as a barrier, and the change agent led capacity building. Capacity building was facilitated during presentations and meetings, and by implementing small health promotion programs. This gave staff and community members the opportunity to be actively involved in learning new skills and observing others.

8.3.3 Contributions from Organisational Change Literature

As shown in Table 10 earlier in this chapter, the organisational change literature also identifies leadership support, planning processes, celebrating short-term wins and building internal capacity and a broad base of action as important aspects to successful change. Additionally, some of the differences outlined above were described in the change literature, such as using a collaborative process, rather than a specified small
group, and using systems of data collection to focus on school-specific priorities, rather than an audit. Other findings in this research were also described in the change literature, including establishing a clear need, developing a shared vision and communicating a change message.

8.3.4 A Clear Need, Plan and Shared Vision

As discussed in detail in Chapter 6, a need (or discrepancy) was identified. This need was linked to the school’s mission and vision, and was supported by the LT. The vision and plan were further developed through the collaborative processes used to build capacity and a sense of shared ownership. There was a high level of understanding and support in the LT for the vision. While the HPS guidelines identify the need to set realistic goals, the need for a vision could potentially be something more. It could be a way of articulating the discrepancy—of describing a different organisation that is better able to meet its mission, consistent with the organisational change literature.

8.3.4.1 Delivering a Targeted Change Message

Chapter 7 argued that the change message and delivery is more likely to be successful if drawn from the readiness literature and focusing on certain key beliefs and specific conveying strategies. Thus, in this case, the literature on change provided some alternative strategies or differences to those already recommended for establishing HPS in schools. Dooris’s (2007) model was found to be closely representative of how the change process unfolded.

8.3.5 Whole-system Approach or SBA to Change

When considering an SBA, it was apparent that a number of bottom-up strategies were also being employed when the school leaders were being engaged early in the process of change. Thus, a linear view of the change process would not do justice to the complexity of the events occurring, or give the reader a thorough picture. Thus, it was useful to consider the top-down processes and bottom-up processes presented in the Dooris et al. (2007) model.

To re-cap, Dooris proposed links between top-down and bottom-up processes. For example:
• the top-down processes of organisational development and change management are related to the concurrent bottom-up process of high-visibility innovative projects

• the top-down process of managerial commitment is related to the bottom-up processes of engagement and empowerment

• the top-down processes of institutional agenda and core business are related to the bottom-up process of the health promotion agenda.

Figure 14 is a timeline of the key activities that occurred during the first 18 months of the case study, and illustrates the simultaneous nature of the change process. The top section, titled ‘Global’ in the timeline, illustrates health promotion programs targeted at the whole community. The second section includes the top-down strategies, and the third section corresponds to the bottom-up strategies.
Figure 14: Timeline of the Process of Change from February 2009 to November 2010
8.3.5.1 Linking the Top-down and Bottom-up Strategies

As can be seen in Figure 14, a number of strategies occurred simultaneously. The LT recognised this process in the following comments:

I see it as the perfect situation that it’s not bottom-up or top-down, it’s both and hopefully it meets in the middle (Lower LT.5).

She’s really worked on that bottom-up. What do we say as a staff in terms of recommendations? (Lower LT.6).

Categorising the top-down strategies employed in the separate headings proposed by Dooris et al (2007) was difficult. For example, does the school’s strategic plan best fit under managerial commitment, institutional agenda or organisational development? Such a struggle may be indicative of the concern raised by Dooris about the constraints of implementing the theory. However, the whole-system figure (Figure 7) was useful in structuring the top-down and bottom-up strategies, and an attempt was made to connect the strategies in this case study. Figure 15 is a poster that was developed in 2012/13 for presentation at the IUHPE conference in Pattaya, 2013. It illustrates how the strategies in this research were categorised and linked in the setting-based model proposed by Dooris (2006).
Figure 15: The Whole-system Approach or SBA Adopted in This Research
8.3.5.1.1 Organisational Development and Change Management Linked to High-visibility Innovative Projects

Dooris et al (2007) described making a commitment to embed health into existing processes and structures as organisational development. As highlighted above, this could be viewed as including health in the SLP of the school. However, in this context, changing the school’s mission and anchoring the proposed change to this new mission was identified as a key to organisational development and change management. This was linked to the high-visibility and innovative projects managed by the parent and staff committees, such as the student-led activities in the health fair, the new plates in the ES, the staff physical activity release time and the newsletters.

8.3.5.1.2 Top-down Political or Managerial Commitment Linked to Bottom-up Engagement and Empowerment

The SLP was instead identified as the key to building top-down commitment by identifying specific actions and realistic goals for the school to achieve. Providing human and fiscal resources to achieve these goals also indicated a managerial commitment. Developing and implementing these plans are represented in the bottom-up engagement and empowerment facilitated through the planning processes. The staff and parent committees were the prime focus of engagement with bottom-up stakeholders, with students included more indirectly through health classes.

8.3.5.1.3 Top-down Institutional Agenda and Core Business Linked to Health Promotion Agenda

In this case study, linking the institutional agenda and school business with the health promotion agenda necessitated sharing information and raising awareness in the school’s leaders. As presented above, this awareness or knowledge was focused on the link between health and educational outcomes, while further awareness was raised on the multifaceted aspect of a HPS approach, as described by an LT member:

when we first started talking about the healthy schools model was the—I think ubiquitous—I don’t know if that’s the right word, but that this was big. It wasn’t just we were going to put a health curriculum into place. Not only did I find that refreshing, but that made so much sense. Like if we don’t—if it’s not that holistic
approach, I’m not sure that it would be successful. So to me, that was so refreshing. I had never seen something like that and [found it] very exciting (Lower LT.4).

Health and educational agendas were practically united for the school by modifying a comprehensive school health model. The school-specific modifications included being data driven and ultimately focused on learning. The multifaceted areas of curriculum/pedagogy, policy and procedures, the learning environment and community action and partnerships represented the health promotion approach to plan and manage actions. The following sections discuss the methods and values that form the base to Dooris (2006) figure, and will be discussed as they related to the findings.

### 8.4 Methods

Examples of the methods given in Dooris’s figure include policy, environmental modification, education and marketing. As these are only suggestions, it is understood that these examples are not exhaustive. These methods could potentially relate to the essential elements identified in the IUHPE guidelines related to policy, environment, skills, services and community links. In this research, policy, environmental modification and education were all represented in the model chosen for the school, and marketing was a role undertaken by the LWLW Committee, with the LWLW logo an example of a specific marketing strategy. Thus, in this case study, the examples given could arguably be better placed as the health promotion agenda explicitly represented by the model. This included policy, environmental modification and education, alongside community action and partnerships. In terms of managing change efforts, and thus potentially methods, this research reinforced that the conveying strategies of managing internal and external information, active participation and persuasive communication were important to create readiness for change, and could potentially replace the methods suggested by Dooris (2006).

Given the calls for more direction in how to achieve whole-system change and implement an SBA in schools (Teutsch, Gugglberger & Dür 2015), the conveying strategies used to create readiness and build the key beliefs in change recipients may provide some guidance and strategies for change agents to use. Specifically, change agents could address the key beliefs of discrepancy, appropriateness, principal support, efficacy and valence by using the conveying strategies outlined above. Thus, SBA may
benefit from an examination of the literature on creating readiness for change. Methods could include examples such as manage internal and external information, facilitate active participation and use persuasive communication to address the five key beliefs. As such, a suggested change to the poster above would be amending the methods to read ‘active participation, manage internal and external information, persuasive communication’.

8.5 Values

Examples of the underlying values identified by Dooris (2006) are participation, equity, empowerment and sustainability. With these values mirroring the principles of HPS, they were also important in guiding the collaborative approach used in this change process, and, throughout the process, the change agent tried to maintain these core values. Chapter 6 examined how participation and collaboration were facilitated, and the feedback described earlier in this chapter indicated that some empowerment was achieved, although this was not consistent. The change to the mission, and subsequent integration of health into the existing LET structure, was identified by members of the LT as instrumental in making the change sustainable. In regard to equity, the following quotation from the record of emails shows how the change agent worked to maintain a sense of equity between all stakeholders. This comment was in reply to a suggestion from a Staff Committee member to identify administrators in the staff survey: ‘I really want us to feel like a collective and not an “us” and “them”’ (change agent to teacher 2011, email, 9 September).

It is acknowledged by the change agent that greater empowerment of students would be desirable when moving onto implementation. Thus, the values aspect to Dooris’s (2006) figure was largely representative of the SBA experienced in this research and provided a realistic framework to discuss the complex interplay of strategies used to create readiness. It could be argued that definitive placement of strategies into certain categories was less important than the simultaneous focus on top-down and bottom-up mechanisms to create a broad base of support and empowerment, and to use organisation structures to embed health, and thereby link health and education agendas.
8.6 Super Settings in the International School Context

Bloch et al. (2014) described a potential interaction and merging of settings into what is described as a ‘super setting’. In the international school arena in a developing country, the multiple settings and potentially divergent priorities and values may create a practical challenge in building the vast partnerships necessary for a super setting approach.

8.7 Was This Case Study Consistent with an SBA?

It could be argued that an SBA was used to create readiness in this school, as reflected in Figure 15. The approach focused on the whole system, engaged multiple stakeholders, developed individual skills and capabilities, and used an empowering approach from the bottom-up, consistent with SBA. Partnerships outside the setting were not a focus of the process of creating readiness. However, two hospitals were involved in the health fair and the following email was received after the fair:

Thank you for inviting us to be a part of such wonderful initiative. We appreciated your efforts to get the entire school’s participation. I know it’s not easy. I have learned quite a bit too about being meatless and more vegetarian (Hospital liaison, email, 17 September, 2010).

Strong leadership to direct and manage change is another feature of using an SBA, and Chapter 9 argues that this was evident in this case study. The challenging role of leading change from a bottom-up position is also examined in the following chapter. As described by Dooris (2004, p. 54):

Coordinating a healthy setting initiative is a complex business, requiring an ability to hold on to underpinning values, to wrestle with conflicting interests and to know when to compromise and when to stand up and be counted.

The HPS approach was successfully modified to the international school context in this case, and the integrity of the approach was retained. A number of the processes that have been suggested for establishing HPS were also evident in this research, while some differences were identified and discussed. The process of creating readiness for change was consistent with the simultaneous top-down and bottom-up framework proposed by Dooris (2006).
Chapter 9: Leading Change in Schools—‘It’s More Like Sort of Turning an Oil Tanker’

9.1 Introduction

The goal of the change agent is to influence the change recipients in a way that will build support for change—in this case, a HPS approach. Chapter 7 argued that encouraging school leaders to adopt a HPS approach entailed building key beliefs that a discrepancy existed, proposing an appropriate solution, and gaining support from leaders and key stakeholders in the community for the change. Stakeholders were actively involved in decision-making processes and implementing, or participating in, pilot health promotion programs. This helped to build capacity in the school and the key belief of efficacy. Certain qualities in the change agent were identified as important in leading this change process, which are discussed in this chapter.

St Leger (2006) claimed that change is more successful if teachers drive it and if schools have more autonomy in determining the content of the change, as was evident in this case study. The change agent was a teacher and can be considered as internally driving change from a bottom-up position. This chapter examines two perspectives—first, the role of the change agent in creating readiness, and, second, a teacher as the agent of change. Leading this discussion is the role and qualities of the change agent.

9.2 Qualities of the Change Agent

To review, in addition to contextual knowledge, successful change agents commonly have interpersonal skills, such as listening and understanding stakeholders’ priorities and an ability to facilitate collaboration and articulate a way forward that fosters support and confidence. Examining which skills the LT identified as important in the change agent will lead this analysis. To reduce the influence of personal or professional bias, a research assistant collected these data.
9.2.1 Communication Skills

The change agent requires certain communication skills to facilitate stakeholder input, including thoughtful presentations with engaging questions and an ability to listen. Nine of the LT members referred to listening skills, and hearing and using feedback:

listening and understanding stakeholder priorities. Passion I mentioned already, great people skills, teachability. She accepts feedback and she uses it well (Senior LT.1).

skill set is making people feel listened to and their points of view were being considered (Middle LT.3).

she has provocative questions that she communicates and puts out there. She respects the people in the group, that they have valuable input into the change process (Middle LT.1).

Communication, again, she’s come to communicate with LT several times and was always able to answer all questions clearly, explain that model and so I thought that was—her communication system was great (Lower LT.4).

One Middle LT member commented that they felt as though the communication had improved over time, specifically in regard to why adopting a HPS was the right direction to take. Additionally, some members of the LT recognised the planning and preparation required to articulate clearly:

there’s a lot of meeting and planning before she comes in, so that’s part of that being a good change agent is thinking through all the issues that could come up during whatever piece is coming next, what are ways that are going to help the thinking and help the understanding, the communication, she’s really clear (Lower LT.1).

These comments highlight the careful preparation that change agents need to undertake before meeting with stakeholders, as described by Armenakis and Harris (2009). The comments above also indicate that part of the preparation included anticipating the potential learning or PD that was required to support the next discussions. Thus, it is proposed that these meetings are not only opportunities to motivate and build support, but also opportunities to develop capacity and build knowledge and skills.
9.2.2 Problem-solving Skills

Another skill that five LT members discussed was the ability to solve problems by identifying and defining key issues, and then developing solutions: ‘seeing where maybe the real issues are in terms of the problems and then coming up with plans to address those I think has been strong’ (Lower LT). Problem solving was also discussed in light of being able to relate to different personalities in the LT and having a broad vision:

the problem solving … in terms of how you get around different characters in our leadership team. Very difficult (Lower LT.6).

Vision and problem solving go together (Middle LT.4).

Put the pieces together into the big puzzle, rather than just really focused on one piece of that puzzle (Lower LT.4).

These aspects of problem solving could be considered as related to the ability to understand the context and develop appropriate solutions to address identified needs or potential barriers.

9.2.3 Capitalising on Opportunities

A skill that was enhanced by being an inside change agent was the ability to identify and capitalise on opportunities that linked the HPS approach to other initiatives in the school. Examples of this (discussed in Chapter 6) included linking HPS to the psychologist’s plans, using the health fair to implement student-led sessions, and initially introducing a HPS approach through a review of the health curriculum. It also enabled the change agent to use familiar language, as HPS was aligned to other internal initiatives (Herrmann 1989; Unluer 2012).

9.2.4 Developing a Shared Vision

Through deep contextual understanding and collaboration, the change agent was able to develop a shared vision to lead the change process and motivate the LT. As stated by a Senior LT: ‘we’ve talked about it so much that I can’t distinguish with what’s her vision and my vision’. Initially, when a Senior LT felt the HPS was too broad and potentially vague, it was necessary for the change agent to rework the vision with more specific
goals and plans for implementation. This supports the IUHPE guidelines (2009) of setting realistic goals, as well as Kotter’s (1996) perspective that a good vision should not be too specific or vague. Additionally, Kotter claimed that a good vision is easy to communicate, and the LT indicated that communication of the vision was effective. It was difficult to gauge whether stakeholders other than the Senior LT shared the vision or if there perspective was that they understood and supported it.

Ten of the 11 LT members identified a clear vision as an important component of leading change:

I think we all got the vision as well (Middle LT.3).

I think she created her vision with people in an interactive kind of thing. I said before, she’s really good at communicating what the endeavour’s about (Senior LT.1).

She has the vision—I mean, she knows the goals of what she wants it to be like (Lower LT.1).

These findings suggest that there was visionary and effective leadership exhibited by the change agent, which was identified by Hoyle, Samek and Valois (2008) as necessary to support the implementation of a HPS approach.

Contextual factors also include awareness of the social dynamics. As argued by Armenakis (1993), the attributes of the change agent work in conjunction with the existing social dynamics of an organisation; thus, having existing positive relationships with established trust is a key factor as an insider change agent and researcher.

9.2.5 Personal Qualities of the Change Agent

The next qualities identified in the literature review included the need to be dynamic, be visible and empower others. These qualities were possibly not as evident. Chapters 6 and 8 explored that some empowerment occurred, although not consistently, even though there was substantial collaboration. This may relate to the decision-making processes at the time being perceived as more top-down in the school, rather than being the responsibility of the change agent. In regard to being dynamic and visible, comments made by Senior LT members may allude to this not being as evident. When asked to suggest areas for improvement, the following comments were made:
I think seizing agenda time specifically with the LT, so that she said ‘I really need to
be in the agenda once a quarter’, which I think would be the minimum that’s
appropriate and being a bit assertive about that because it is part of the school. The
LT have tonnes of priorities so you’ve got to keep reminding them this is a big deal
(Senior LT.1).

I could’ve maybe seen more aggressive sort of push on that and holding us more
accountable (Lower LT.6).

Pretty soft in her way, which is a plus and a minus (Middle LT.4).

Not all LT members agreed on this point:

I don’t see that as her responsibility. That assertiveness, to me, that needs to come
from the Leadership Team. I mean, it’s difficult to lead from the middle … I,
personally, would say that’s a tough expectation to say (Lower LT.5).

It isn’t her decision as to when she gets on an agenda or when she doesn’t get on an
agenda or when she has access to people and when she doesn’t have access to people
(Middle LT.2).

Another Senior LT made the following comments:

I don’t see how she could have acted any differently. Possibly, I mean, she might
have been more persistent, more demanding of people’s time, more demanding of
getting on agendas and things like that, but it’s probably not in her nature. (Senior
LT.2)

Thus, rather than using terms such as dynamic and visible the LT identified
assertiveness as a quality that may be desirable in change agents. However, as the
comments above show there was some disagreement regarding the assertiveness of the
change agent and whether being on the LT and BOT meeting agenda was in her control.

Some authors have disagreed on the notion that dynamic, charismatic leaders are more
successful. Fullan (2002b, p. 21) argued that:

the good news for most of us is that charismatic leaders are actually a liability for
sustained improvement. Collins suggests that leaders who build enduring greatness
are not high-profile, flashy performers but rather ‘individuals who blend extreme
personal humility with intense professional will’.
Based on some of the LT comments above, it could be argued that the change agent was not a ‘high-profile, flashy performer’, and the comments below indicate that this was not a liability:

She’s persistent in a very nice way, not a pushy, dogmatic way (Middle LT.4).

She’s not very pushy, which I actually like. Personally, I prefer that (Lower LT.6).

There’s some people that that personality of being pushy and trying to get something through and it kind of rubs the wrong way, where she’s not that way at all (Lower LT.2).

However, by not pushing for agenda time, the change agent may have increased the time taken for change to occur. This is difficult to assess because building sustainable, organisational change is a process that takes time (Green & Tones 2010). It took over five years from the point of introducing a comprehensive approach to the LT and BOT changing the mission statement. According to a senior administrator: ‘When you’re looking at significant change in schools, it’s more like sort of turning an oil tanker’ (Senior LT).

When asked about the length of time the change process had taken thus far, the comments from the LT varied. The majority commented that it was consistent with change at the school. One LT member commented that, with systemic, sustainable change, the timeframe was not important, while two LT members commented that the change had been too slow:

It’s hard to say. Like, I’ve seen some initiatives go fast and others take a long time and knowing that change is only going to happen if an institution is ready to have that change, and the only way you’re going to be ready is to be aware and you need to have a certain number of people on board (Lower LT.2).

They can’t give up because it takes three to five years to implement big change—minimum three to five years (Middle LT.4).

actually three to four years would be about what I would expect at … But that’s to get meaningful change. The number of different people that need to be involved in it, that’s just what it takes here (Lower LT.5).
She kept getting put in the back burner. So too slow, yeah. I mean, think about our changing community, but she gets people in the committee going, then they leave (Middle LT.4).

If in fact it becomes part of our culture and it does have sustainability, then the time element is not an issue at all (Middle LT.2).

Spending time with stakeholders and building common knowledge and vision was identified as a time-consuming, yet necessary, aspect to creating readiness for change:

I know that she’s committed an awful lot of time to meeting with different constituencies, which I think—in any change process—that reaps amazing dividends (Middle LT.3).

You've got to put your time in in raising awareness to get a certain bulk of the community to that—on board to that level. Then things fly easily (Lower LT.2).

You need to do a lot of communicating, you need to have the vision, have the ideas and educate, educate, educate (Middle LT.4).

Having a high degree of commitment and relentless effort is also a quality identified in successful change agents, and was evident in this case study. All members of the LT referred to a high degree of commitment, patience and persistence:

Absolutely she has passion for it. She’s been like a dog with a bone with it. She just keeps going even though she got discouraged a lot of times. When it got put on the bottom of the leadership team meeting and when the board didn’t approve that bullet to the vision … she persisted (Middle LT.4).

Commitment, which goes with that tenacity and staying with it. She’s stayed with it for a long time now. You have to be super committed to something like this, I think (Middle LT.4).

I think … been really patient, which I guess would be maybe the commitment piece. She’s been very, very committed (Lower LT.1).

In addition to problem solving and passion, the other qualities the LT identified as important included competence, people skills and authenticity:
She also models what she’s talking about throughout her daily life and interactions with us and it’s like that—she’s passionate about this and so she’s walking the talk (Lower LT.1).

She believes in this, she sees the importance of it, she lives it in her own sort of lifestyle choices and behaviour and food choices (Lower LT.3).

She’s not doing this for recognition. It’s very clear she’s doing it for a moral purpose. She’s taken the initiative. She’s been the driving force on this whole thing (Lower LT.4).

One member of the LT identified passion as the key quality of change agents:

I think the passion, for a change agent, is—I mean, I think they’re all important—but, for me, having the passion can compensate for deficiencies in other areas and without passion I don’t think anything else can move forward (Lower LT.5).

Some of these qualities identified by the LT reinforced those discussed in regard to teachers as change agents.

9.3 Teacher as Change Agent

Lukacs and Galluzzo (2014) identify and promote the potential of teachers as agents of change in individual school improvement. Thus, it is pertinent to explore if the qualities identified in this case study are consistent with those discussed in recent literature. Lukacs and Galluzzo (2014) identified that teachers who are successful change agents reach beyond the classroom and use their area of expertise to effect change on the school. They can read the school context, make connections across the school community and facilitate problem solving with colleagues. They have the skills to address the problems they identify and feel a sense of ownership and personal responsibility in addressing these problems. They are risk takers and are confident in their ability as teachers and problem solvers (Lukacs & Galluzzo 2014; van der Heijden et al. 2015, p. 467). From the data presented above and in Chapter 5, it can be seen that a number of these qualities were reinforced in this case study, including having contextual knowledge; expertise in health promotion, problem solving and collaborative abilities; and connecting with and motivating stakeholders across the community.
Van der Heijden et al. (2015) also described teachers as change agents as lifelong learners who are reflective and who strive to improve their professional practice and effect on students. One of the Lower LT commented on this:

she portrays herself as a learner and I don’t know if I said enough about that. Like I see her as really valuing people’s input and then she just is learning herself and I think that’s important. (Lower LT.1)

Thus, the findings in this research reinforced the characteristics of the teacher as a change agent identified in the literature. As discussed previously, there were advantages in being a teacher leading change, and some frustrations encountered by leading change from a bottom-up position, as discussed in the following sections.

9.4 Frustrations of Leading from Below

As a change agent in a bottom-up position, there were some frustrations and hurdles encountered, such as not being part of regular communication and planning processes, accessing funds and navigating issues of control in the LT.

9.4.1 Planning and Communication

Not being in the LT and losing a strong LT advocate for change early in the process meant that the change agent was not always privy to pertinent developments or discussions. Examples included not having the Strategic Planning Preamble to help prepare the SLP, or the final version of the SLP to work with. The final SLP was completed on 19 March 2011, yet the change agent did not receive this until February 2012, prior to the BOT presentation. While the differences to the November 2010 version were minimal, this is indicative of some of the challenges facing bottom-up change agents, such as not being part of regular communication channels in the LT and thus being left out of correspondence. Missing important information has been identified in the literature as a potential problem of being an insider researcher (Unluer 2012. To minimise this risk, it is suggested to specifically ask to be included in these channels or to have a system implemented to regularly touch base with an LT contact.
9.4.2 Difficulty Merging Different Agendas: LET

The school year in which the HABL LET was established (2012/2013) was also a pre-WASC accreditation year, and the curriculum office was tasked with helping to provide evidence for the WASC Report. The change agent felt that the two agendas of the HABL learning evidence and WASC evidence needed to be addressed separately. As written in the researcher’s journal: ‘There seems to a mixing of agendas regarding collecting data for WASC and as learning evidence’ (Researcher’s Journal, 22 April, 2013).

The curriculum coordinator wanted the LET to only focus on data collected that year, which was a WASC constraint. As no Wellness Survey was conducted during the year, and this survey was the main driver of the action plan and existing evidence, it was a constraint that the change agent felt was counterproductive to the LET agenda. It was also difficult to take a complex model and try to fit it into another format with new leaders. As recorded:

I needed to clarify misunderstanding regarding the model and process of establishing priorities and our existing action plan as the new curriculum head had started us off on a process of identifying priorities again. The new leaders were understandably still not clear with the process (Researcher’s Journal 10 April 2013).

These frustrations may indicate the need for change agents to be more highly involved in leading the next implementation phase, and to continue building capacity as the approach is further integrated into existing structures, thereby further supporting the concept that readiness is developed in stages (Stevens 2013). The high staff turnover in the international setting may exacerbate this.

9.4.3 Unclear Decision Making

Another frustration linked to the specific context was the unclear decision-making process and access to funds. Wellness being on the SLP did not automatically translate into funds being available to implement the plan, as was suggested by a Senior LT member (Chapter 6). The CFO was not always present at meetings and a budget was not designated for wellness. This meant that every request for expenditure had to go through the CFO, who did not always support decisions, even if they had been reached through a collaborative process. This was an issue throughout the process that slowed
any activity requiring funds and/or affected the aesthetics of the schools, which was another area of responsibility for the CFO. An example of this was in April 2012—while implementing the Nutrition Plan, there was a need to involve a Senior LT staff member in communications with the CFO. The email below illustrated the change agent’s frustration at the need to seek their approval, in addition to the LT. This process involved more meetings and presenting information again, which further delayed plans:

I am writing in regard to the part of the strategic plan related to food. I have presented the plans in a number of different settings and I apologise if you have missed out on some of the details related to this plan. In all honesty I am unclear on general decision-making processes and to whom I need to talk with (Change Agent, email, 29 April 2012).

This particular funding was finally approved in August 2012, and was typical of the frustrating process of having two lines of approval, with any final budget approval coming from a member of the LT who was not primarily responsible for achieving the SLP. Other examples were strategies that had been approved by Senior LT members only to be rejected by the CFO after considerable time had been spent planning these strategies. To help pay for the new plates in the ES, a grant from the PTA was necessary. This entailed two presentations to the PTA meetings, written applications and follow-up correspondence.

This raised the question of how decisions were made in the school, and whether a collaborative process results in shared decision making. Thus, the LT, staff and parents were asked how they viewed decision making in the school. In regard to the decision to adopt a HPS approach, the responses from the LT showed some different perspectives:

the actual decision came the right way through the, probably the twin forums of the leadership team and the school board. I think the Strategic Learning Plan preceding the formal recognition of the school board. I just made sure that it was included in the plan (Senior LT.2).

I remember presentations about it, but I thought it was kind of a fait accompli and that we were already kind of headed in that direction (Lower LT.4).
I don’t think the decision was made at LT level. It was sort of—I mean, it was more—everyone was very positive about it so I can only assume it was even made at a higher level (Lower LT.5).

The idea that middle and lower levels of the LT provided confirmation and support for the decision, rather than making the decision, was a common theme in their responses. The other Senior LT member alluded to his role in initially supporting a HPS approach when he replied: ‘What I should say, it was based on evidence and careful analysis of strengths and weaknesses. There was a long analytical process and that resulted in that decision, but that’s not what happened’. He went on to say it was an area that was not receiving enough attention, and that this was the vehicle to address that need. Thus, the overall decision-making process was vague from within the LT. A general consensus was that the two senior administrators set this direction and the other LT members supported it.

Parents commented that they either did not know how decisions were made or that they perceived them to be top-down:

I feel like only a few people in the top positions make the decisions at … Parents and teachers are invited to the discussion, but for the most part, it seems that the invitation comes after the decision has already been made (LWLW Committee.1).

Top down. Decisions are made, the community is (sometimes) informed (LWLW Committee.2).

Staff responses were similar, in that they either felt they did not know or were seen as top-down:

On the surface it is made to look collaborative, but in reality it is top-down (Staff Committee.1).

Top-down decision making at the moment. Although information gathering occurs, as to how much they play in a final decision, not sure, but collaborative energy and effort is not occurring (Staff Committee.2).

Not always based on a definitive set of criteria or a decision-making matrix. Often based on student learning, but sometimes based on teacher needs and or political needs in the school (Staff Committee.3).
I don’t really know how decisions get made—It’s a mystery. Not on any executive council etc so I don’t know (Staff Committee. 5).

Events illicit responses quickly sometimes without due process and then other times it takes a long time (Staff Committee. 4).

As a bottom-up change agent, managing the personalities and navigating the interpersonal relationships in the LT was challenging, as well as understanding how decisions were made and activities funded. Being assertive with those in positions of power came with an element of risk of negatively influencing existing relationships. As presented below, trust, rapport and credibility in existing relationships can be an advantage as both a change agent and researcher.

9.5 Insider Researcher and Change Agent: Shared Benefits and Risks

There are benefits to leading change internally, and some of these benefits are common with being an insider researcher.

9.5.1 Benefits: Established Trust and Credibility

Armenakis and Harris (2009) argued that, without credibility, the change message may not be believed. As an internal change agent, having existing trust, rapport and credibility in relationships helps understand and engage stakeholders and, as a researcher, can help access participants and gain support for the study. Additionally, it helps keep interactions natural. Six of the LT members spoke of the existing credibility and that this was an important factor in engaging the LT:

She is highly regarded, her thinking is very credible, the way she presented herself was never threatening or offensive, because we know her, she’s got a reputation. So as I say, I think—so she immediately engages—she was able to engage with the group (Middle LT.3).

She really knows the subject in and out and is very believable (Senior LT.1).

There was confidence in the people doing it (Lower LT.3).

There’s a lot of people who really trust her (Lower LT.6).

She’s aware of situations on campus (Lower LT.6).
The teaching role also contributed to establishing credibility:

So as administrators, we know that she’s talking to kids about a better, healthier, safer environment and lifestyle choices for them, so knowing she does that, that gives her credibility when she then steps in front of us and proposes there are ways for us to be a better school (Lower LT.3).

A Senior LT also identified that the teacher/change agent was involved in research, and this also gave the proposed change credibility. This raises the possibility of a symbiotic relationship between the dual roles of researcher and change agent: ‘the fact that you’re connected with the program, getting a PhD, that also gave it credibility’ (Senior LT). This credibility and trust helped the researcher gain permission to conduct the research and access documents, while the contextual knowledge helped identify the research focus and reinforced the benefits of being a ‘deep insider’, as described by Edwards (2002, p. 71). However, the dual roles of change agent and researcher also shared the risk of changing existing relationships.

9.5.2 Risk: Potential to Change Existing Relationships

A risk as an insider researcher and change agent is changing positive relationships. Asking time of people who are busy and raising areas that need attention can be viewed negatively. Lukacs and Galluzzo (2014, p. 103) wrote that teachers as change agents can be labelled ‘troublesome’. Defining boundaries and managing relationships was necessary so that the researcher/change agent could continue working at the school. It could be argued that a softer approach and reliance on facts contributed to maintaining positive relationships: ‘She’s always been very positive, in a sense it’s going from the facts, from the information, rather than coming across as this is me trying to push this’ (Lower LT).

9.5.3 Risk: Compromising Roles

Managing the many roles was challenging in this case study, as other authors have acknowledged (Unluer 2012). Teachers’ days are dictated largely by students’ timetables, and free time is limited. Therefore, the time and availability to attend meetings that could be of benefit as a teacher, change agent or researcher is also limited. The LT meetings were during the school day; thus, attending these meant either having a substitute teacher or trying to align attendance during a free period. Similarly, each
school used after-school times to schedule various meetings with staff and the community. Thus, as a teacher change agent and insider researcher, managing time and accessing organisational time was challenging, and there was a risk that roles could be compromised when trying to juggle them all.

9.6 Discussion

It could be argued that the change agent was successful in creating readiness for change in the LT. The change in the school mission was indicative of a systemic, organisational commitment to address health, and the model as a tool to plan for health comprehensively or adopt a HPS approach. While change agents may be external or internal to the organisation, Armenakis (1993) stated that the energy and support to create readiness must come from within an organisation. In this case study, the change agent was a teacher, and thus an internal, bottom-up leader of change. By collaborating with key stakeholders, the change agent was able to create the energy required to build a broad base of support and motivate the LT to include health in the existing structures of the school.

A number of the attributes of change agents described by Armenakis (1993, 2009) were reinforced in this case study, including expertise, credibility, trustworthiness and sincerity. Additionally, having a deep knowledge of the context; established positive relationships; and a collaborative, flexible approach were important in leading change. It could be argued that the leadership was visionary and effective, thereby supporting Hoyle, Samek and Valois’s (2008) argument that this is an important element in the organisational capacity necessary for HPS.

The influence of context has been examined throughout this research as a key consideration in developing the change message and using an SBA to organisational change. In addition, in this chapter, contextual understanding was discussed as a key factor in managing change and the research process.

As a change agent, it is necessary to understand the priorities of the school, and be able to identify problems and find solutions that will fit the school’s ethos. In this case study, this required flexibility and time—time to meet with stakeholders, listen to their perspectives and integrate these perspectives into the vision and plan. Kotter (1996) argued: ‘Good visions are also clear enough to motivate action but flexible enough to
allow initiative’. Green and Toner (2010) concurred that settings in a postmodernist world are neither predictable nor clearly structured; thus, change agents need to be flexible and open to the ideas and perspectives of others. Armenakis and Harris (2002, p. 180) added that: ‘An effective vision must include more than a goal, it must be true to the culture and the values of the organization and be presented vividly with “passion, emotion and conviction”’. The vision was developed over time in consultation with Senior LT members and committees. As the responses from the LT indicate, this vision was well understood. Additionally, the findings suggest that the change agent was able to communicate effectively with passion and conviction. In building support, the change agent needed to choose data that were influential and share information to educate recipients on why change was necessary.

As an internal change agent, this deep contextual knowledge was useful in seeing the potential and creating the vision. However, areas such as decision making and budgeting were not well understood by the change agent, even as an insider, and clarifying this at the start of the research may have saved time and energy throughout the change process. This lack of awareness may represent the role of a change agent in a bottom-up position as a teacher, and not being as involved in leadership processes. Thus, understanding the leadership ethos of the context was a challenge for the change agent. Early in the research, having a member of the LT as an advocate and close support was valuable in helping to process some of the reflections and questions for the change agent. However, as mentioned in Chapter 6, this LT member left the school at the end of the first year of the research. Thus, a gap existed in communication for the change agent. Some suggestions to fill this gap could include finding a new advocate in the LT, asking to be included in certain communications and information sharing, and regularly checking in with an LT contact for updates regarding strategic planning.

Similarly, being in a bottom-up position may have meant that the change agent was not as assertive in seeking agenda time and keeping the change higher on the list of priorities. This was potentially compromised further by issues such as the Red Shirt political unrest in 2010 and the Bangkok floods in 2011, which thrust the school into a crisis management situation. While such crises cannot be planned for, it could be useful to establish a regular reporting and meeting schedule at the start of the change process.
Another issue facing the change agent was the staff and community turnover, which is characteristic of this international school. It could be argued that, in the international school environment, change agents need to plan for continual capacity building with structures such as PD during orientation or in the first year for new staff members, and as part of the orientation for students and new members of the community.

The value of existing positive relationships was reinforced in this research. Change agents need to reach out and engage others to become advocates for change and participants in the research process. As an internal change agent with established positive relationships, both of these roles benefited.

As was argued in this chapter, the need to be a dynamic change agent was less evident, while the need for passion, patience and commitment was reinforced. Supporting the literature on teachers as change agents was the need to have an area of expertise, the ability to think beyond the classroom and the need to have problem-solving capabilities. Additionally, the LT identified that being authentic or ‘walking the talk’ was also important to building credibility.

The organic process that was supported by the LT and the wider school community enabled the teacher to learn, adapt and grow professionally. It also provided valuable personal support to maintain the focus and commitment required. As Inchley et al. (2007, p. 70) wrote:

Our findings suggest that ownership, leadership, collaboration and integration are all critical to ‘improving schools from within’ (O’Hara and McNamara, 2001). However, there needs to be greater recognition of the time it takes to achieve such change and the support schools need to actively engage the whole school community in pursuing the HPS ideology. Teachers lie at the heart of such efforts as key agents of change in the school setting.
Chapter 10: Conclusion

This case study was concerned with examining the adoption of a HPS framework in a school and represented an educationally driven process of change, led by a teacher. There were a number of ways this research aimed to contribute to the existing literature including how to introduce and integrate a HPS approach in to the existing organisational structure of a school and examining the feasibility of a HPS approach in a different context, in this case, an international school. The findings also supported the literature describing the central role context plays in the adoption of HPS and the need to build capacity to facilitate the implementation of a HPS approach.

The questions that were central to this research involved examining if a HPS approach could be adapted to the context of the school and if the leaders would support the move to adopt a HPS approach. Additionally, understanding which factors were most influential in the leaders’ decision was fundamental to adding to the evidence on how to engage schools and potentially increase the uptake of HPS. Using a qualitative approach, the following questions guided the research process:

1. Can the HPS framework be modified to the international school setting and retain the integrity of the approach?
2. How was HPS introduced and integrated into the existing school structures?
3. Using the readiness for change theory, how did discrepancy, appropriateness, efficacy, principal support and valence influence the leaders’ decision?
4. What contributions can readiness for change theory make to increasing the uptake of HPS?

To manage the research, these questions were broadly structured into two sections. One section focused on creating readiness and understanding the factors influencing the school leaders’ decision to adopt a HPS approach, the other section focused on HPS in the international school context. Data were collected through semi-structured interviews, document analysis and a researcher’s journal, and were analysed using content analysis to explore these lines of enquiry. The findings were then examined in light of the IUHPE (2009) guidelines for establishing HPS and the whole-system
change model proposed by Dooris (2007) to identify ways Readiness for Change theory could contribute to these models.

This chapter begins by examining how the findings contributed to the existing evidence in regards to the adoption of a HPS approach and then moves to examining the potential of creating readiness for change in school leaders.

The findings indicated that the HPS framework was able to be modified for this international school, while retaining the integrity of the approach—that is, the characteristics central to the success of the whole-school approach. Introducing a HPS approach was done via the health curriculum. HPS and whole-school approaches were presented as a best practice model to deliver the health curriculum, which aligned to the school’s mission of drawing on best practice models from around the world. The taught curriculum was an existing educational platform to link HPS to, and made a HPS approach immediately relevant. Making HPS relevant to schools has been a challenge identified by many authors (Deschesnes, Trudeau & Kebe 2010; Mohammadhi Rowling & Nutbeam 2010).

Thus, in response to St Leger’s (2006) calls to find ways to introduce HPS, the school’s curriculum provided an avenue in this context. Other potential avenues to reach school leaders were also identified. The findings revealed that the administrators, or members of the LT, were frequent readers of publications from educational journals and websites, including Educational Leadership, Education Week, The International Educator, Principals Training Centre and The Marshal Memo. Thus, to increase the understanding of comprehensive approaches and introduce HPS to schools, it is suggested that targeted publishing through these avenues may be beneficial. Such publications could explain the value of a HPS approach and show the link between health and education. This knowledge was instrumental in facilitating support for a HPS approach in this study. Further, these publications may help address the inconsistencies in school staff regarding what a HPS approach is, which has been identified as a potential barrier to a greater uptake of HPS (Mohammadi, Rowling & Nutbeam 2010).

In addition to introducing a HPS approach, the curriculum was also a key avenue to engage staff and students in health promotion activities, and build capacity in the school. Through the Grade 10 health curriculum, students were asked to lead sessions
with ES students. The response from students (both HS and ES) and staff was very positive, and inspired a Grade 11 student to develop a Student Health Ambassador program. Thus, it was indicated in this research that the curriculum was an important avenue to introduce HPS, and build awareness and capacity in the staff and students. It could also be seen as a way to engage students to take responsibility for leading health promotion in the community.

While curriculum was an important initial anchor linking HPS to the school’s agenda, it was not the only one. As the organic process of change evolved, so did the process of aligning HPS to the school’s core business. Such was the complex process of change that occurred. Once the senior leaders of the school supported a HPS approach, it was incorporated into the strategic planning process, which led to the school’s mission being changed to explicitly include health. The final stage of integrating HPS entailed expanding the existing structures in the school to accommodate the new mission statement.

Changing the mission was identified by the school leaders as a key factor in making the change sustainable, which supports Mohammadi, Rowling and Nutbeam’s (2010) claims that HPS change is more sustainable when it is linked to the core business of the school. This also reduced the risk that Buchanan (2009c) identified, in which change is person dependent and, once the person or change agent leaves, the change will not be sustained.

The findings of this research indicate that the motivation for leaders to address health is facilitated when it is linked to the accountability processes in the school. The school’s mission was found to be the point of accountability of the LT. This was an important finding because central to this research was responding to calls for evidence on sustainable change and ways to make health a priority and integrate it into the school setting (St Leger et al. 2007; Whitelaw et al. 2006). Thus, the findings of this research may provide an important starting point for others trying to integrate health into existing school structures, by identifying the process of accountability of the school and ensuring health is represented within this. Once this occurs, health can potentially be integrated into the other existing processes aligned to accountability. It could be argued that, until this happens, there is an ongoing risk of health being viewed as peripheral to the core business of schools.
10.1 The Critical Influence of Context

The flexibility of the HPS approach allowed the necessary modifications to the model and implementation process to accommodate the international school context. Carefully considering the context allowed for effective planning and leadership, which Deschesnes, Trudeau and Kebe (2010) and Fullan (2005) argued is instrumental to facilitate effective change.

A number of contextual factors identified in the literature were considered prior to creating readiness, including a previous investment in health promotion, parental engagement, potential partners and leadership support (Deschesnes, Trudeau & Kebe 2010; Hoyle, Samek & Valois 2008). However, as this research highlighted, it was also necessary to review accreditation documents to identify priorities and determine leadership accountability measures and the drivers of change in the school. Additional context issues—such as the decision-making process and accessing funds in light of how decisions are made—were also found to be influential contextual factors. Table 11 presents the processes that emerged in this research and were related to a contextual analysis for HPS.

Table 11: Contextual Considerations for Creating Readiness for HPS

<table>
<thead>
<tr>
<th>Contextual Considerations for Creating Readiness for HPS</th>
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<tbody>
<tr>
<td>Review accreditation documents to identify priorities, determine leadership accountability measures, and processes and drivers of change in the school.</td>
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<tr>
<td>Identify key stakeholders, including students, and the existing avenues for collaboration to identify (and plan to fill) any gaps.</td>
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<tr>
<td>Identify the decision-making processes in the school and the key people involved.</td>
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<tr>
<td>Identify existing health promotion skills in staff and parents or other volunteers, and identify PD needs.</td>
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<tr>
<td>Assess level of support for and awareness of health education and health promotion in key stakeholders, and plan PD.</td>
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<tr>
<td>Determine the existing health education curriculum and who has responsibility for this.</td>
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<tr>
<td>Determine the financial and human resources available, internally and externally.</td>
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<tr>
<td>Examine previous investment in health promotion to indicate the organisational support for HP, as well as identify potential partners and ways to link HPS to the school.</td>
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<tr>
<td>Identify and plan for potential barriers, such as cynicism to change, lack of trust towards the change agent, no sense of community and disengaged parents.</td>
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It is acknowledged that there was a lack of student representation in the decision-making processes that occurred in this study, and this is not representative of the
principles of a HPS approach (IUHPE 2009). The lack of student involvement in leading the readiness phase could be considered from a contextual perspective, as well as from the perspective of the stage of change. Contextually, the existing practices in the school did not facilitate student input into strategic planning, and because the overall plan was to integrate HPS into existing practices, this was a contextual barrier identified.

However, in considering the stages of change, it could also be argued that it is common in schools for administrators, boards and education departments to set strategic directions; thus, it may be a more realistic objective to involve students in the implementation phase, rather than the adoption phase, as was indicated in this research. This study does not suggest that this is conceptually the best framework because the literature suggests that students’ participation and engagement are crucial to successful change (IUHPE 2009); rather, this is more an acknowledgement of the slow pace of change in schools (Deschesnes et al. 2010). In either case, as indicated in Table 11, it is proposed that examining the opportunities for student input into strategic planning should be included in an initial contextual analysis and, in the absence of avenues for student input, building such mechanisms should also be a goal of building capacity in the school.

Other contextual barriers identified in this study that supported those described in the literature included limited time (for staff, students and within the curriculum) and difficulty accessing resources (Deschesnes, Trudeau & Kebe 2010; St Leger 2006). Time was found to be a barrier to the psychologists and counsellors becoming more involved, and some administrators identified the challenge of finding more time in the curriculum to include health. Accessing funds was associated with personalities and power in the LT, rather than the school not having available funds. Thus, external sources were necessary to resource some health promotion activities. These findings reinforce those of St Leger (2006) and Deschesnes et al. (2010) regarding the need for human and financial resources to support the implementation of HPS, and of Buchanan (2009b) regarding potentially needing to use external sources of funding.

The breadth of the HPS approach has been acknowledged as difficult to implement and evaluate (Deschesnes, Martin & Hill 2003, Rowling & Samdal 2011; Stewart-Brown 2006) and was a potential barrier to adoption in this case study. The use of local data
enabled priorities to be identified and realistic goals and plans to be developed. This may highlight the need for change agents to have strategies to deal with the issue of the breadth of using a HPS approach, and to develop or identify local sources of data.

Language disparities between health and education were not seen as barrier in this case. This may have been because the change message was articulated from an educational perspective using familiar language, which is in line with Deschesnes, Trudeau and Kebe’s (2010) suggestions that the health sector needs to move closer to the education sector. A mechanism to facilitate this was linking HPS to other initiatives in the school, and then choosing language that was consistent with these other initiatives. In addition, the change agent had a background in health promotion, as well as education. If this had not been the case, it may have been necessary to access support from other health agencies to make the links between health and education. Thus, a lack of health promotion knowledge in the school was also not a barrier in this case.

### 10.2 The Potential of Creating Readiness

It could be argued that the findings of this research support Adelman and Taylor’s (2007) claims that spending time on creating readiness is necessary and arguably a major factor in building support for a HPS approach. By carefully considering the context, a change message was developed using Armenakis and Harris’ (2009) framework addressing the key beliefs of discrepancy, appropriateness, leadership support, efficacy and valence. The findings indicated that discrepancy, appropriateness and leadership support were the most influential factors in the leaders’ decision to adopt a HPS approach; however, efficacy and valence were also expressed. This supports Armenakis and Harris’ (2009) view that the key beliefs are influential in building support for change. Additionally, these findings support the idea raised by Armenakis and Harris (2009) that some key beliefs may be more influential than others in certain change endeavours. That is, when engaging leaders in adopting a new initiative, building the key beliefs of discrepancy, appropriateness and leadership support may be more important.

The findings of Deschesnes, Trudeau and Kebe (2010) suggest that there is potential for some beliefs to mediate others. For example, Deschesnes, Trudeau and Kebe (2010) found that the contextual factor of a belief in efficacy was mediated by receptivity or the
perceived popularity of a HPS approach, which may relate to the belief of principal support. Thus, exploring whether one belief (such as principal support) mediates another (such as efficacy) may also highlight how readiness for change can be successfully developed.

Armenakis, Harris & Mossholder (1993) also described three conveying strategies—persuasive communication, active participation and managing information—as ways change agents can deliver the change message. All three of these strategies were used in this research to create change, and reinforced the need to use multiple conveying strategies when change readiness and urgency are low. These findings are significant because they indicate that others who are constructing change messages in the adoption of a HPS approach should address the key beliefs and use multiple conveying strategies.

The findings of this research also suggested that the process of adopting a HPS approach and building motivation and support in leadership may necessitate an initial intense phase with a focus on building structural support for HPS in the organisation and human capacity in regard to knowledge, skills and time. To explain this concept further, after the change to the mission, the implementation moved into existing organisational structures for collaboration, coordination, management and data collection, such as the LET structure and annual surveys. Prior to this, temporary collaborative structures, such as a Parent and Staff Committee, were used and a comprehensive assessment of student and staff wellness was conducted. Thus, during the initial phase of change, more intensive collaboration, meeting and data collection were necessary to build motivation, readiness and capacity in the school. In addition, this more intense phase included sharing research on the connection between health and academic achievement in order to increase awareness throughout the wider community of the relevance of health to academic outcomes. This further supported St Leger’s (2004) call to acknowledge that learning is the key responsibility of schools, and that demonstrating how HPS contributes to learning is important for schools to adopt the approach.

The results also indicated a shift in focus of the change message from adoption to implementation. That is, in the adoption of the approach, the LT members were the main change recipients, and the senior administrators were the key, initial target. It was acknowledged that, while support was expressed across stakeholders in the community,
the critical mass required in the adoption of the approach was focused on the LT in this case. During the next implementation phase, further efforts to create readiness in a larger mass of staff are indicated. Thus, the findings supported the concept of readiness occurring in stages, as proposed by Stevens (2013).

Further research to determine whether an intense initial phase correlates with a greater chance of adoption or sustainability may be of value in adding to the evidence base for increasing the uptake of HPS. Similarly, it would be valuable to examine the key beliefs in the wider staff responsible in the implementation phase to assess the effect of each of the beliefs. In the next phase, it may be important for efficacy and valence to be carefully presented to staff to achieve wider support for the change. Similarly, assessing how students can be engaged more in such a transient, time-poor setting would be valuable to further understand HPS in the international school setting.

10.3 The Need for Organisational Capacity

Of the four key areas identified in the literature as influencing the implementation of HPS (effective leadership, institutional anchoring, allocation of resources and PD, and building partnerships), it could be argued that effective leadership, institutional anchoring and PD were particularly influential in this study. Accessing resources was challenging and potential avenues to develop partnerships in the international setting were limited. As explained earlier, the change to the mission anchored HPS to the school and was facilitated by professional development of the key stakeholders and effective leadership by the change agent.

10.3.1 Professional Development

As reported in the literature and supported by this research, many different layers of PD are necessary for the adoption of HPS (Deschesnes et al. 2015; Lee 2014). The administrators, HPS coordinators, teachers and other staff, parents and wider community can all be considered targets for PD. This research identified the importance of an initial intense phase of PD targeted at school leaders and key stakeholders in order to explain the principles and value of the HPS approach and highlight the link between health and educational outcomes. However, Deschesnes, Trudeau and Kebe (2010) argued that supporting schools with strategies to accommodate HPS and build capacity may be more important than convincing them of the value of a HPS approach. This
study found that both were important. Explaining the value of HPS was particularly important initially for key stakeholders to understand the relevance and appropriateness of a HPS approach for the school. After support for the change was demonstrated then building capacity and the supportive infrastructure was critical. During this phase PD focused on how to implement a whole-school or HPS approach, which was facilitated through active involvement in health promotion activities.

Of the many strategies employed in this research to support a change to a HPS approach, it is argued that effective leadership, using local data and having a model adapted to the school were the most critical.

### 10.3.2 Effective Leadership

Having an effective leader with health promotion knowledge and vision to lead the implementation of a HPS approach was critical in this research, and has been described by other authors (Deschesnes, Trudeau & Kebe 2010; Hoyle, Samek & Valois 2008). Further, the findings support Hoyle, Samek and Valois’s (2008) research regarding leading change and the need to clearly articulate a shared vision, empower and mobilise others and enable collaborative action.

#### 10.3.2.1 The Potential of Teachers

This study indicated the potential of teachers as leaders of change by the addition of the fourth bullet point, ‘to lead healthy, active, balanced lives’, in the school’s mission statement. This supported Armenakis’s (1993) argument that the energy and inspiration required for change must come from inside an organisation. The deep contextual knowledge and ability to engage stakeholders and provide solutions to identified problems were positive attributes of the teacher as change agent, supporting those attributes cited in the literature (Lukacs & Galluzzo 2014; van der Heijden et al. 2015). However, the difficulty of leading from the bottom-up also presented challenges and may have influenced the degree of assertiveness displayed by the change agent (who was also a teacher) towards members of the LT.

Thus, this research supports the findings of many other authors (Deschesnes 2015; Lee 2014; Ollis, Harrison & Richards 2012) who stress the importance of training teachers in HPS knowledge and skills, as well as skills in leading organisational change.
Training new teachers and the PD of existing teachers were indicated as key areas to increase the uptake of HPS.

10.3.3 Allocation of Resources

This research supports the findings of others that school change takes considerable time (Inchley 2006; Rowling & Samdal 2011) and that the uptake of HPS is hampered by competing demands (St Leger 2006). As shown in the timeline in Chapter 8 (Figure 14), there was considerable work undertaken on a voluntary basis prior to the change agent being offered a .1, or half a day a week position, to coordinate the HPS part in the school’s strategic plan. Thus, it could be argued that this model, which is heavily reliant on a passionate champion, would not be realistic in achieving a wider uptake of HPS because it relies too heavily on individuals. This raises the need for schools to be supported by trained, passionate teachers or internal staff with knowledge and skills in health promotion and time to lead HPS initiatives.

10.3.4 Local Data

Using local data was a powerful motivator to change in this study, as was also identified by Lee (2014) and Mohammadi, Rowling and Nutbeam (2010). Using local, school-based data linked to learning outcomes and the school’s mission, alongside building knowledge of HPS, were critical factors in developing the belief that a discrepancy existed. The change agent was a key driver of gathering local data in this case. In the Hong Kong Health Schools Award Scheme (Lee 2014), schools are supported to collect local data by academic institutions. The issue of local health data is arguably a priority in building motivation to adopt HPS, and an area that schools may need support to access. Thus, future research on understanding how schools in other contexts can be supported to identify local health priorities, that are influencing student learning, could be a valuable addition to the existing literature.

10.3.5 School-based Model

Adapting a HPS model to the context of the school was important to build the belief that the model was appropriate and provided a structure for any health priority to be managed comprehensively. Additionally, expanding the existing structures in the school to include health provided a sustainable, established internal process. One could argue
that having an existing model and infrastructure, alongside trained staff, would support
the comprehensive implementation of any topic-based approaches and provide
important capacity for schools to be able to implement a HPS approach.

10.4 Creating Readiness for HPS in the International School Setting

This case study used both the literature on organisational change and the HPS
guidelines to help develop readiness for change. This revealed some alternative steps in
the adoption of HPS such as constructing, and comprehensively delivering, a change
message to address key beliefs and completing a detailed contextual analysis (outlined
on page 197). Table 11 and 12 highlight the original contribution this research makes to
the implementation of HPS. Of particular note is the implementation of HPS in the
international school context and as a result of the findings in this case study, the
following guidelines are proposed for creating readiness for HPS in the international
school setting (Table 12). Contextual issues that were possibly unique to the
international school setting included three schools being on one campus, limited support
available locally to help implement HPS, and a high turnover of staff. These may have
influenced the process of creating readiness.

Table 12: Creating Readiness for HPS in the International School Setting

<table>
<thead>
<tr>
<th>Creating Readiness for HPS in the International School Setting</th>
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<tbody>
<tr>
<td>Complete a contextual analysis</td>
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<tr>
<td>Identify the link between the school mission and HPS</td>
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<tr>
<td>Engage school leaders and other key stakeholders through PD</td>
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<tr>
<td>Form appropriate committee(s) with representatives from across the school to develop a shared vision and lead innovative health promotion programs</td>
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<tr>
<td>Develop a model linked to the school’s mission and vision</td>
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<tr>
<td>Identify priorities in local school data</td>
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<tr>
<td>Develop a shared vision and plan, with realistic goals, using established school processes</td>
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<tr>
<td>Develop a change message addressing key beliefs and using different conveying strategies</td>
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<tr>
<td>Implement health promotion projects using active participation to build capacity</td>
</tr>
<tr>
<td>Celebrate short-term wins</td>
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</table>

It should be noted that there is much overlap in the simultaneous nature of many of
these steps, and that the efforts of the change agent were directed concurrently to the
bottom-up and top-down engagement of stakeholders. Thus, the whole-system approach
proposed by Dooris (2007) was a useful tool to represent the complex process that
unfolded, and facilitated examination of the system change required for a sustainable program, as called for by Deschesnes, Trudeau and Kebe (2010).

**10.5 Professional Growth as an Insider Researcher**

The change process was organic and enabled the researcher to grow and develop professionally in all roles, including teacher and change agent. Professional growth as a teacher included greater awareness of the management and drivers of school change and the need for processes to more fully engage students and give them a voice. Additionally, there was practical experience of linking curriculum to clearly articulated data and school improvement targets and initiatives. As a change agent, there was a steep learning curve in leading change. The skills and knowledge necessary to lead change—such as solving problems, developing persuasive messages and engaging others throughout the school community—were professionally challenging and rewarding. The outcomes of the process resulted in a sense of achievement and empowerment in making a contribution to the direction of the school, in a way that was potentially sustainable.

**10.6 Challenges and Opportunities**

**10.6.1 Defining HPS and Whole-school Approaches**

The need to clarify what HPS and other comprehensive approaches are and are not was highlighted by the recent Stellenbosch consensus statement on HPS (Macnab, 2013). The separation of health promotion and HPS adds to the confusion surrounding HPS dialogues. In the Australian context, documents describing topic-based approaches—such as *Building Respectful Relationships* (Victorian Government 2015a)—stress the importance of using a whole-school approach to implement the program. Thus, it would seem appropriate to include topic-based approaches as long as they are implemented in a comprehensive way, as advocated by St Leger et al. (2010). With apparent confusion in the HPS field, it is unsurprising that there is confusion in schools about what a HPS entails. Addressing this is arguably an urgent priority.
10.6.2 Students: Thinking Outside the Curriculum Box

Exploring avenues for greater student involvement in the strategic directions of schools was another area highlighted by this research. Observing students in health class indicated that the curriculum might provide a potential avenue for this to occur. Students of approximately 15 or 16 years of age interpreted data and critically discussed potential strategies to address identified priorities. It may be valuable for future research to explore the potential shown here to approach health curriculum differently by focusing on facilitating student input into HPS as part of the curriculum. This would require students to be involved in strategic planning processes, as well as implementing strategies in a comprehensive way. In this manner, students would need to:

- consider the essential elements of HPS, and identify and liaise with local services, thereby developing health literacy
- seek environmental and policy change, and thus be advocates for health
- critically think about data and solutions.

It could be argued that this strength-based approach has the potential to build a range of educational skills and knowledge, and would subsequently incorporate the five propositions underlying the Australian curriculum (2012). Having such a course incorporated into the curriculum may help engage students and schools in HPS, and be a motivating factor to develop the capacity in schools and incorporate HPS into existing structures. However, the existing pressure on school curricula was highlighted in this study by the limited time available for the health curriculum. Thus, incorporating health education standards in other curriculum areas such as English, history and science may be another way schools can give more time to developing awareness and skills in the students and teachers.

10.6.3 Marrying Health and Education

It was an aim of this research to take an educational perspective in creating readiness for a HPS approach. In doing so, it could be argued that the change was adopted because it was seen as relevant and (to some LT members) necessary for the school’s mission to be realised. However, there were tensions in what was discussed in the health promotion literature and what was guiding the school. This was particularly evident around identifying realistic outcomes to measure. Student data were powerful in this case to
gain support from the LT. However, it is acknowledged that creating change in these data would take time once strategies were implemented.

Inchley (2006) discussed the need to keep long-term goals in sight while focusing on the way HPS is being implemented in the short-term, that is, the process rather than behavioural outcomes. Thus, Inchley (2006) suggests using process outcomes as a measure of short-term progress. Such process evaluations were not supported by the LT in this school, and learning outcomes were key drivers of change. This may indicate a fundamental conflict between measurement in HPS and education, which supports Lee’s (2014) claim that, when measuring the efficacy of HPS, it is important to consider whether indicators of HPS do reflect both health and educational outcomes. Further research is indicated to better understand how to set realistic outcomes and measure HPS in a way that reflects both health and educational outcomes.

Additionally, operationalizing all of the HPS principles was challenging and it was indicated that there is a need to define principles in a practical and measurable way.

**10.6.4 Establishing a Moral Purpose**

This case indicated the need to appeal to a moral purpose in school leaders, thereby supporting Fullan’s (2005) claim that this is a way to engage schools and communities. This moral perspective may indicate that, while aligning HPS to academic outcomes is important, it may not necessarily be the only avenue to structure change messages. A number of LT members recognised the lifelong benefits of a HPS approach, and that schools have a moral responsibility to prepare students the best they can to lead a healthy life, as well as potentially making school a more positive experience. Thus, the change to a HPS approach and associated health and quality of life benefits may be considered equally important as academic potential. Both of these outcomes could possibly be promoted in the change message—that is, academic outcomes, as well as quality of life and health outcomes. As outlined by Fullan, the key factor to consider is finding ways to motivate those involved in the change, and to increase a sense of need. The findings indicate that the school-specific data played a key role in building motivation in this case.
10.6.5 Building Partnerships for International Schools

There are more than three million students attending international schools throughout the world, with numbers predicted to grow to more than six million in the next 10 years (Custer 2014). Further research on health in the international school setting is an important area for future consideration to ensure that this growing educational setting is included in the dialogue of comprehensive approaches to school health. Creating ways to provide both internal and external support for international schools is an area of need that was highlighted during this research. Lee (2014) reported success in Hong Kong by building relationships between schools and academic institutions. Lee (2014) explains that the schools receive support for PD, organisational development, and monitoring and evaluation from tertiary institutions. Some international schools have relationships with academic institutions, which may be an avenue to build supportive partnerships. Potential departments in an international school in which partnerships could develop include the administration, curriculum office, psychologists and counsellors, Physical Education and health departments.

The WASC accreditation process was also a key driver of the strategic direction of the school, and subsequently another avenue for accountability. Thus, there is potential to explore whether accreditation processes provide another way to advocate for and initiate systemic change. To explain this further, having comprehensive health programs recommended during accreditation processes, or included as a part of the accreditation process, could potentially be a strong catalyst for change.

10.7 Strengths and Limitations

There were limitations in the research in regard to measuring readiness—specifically, valence—and using the quantitative scale to measure the key beliefs. Armenakis and Harris (2009) suggested building a vision using a combination of the key beliefs of appropriateness, discrepancy, efficacy and valence. This did not occur, as the initial planning was focused on discrepancy, appropriateness and efficacy. This may have resulted in the ambiguity of the meaning of valence. Additionally, the key beliefs scale was not piloted prior to the delivery. The dynamic nature of the setting and the timeframe of the strategic planning process meant there was no time for such a pilot of the survey. This was a limitation because some of the questions—especially those
targeting valence—were not well worded for the school setting. Thus, piloting the survey tool in future research is recommended. In addition, the number of participants completing the scale were very low, but added information to the specific case under study.

Another potential limitation was the small number of BOT members who returned the survey, and that there was not a stronger student voice in the data collected. There was also potential for data to be missed, as the researcher juggled various roles during the school day, which may not have been undertaken by an external researcher. In addition, it has been recently argued (Rafferty et al., 2013) that more attention needs to be given to the influence of affective elements in creating readiness for change. In this research the affective dimension of the change recipients was not assessed as a factor in creating readiness, and thus may also be considered a limitation.

Adopting a HPS approach is the first phase of implementation. Long-term research may demonstrate whether the integrity of the chosen model is maintained as implementation continues. It may also indicate whether there was sufficient internal capacity to maintain the change momentum after the change agent (who was also the initiating champion) had left the school.

This research explored only one case; thus, it cannot necessarily be used to generalise to other settings. However, the process used in this research may provide some guidance for those working in similar settings, such as with large schools, independent governing structures or other international schools. By carefully planning the process for establishing HPS and modifying the HPS model to specific contexts, HPS may be more readily adopted throughout the world. Spending time creating readiness for change indicates a promising way to build sustainable change for HPS.

To conclude, what was apparent in this research was how much the LT cared about optimising the health and wellbeing of the students, some arguably even more so than academic outcomes. However, what was also apparent was the continual pressure on the school curriculum to be devoted to traditional academic areas such as English, mathematics, science and history in response to data driven reporting. This pressure indicated that there might be a need to implement health standards in new ways. Additionally, what was also highlighted was the lack of awareness in the school of the
health factors that were potentially influencing the students’ learning as well as a lack of awareness of how to address health comprehensively. Therefore, the findings in this research indicate that no matter if the health curriculum is delivered in the context of a health class, or integrated in other subject areas, schools need to understand what the specific health issues are that are effecting their students’ learning and they need to have an internal infrastructure in place to support a comprehensive approach. Finally, they need to have staff that are trained in whole-school or comprehensive approaches.
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Appendices
Appendix 1: Rationale for Student Wellness Survey

Wellness Survey Rationale

Overview
The Wellness Survey has been developed to provide accurate data on health behaviors and protective factors among students in Middle School and High School. The Survey has been based on the Global School-based Student Health Survey (GSHS) developed by the World Health Organization and the Centre for Disease Control (USA). The information generated from the Health Survey will be used to guide decisions relating to relevant school policy, curriculum and health services. The survey will also help to develop initiatives in order to create a supportive and nurturing school environment. The results will also provide a base for assessing future trends in students’ health behaviors.

The following rationale has been based on the World Health Organization rationale: http://www.who.int/chp/gshs/GSHS_Item_Rationale.pdf

Introduction To follow is the rationale for inclusion of each of the modules. For each module there is a summary of research findings and how school health programs can help.

The Modules are listed as follows.

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<td>Hygiene</td>
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<td>Physical Activity</td>
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<td>Protective Factors</td>
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<td>Sexual Behaviors that Contribute to HIV Infection, Other STI, and Unintended Pregnancy</td>
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<td>Tobacco Use</td>
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<td>Unintentional Injury</td>
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<td>Internet Use</td>
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Respondent Demographics

Introduction The questions in this module measure the age, gender, nationality, grade/section/level/form of the respondents.

Rationale The rationale for including these questions is that these characteristics are related to the health risk behaviors and protective factors assessed by the survey.

How these data can help Data describing how health risk behaviors and protective factors vary by demographic characteristics can help guide policy and program planning and implementation.
Alcohol and Other Drug Use

Introduction The questions in this module measure:
• current alcohol use
• amount of alcohol use
• how students get the alcohol they drink
• episodes of heavy drinking
• problems associated with alcohol use
• lifetime drug use.

Research findings
Some research findings related to alcohol use are as follows:

• Worldwide, alcohol use causes 3% of deaths (1.8 million) annually, which is equal to 4% of the global disease burden.

• Across sub-regions of the world, the proportion of disease burden attributable to alcohol use is greatest in the Americas and Europe ranging from 8% to 18% of total burden for males and 2% to 4% of total burden for females.

• Besides the direct effects of intoxication and addiction, alcohol use causes about 20% to 30% of each of oesophageal cancer, liver disease, homicide and other intentional injuries, epilepsy, and motor vehicle accidents worldwide, and heavy alcohol use places one at greater risk for cardiovascular disease.

• In most countries, alcohol-related mortality is highest among 45- to 54-year-olds, but the relationship between the age of initiation of alcohol use and the pattern of its use and abuse in adulthood makes the study of alcohol consumption among adolescents important.

• Intentional and unintentional injuries are far more common among youth and young adults.

• Unintentional injuries are the leading cause of death among 15- to 25-year-olds and many of these injuries are related to alcohol use.

• Young people who drink are more likely to use tobacco and other drugs and engage in risky sexual behavior, than those who do not drink.

• Problems with alcohol can impair adolescents' psychological development and influence both the school environment and leisure time negatively.

How school health programs can help
Although scientific evidence on the efficacy of school health programs conducted in schools is limited, such programs have been designed to help reduce risks associated with alcohol use among young people.
School health programs can help students acquire communication, critical thinking, refusal, and other life skills needed to avoid problems associated with alcohol and other drug use.

Dietary Behaviors

Introduction The questions in this module measure:
• self-reported height and weight
• fruit and vegetable consumption.

Research findings
Some research findings related to dietary behaviors are as follows:
• During adolescence, overweight is associated with hyperlipidemia, raised blood pressure (hypertension), abnormal glucose tolerance, and adverse psychological and social consequences.

• Overweight acquired during childhood or adolescence may persist into adulthood and increase risk later in life for coronary heart disease, diabetes, gallbladder disease, some types of cancer, and osteoarthritis of the weightbearing joints.

• Nutritional deficiencies (protein-energy malnutrition, iron, Vitamin A, and iodine deficiency) affect school participation and learning.

• Fruits and vegetables are good sources of complex carbohydrates, vitamins, minerals, and other substances important for good health. Dietary patterns that include higher intakes of fruits and vegetables are associated with several health benefits, including a decreased risk for some types of cancer.

How this data is used
Data on self-reported height and weight will be used to calculate body mass index and provide a reasonable proxy measure of whether students are overweight or underweight.

How school health programs can help
As part of a school health program, school meal programs can be a source of healthy foods to students and can promote daily attendance, class participation, and academic achievement. Schools can teach nutrition education as part of health education curricula to help students develop the knowledge, skills, and behaviors needed to foster lifelong healthy eating habits.

Hygiene

Introduction The questions in this module measure frequency of:
• hand-washing
• hand-washing with soap.

Research findings
Some research findings related to hygiene are as follows:

• Diarrhoeal diseases kill nearly 2 million children every year. Hygiene education and the promotion of hand-washing can reduce the number of diarrhoeal cases by 45%.

• About 400 million school-aged children are infected with worms worldwide. These parasites consume nutrients from children they infect, cause abdominal pain and malfunction, and can impair learning by slowing cognitive development.

How schools can help
Schools can help improve child and adolescent health by providing and maintaining sanitary conditions. By providing well-maintained and adequate numbers of sanitation facilities and safe water as part of the school health program, schools can reinforce the health and hygiene messages delivered in health education and serve as a model to both students and the broader community.

Mental Health

Introduction The questions in this module measure:
• feeling of loneliness
• loss of sleep due to worry
• sadness and hopelessness
• attachment.

Research findings
Some research findings related to mental health are as follows:

- World-wide, approximately 20% of children and adolescents suffer from a disabling mental illness.
- Anxiety disorders, depression and other mood disorders, and behavioral and cognitive disorders are among the most common mental health problems among adolescents.
- Half of all lifetime cases of mental disorders start by age 14.
- Every country and culture has children and adolescents struggling with mental health problems. Most of these young people suffer needlessly, unable to access appropriate resources for recognition, support, and treatment. Ignored, these young people are at high risk for abuse and neglect, suicide, alcohol and other drug use, school failure, violent and criminal activities, mental illness in adulthood, and health-jeopardizing impulsive behaviors.

How school health programs can help
As part of a school health program, school mental health and social services can play a critical role in fostering healthy social and emotional development among students. To help students develop positive mental health, school mental health and social services can teach life-skills such as problem-solving, critical thinking, communication, interpersonal relations, empathy, and methods to cope with emotions and crises. In addition, school mental health and social services can include prevention, assessment, treatment, and case management for students either directly or through referrals to community-based programs.

Physical Activity

Introduction
The questions in this module measure:
- physical activity
- participation in sedentary leisure behavior
- travel to school.

Research findings
Some research findings related to physical activity are as follows:

- Participating in adequate physical activity throughout the life span and maintaining normal weight are the most effective ways of preventing many chronic diseases, including cardiovascular disease and diabetes.
- The prevalence of type 2 diabetes is increasing globally and now is occurring during adolescence and childhood.
- Participating in adequate physical activity also helps build and maintain healthy bones and muscles, control weight, reduce blood pressure, ensure a healthy blood profile, reduce fat, and promote psychological well-being.
- Roughly 60% of the world's population is estimated to not get enough physical activity. Patterns of physical activity acquired during childhood and adolescence are more likely to be maintained throughout the life span, thus sedentary behavior adopted at a young age is likely to persist.

How school health programs can help
As part of school health programs, schools can offer physical education and opportunities, both during and outside the school day, for all students to participate in physical activity and sports. Physical activity helps children to stay alert and concentrate better. Students who are physically active are more likely to have higher academic performance and fewer disruptive behaviors.
Protective Factors

Introduction The questions in this module measure:
• school attendance
• perceived social support at school
• parental regulation and monitoring
• parental bonding and connection.
• school resilience assets, relationships with teachers, support received

Research findings
Some research findings related to protective factors are as follows:

• For most adolescents, school is the most important setting outside of the family. School attendance is related to the prevalence of several health risk behaviors including violence and sexual risk behaviors.

• Adolescents who have a positive relationship with teachers, and who have positive attitudes towards school are less likely to initiate sexual activity early, less likely to use substances, and less likely to experience depression.

• Adolescents who live in a social environment which provides meaningful relationships, encourages self-expression, and also provides structure and boundaries, are less likely to initiate sex at a young age, less likely to experience depression, and less likely to use substances.

• Being liked and accepted by peers is crucial to young people’s health development, and those who are not socially integrated are far more likely to exhibit difficulties with their physical and emotional health. Isolation from peers in adolescence can lead to feelings of loneliness and psychological symptoms. Interaction with friends tends to improve social skills and strengthen the ability to cope with stressful events.

• Parental bonding and connection is associated with lower levels of depression and suicidal ideation, alcohol use, sexual risk behaviors, and violence.

• School resilience assets have shown consequences for improving academic performance.

How school health programs can help
School health programs can help create a supportive and caring school environment and provide students with knowledge and skills they need to develop positive and supportive relationships with their peers and families.

Sexual Behaviors that Contribute to HIV Infection, Other STI, and Unintended Pregnancy

Introduction The questions in this module measure the prevalence of:
• lifetime and current sexual intercourse
• age at first intercourse
• number of sexual partners
• condom use.

Research findings
Some research findings related to sexual behaviors are as follows:

Topic Research findings

HIV infection and AIDS

• Young people between the ages of 15 and 24 are the most threatened group, accounting for more than half of those newly infected with HIV.
• At the end of 2003, an estimated 10 million young people aged 15 to 24 were living with HIV.

• Studies show that adolescents who begin sexual activity early are likely to have sex with more partners and with partners who have been at risk of HIV exposure and are not likely to use condoms.

*Sexually transmitted infections (STI)*

• STIs are among the most common causes of illness in the world and have far-reaching health consequences. They facilitate the transmission of HIV and, if left untreated, can lead to cervical cancer, pelvic inflammatory diseases, ectopic pregnancies and infertility.

• Worldwide, the highest reported rates of STIs are found among people between 15 and 24 years; up to 60% of the new infections and half of all people living with HIV globally are in this age group.

**How school health programs can help**

School health programs can play an important role in helping students reduce their risk of pregnancy, STI, and HIV infection and AIDS. Based on community norms and preferences, school health education can help students develop the knowledge and skills they need to avoid or reduce sexual risk behaviors, school health services can provide or refer to reproductive health services, and school health policies can foster a safe and respectful environment for everyone.

**Tobacco Use**

**Introduction** The questions in this module measure:

• current cigarette use
• age of initiation of cigarette smoking
• current use of other tobacco products
• attempted cessation of cigarette smoking
• exposure to second-hand smoke
• tobacco use by parents/guardians (i.e., role models).

**Research findings**

Some research findings related to tobacco use are as follows:

• About 1.1 billion people worldwide smoke and the number of smokers continue to increase. Among these, about 84% live in developing and transitional economy countries.

• Currently 5 million people die each year from tobacco consumption, the second leading cause of death worldwide. If present consumption patterns continue, it is estimated that deaths from tobacco consumption will be 10 million people per year by 2020.

• The overwhelming majority of smokers begin tobacco use before they reach adulthood. Among those young people who smoke, nearly one-quarter smoked their first cigarette before they reached the age of ten.

• Smokers have markedly increased risks of multiple cancers, particularly lung cancer, and are at far greater risk of heart disease, strokes, emphysema and many other fatal and non-fatal diseases. If they chew tobacco, they risk cancer of the lip, tongue and mouth.

• Children are at particular risk from adults’ smoking. Adverse health effects include pneumonia and bronchitis, coughing and wheezing, worsening of asthma, middle ear disease, and possibly neuro-behavioral impairment and cardiovascular disease in adulthood.

• Many studies show that parental smoking is associated with higher youth smoking.
How school health programs can help
Schools can provide an ideal venue not only to teach about the harmful effects of smoking, but also to teach students refusal skills and an understanding of the behavior of the tobacco industry. A school tobacco control program must also incorporate prohibiting tobacco use at all school facilities and events, and helping students and staff to quit smoking.

Unintentional Injury

Introduction The questions in this module measure:
• the circumstances surrounding serious injuries
• the nature of bullying.

Research findings
Some research findings related to child unintentional injury are as follows:

• Unintentional injuries are a major cause of death and disability among young children.

• Each year, about 875,000 children under the age of 18 die from injuries and 10 to 30 million have their lives affected by injury.

• Injury is highly associated with age and gender. Males aged 10-14 have 60% higher injury death rates than females. Teenagers aged 15-19 have higher rates than those aged 10-14 years (64 compared to 29 per 100,000).

• Many unintentional injuries lead to permanent disability and brain damage, depression, substance abuse, suicide attempts, and the adoption of health risk behaviors.

• Victims of bullying have increased stress and a reduced ability to concentrate and are at increased risk for substance abuse, aggressive behavior, and suicide attempts.

How school health programs can help
School health programs can help reduce unintentional injuries in schools by:

• Establishing social and physical environments that promote safety and prevent injuries and violence.
• Implementing health education that teaches students knowledge, attitudes, and skills they need to adopt safe lifestyles.
• Establishing crisis response mechanisms.
• Providing mental health and social services to meet the needs of students.
• Providing safe physical education and extracurricular physical activity programs.

Internet Use

Introduction The questions in this module measure:

• The type of information students post on-line and who can access the material they post.
• Respecting other’s people right to privacy.

Based on the Pew Internet & American Life Project Study, “Teens, Privacy & Online Social Networks”:

• 55% of online teens have profiles online
• Among the teens who have profiles, 66% of them say that their profile is not visible to all internet users. They limit access to their profiles in some way.
• 82% of profile creators have included their first name in their profiles
• 79% have included photos of themselves.
• 66% have included photos of their friends.
• 49% have included the name of their school.
• 2% have included their cell phone numbers.
• 49% of social network users say they use the networks to make new friends.
• 32% of online teens have been contacted by strangers online – this could be any kind of online contact, not necessarily contact through social network sites.
• 65% said they ignored the contact or deleted it the last time it happened to them.
• 21% of teens who have been contacted by strangers have engaged an online stranger to find out more information about that person (that translates to 7% of all online teens).

How school health programs can help

• Discuss the implications of irresponsible use to self and others.
• Help students understand how the online world can be hurtful and misused.
• Provide students with a forum to discuss how they have been affected by online misbehavior and what actions they may have done to endanger or hurt others
• Bring cyber-bullying issues out into the open where they can be dealt with
Appendix 2: High School Wellness Survey Report

Wellness Survey Meeting Minutes

May 7, 2009 Present:

These minutes represent the discussion from the planning committee after viewing the results from the first trial phase of the Wellness Survey in the HS with 9th, 10th, 11th grades. The following response rate was noted:

9th Grade: 177/188 PE Classes 10th Grade: 143/197 PE/Health Classes 11th Grade: 131/165 Graduation Practice Ceremony

The priorities were identified during this meeting and by subsequent communication. Possible strategies have been considered under the following headings and are directed to different sectors in the community.

Policy:
Knowledge/Skills:
Supportive Environment:
Community Action:
Health Services (Internal/External):

1. Review Objectives for the Survey

The Wellness Survey has been developed to provide accurate data on health behaviors and protective factors among students in Middle School and High School.

The information generated from the Health Survey will be used to guide decisions relating to relevant school policy, curriculum and health services. The survey will also help to develop initiatives in order to create a supportive and nurturing school environment. The results will also provide a base for assessing future trends in students’ health behaviors.

2. Identify Priorities:

Alcohol Use

Goal: Reduce the % of students who get drunk.

a) Question: During the past 30 days, how many times did you drink so much alcohol that you were really “drunk”?

Seniors: 28% (43 students) drank one or more times in the past 30 days: 25% (32 students) 1 or 2 times 5% (8 students) 3-9 times 2% (3 students) 10 or more

10th Grade: 9% (14 students) drank one or more times in the past 30 days: 9% as: 8% (12) 1-2 times 1% (2) 3-9 times
b) Questions: How old were you when you had your first drink of alcohol other than a few sips?
How old were you when you tried drugs?

Alcohol age of first use curve getting steeper at age 11-12 and drugs age 15.

**Strategies:**
Policy: Is drinking behavior monitored other than for IASAS, WW? Is there any way to send a stronger message that alcohol consumption is not encouraged?

**Knowledge/Skills:**
*Students, parents*: Explore student/parent evening session aimed at increasing awareness of present practice, risks in Thailand (ease of access) and strategies for students and parents to help reduce both incidence of getting drunk, identify safe/unsafe crowds/environments and support (harm minimization) in the event someone is being reckless.

*Parents*: Inform parents of research showing protective function of spending time with children and knowing who your children are with and where they are. Address the legal issue of hiring out venues and making alcohol available to students under the age of 18.

*Students*:
Health class, continue: MS. a) effects of alcohol use. Catch them in middle school with the message about every year you postpone being better for your brain development. b) Teaching the danger of binge/fast drinking as part of the harm minimization approach. c) Use data to address MS normative beliefs and reinforce positive choices of not using alcohol.

HS: Continue refusal skills, supporting/helping friends, reasons for drinking, healthy coping strategies. Reinforce message above regarding harm minimization.

*Supportive Environment*:
Explore the concept of ‘Safe Homes’ – identify places where alcohol use for certain ages is not allowed?

*Community Action*:
Work with PTA to organize parent sessions.

*Health Services*:
Can counselors/psychologist look for alcohol use as a poor coping strategy? Could this be is included as part of the depression screening?

**Other Drug Use**

Goals: a) Reduce Year 12 use of tranquilizers: 15% students using tranquilizers/sedatives.

*Further information needed: Tranquilizer, sedative use: Why, who, when are they using.

b) Delay age of first use: curve getting steeper at 15.

**Strategies**:
Note: Once new information is obtained focused strategies can be discussed.

Policy: Issue a) above: Can we, do we want to test for sedative use?

**Knowledge/Skills**:
Issue a) above:
Students: Ask FCD to focus their delivery and questions regarding the use of tranquilizers and sedatives to help us understand the patterns of use and help students to understand the risks involved.

Parents: Inform parents of the risks for using prescription meds for non-prescribed conditions.

Issue b) above:
MS/HS health class: reinforce the message of delaying use of substance and address normative beliefs.

**Tobacco**

Goal: To reduce the spike in experimental use of tobacco in grade 11/12.

*Strategies*

Policy: Clear non-smoking policy. Can this be extended to include not carrying cigarettes at school?

Knowledge/Skills: Community awareness of content and effect of shisha (and red bull). Use tobacco use as a decision making/values exercise in 10th grade health.

Supportive Environment: Smoke free houses promoted in the community.

Community Action: Explore the possibility of having the PTA/ community promote and organize smoking cessation locally.

Health Services (Internal/External): Smoking cessation courses offered. (ask nurses to research programs)

**Contraception**

Goal: Increase contraception use for students that are sexually active.

<table>
<thead>
<tr>
<th>Use of contraception:</th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never/Rarely</td>
<td>5% (6)</td>
<td>8% (12)</td>
<td>13% (12)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2% (1)</td>
<td></td>
<td>8% (5)</td>
</tr>
</tbody>
</table>

* ( ) Number of Students

*Strategies:*

Policy: Does the school have a policy to address teen pregnancy in the event it happens?

Knowledge/Skills: HS health classes covering contraception well. Health – Ms 7th grade sexual activity – what is it and the risks involved and refusal skills.

Supportive Environment:
a) Can we research avenues available for students to get counseling and find contraceptive options in the local community? (nurse?)

b) Provide information on a notice board as to available health services, to include sexual/reproductive health, addiction, suicide, stress, referring a friend.

c) Provide brochures/contacts for distribution.

Health Services (Internal/External): If services are unavailable, work with local service providers to develop service.

## STD’s

Goal: Increase use of condoms.

Percentage of students having sexual intercourse that are not wearing condoms:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 12</td>
<td>26%</td>
</tr>
<tr>
<td>Grade 10</td>
<td>23%</td>
</tr>
<tr>
<td>Grade 9</td>
<td>31%</td>
</tr>
</tbody>
</table>

## Strategies:

**Knowledge/Skills:**

HS health class: More focus HS: Skills to ask for asking/enforcing condoms use link with responsibilities/values and social health unit.

MS Health Class: Already occurring. As above introduce the importance of using condoms and how they work, what protection they provide.

**Supportive Environment:**

Can condoms be made available through the nurses office or pharmacy for free?

**Community Action:**

Health Services (Internal/External): Also discussed was the provision of HPV vaccinations, this could also be researched by the nurses.

## Sleep

Goal: to increase amount of sleep students are getting.

(9 hours and 15 minutes recommended from a biological perspective)

<table>
<thead>
<tr>
<th></th>
<th>Grade 9 (%)</th>
<th>Grade 10 (%)</th>
<th>Grade 12 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 8 hours</td>
<td>82</td>
<td>90</td>
<td>93</td>
</tr>
<tr>
<td>Less than 6 hours</td>
<td>35</td>
<td>55</td>
<td>65</td>
</tr>
</tbody>
</table>
Strategies:

Policy: Can school starting time be altered?

Knowledge/Skills: (to whom) Educate parents on the effects of lack of sleep, what is the recommended level and how they can help. Sleep awareness week, 8 hour challenges, sleep as late as you want day.

Food

Goals: a) Increase breakfast consumption: 40% of 12th graders rarely or sometimes eat breakfast.

<table>
<thead>
<tr>
<th></th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never/rarely</td>
<td>13% (23)</td>
<td>13% (19)</td>
<td>20% (31)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>10% (17)</td>
<td>12% (17)</td>
<td>20% (18)</td>
</tr>
</tbody>
</table>

( ) number of students

b) Increase overall consumption of fruit/veges and calcium.

Strategies:

Policy: Food Policy for school recommended to support academic performance and student health. PTA or community representative (from this committee or with nutrition expertise) to sit on the food committee.

Knowledge/Skills: Parents on the impact of GI. energy and academic performance as well as breakfast.

Supportive Environment: Continue to ask for smoothies as a breakfast option to address calcium, fruit and breakfast rates. Contract with twist to provide on campus breakfast smoothies.

Community Action: Policy could also encourage school based activities to follow provision of healthy food.

Hygiene

Goals: Increase hand washing prior to eating.

<table>
<thead>
<tr>
<th></th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never/Rarely</td>
<td>48% (85)</td>
<td>50% (72)</td>
<td>54% (51)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>33% (59)</td>
<td>24% (34)</td>
<td>32% (49)</td>
</tr>
</tbody>
</table>

Strategies:

Knowledge/Skills: Education to students as to why it is important to reduce contracting/spread of illnesses. (comm. Groups, especially in light of swine flu)
Supportive Environment: HS/MS: Antibacterial dispensers or bank of taps/soap in cafeteria. ES: focused supervision of effective hand washing before lunch. (Is time an issue??) start good practices early.

Community Action: Encourage community groups to include hand washing before meals and after going to the bathroom.

Health Services (Internal/External)

Physical Activity

Goal: Increase physical activity of seniors.

69% grade 12 not doing PE, the main reason being that they had finished their requirements, and 46% have not participated in a sports team over the past year.

Strategies:

Policy: Explore the possibility of a K-12 requirement of Physical activity.

Supportive Environment: Explore avenues for providing non-competitive physical activity options in the time period between 2.15 – 3.15. (boot camp, yoga, core etc)

Unintentional Injuries:

The 2 areas of concern include riding bicycles without helmets and riding in cars without seatbelts. While both were seen as important the possible impact strategies would have on either was perceived as small.

Community Action: PTA meeting to show statistics and reinforce message of use of seat belts and helmets.

Protective Factors

(Research has shown protective factors to be significantly correlated with academic performance and health behaviors.)

The range of responses from the Protective Factors category could be addressed during a faculty meeting with discussion on strategies to increase percentages. It was discussed that further information would be valuable to see if certain sectors of the student body score lower on protective factors - correlate with culture/nationality and female/male.

Goal: a) Increase the number of students who feel there is an ‘adult at school who really cares about me’.

<table>
<thead>
<tr>
<th></th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>18% (31)</td>
<td>26% (20)</td>
<td>15% (22)</td>
</tr>
<tr>
<td>A little true</td>
<td>36% (59)</td>
<td>36% (23)</td>
<td>38% (27)</td>
</tr>
</tbody>
</table>

(*) number of students
Strategies:

Goal: b) Increase the number of students whose parents know ‘what I’m doing in my free time’.

<table>
<thead>
<tr>
<th></th>
<th>Grade 9</th>
<th>Grade 10</th>
<th>Grade 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never/Rarely</td>
<td>16% (19)</td>
<td>26% (33)</td>
<td>28% (41)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>24% (19)</td>
<td>27% (33)</td>
<td>26% (40)</td>
</tr>
</tbody>
</table>

Strategies:

Again correlate with culture/nationality to see if further information can be obtained.

Knowledge: Informing parents as to the research regarding knowing about how students are spending their free time has been included in the alcohol strategies.

Summary of Suggested Correlations:

Culture/Nationality: Time of first use of alcohol
  Tobacco use (and male/female)
  All protective Factors
Female/Male: Tobacco use
  Getting Drunk
  Sexual activity
  All Protective Factors

Alcohol vs smoking

Other Data considerations:

Sales at the Villa pharmacy. What are the patterns of purchasing? Main items to each age group?

Sales at 7-11: Would be great if we could get someone that works in the 7-11 to answer questions on the student’s buying habits. Who, when, how old, etc... someone with fluent Thai or some authority looking figure could just walk in with the casual question.......... OR and senior student that may have an interest in public health??

Changes to Survey Questions
1. Additional Questions: Who is not living with parents?
2. Define 1 standard drink before alcohol questions.
3. Change/add cigarette question to determine days smoking.
4. Move the question regarding saying no to sexual activities to the beginning of the section to have responses from all students not just those sexually active.
5. Add question – what is your present GPA.
6. How, when and why students are using tranquilizers.
7. Do you know how to get help or to get contraception – Maybe open ended question.

Next Steps:

a) Reporting to Leadership:

b) Reporting to students:

c) Reporting to the community: Newsletter article followed by PTA.

d) Implementation and coordination of strategies.

e) Store of Baseline Data:

f) Cycle of Survey Administration

g) Who has the responsibility of ongoing survey implementation and monitoring?

From committee member:
For reference.
On a personal note: as a mother of two girls, even as early as elementary years we would ask them which teacher or school staff member would they go to for help? We never positioned it as a choice whether to have an elder; they could rely upon, they understood it as a common practice. Once they made their choice, we would discuss why they chose that person and then we would convey that to the teacher. Knowing that a child spends so much more time at school than home, they MUST feel that it is safe and someone will act on their behalf.
Appendix 3: Middle School Wellness Survey Report

Middle School Health Survey

On picture days on September 22, 23 & 24, 2010, 316 students (7th and 8th graders) participated in the Middle School Health Survey.

Student Demographics:
The students were:
- Ranging in age from 11 and younger (2.2%) to 15 years (9.6%). The majority of students were 13 years old (53.2%) and the next largest group was 12 years old (36.4%).
- About half male (50.6%) and half females (49.4%).
- About half 7th graders (47.9%) and half 8th graders (51.1%).
- Mostly from Thailand (30.1%) and the United States (25.1%). With the next largest groups coming from Korea (9.5%), Japan (7%) and Europe (5.4%).
- Over half (55.4%) live in Nonthaburi and surrounding municipalities, while 26.3% live in Bangkok city (Sukhumvit area) and 10.4% live in other Bangkok suburbs.
- Almost all (99.7%) middle school students live with their parents...the living arrangements for one student was not clear.

Dietary Behaviors:
During the past 30 days, how many times did they eat...
- Fruit: 33.8% ate fruit 2 times a day, 27.1% ate fruit 1 time per day, 34.7% ate fruit less than 1 time per day or not at all. 24.5% ate fruit 3 times a day or more.
- Vegetables: 33.2% ate veggies 2 times per day, 25.9% ate veggies 1 time per day, 11.9% ate veggies less than 1 time per day or not at all. 29.1% ate veggies 3 times per day or more.
- Breakfast: 59.9% always eat breakfast, 2.2% never eat breakfast, 22.3% eat breakfast most of the time. When students don’t eat breakfast, most report lack of time for breakfast (30.4%) or that they can’t eat early in the morning (10.4%).
- Dairy: 23.9% consume dairy products 3 times per day, 22.7% 2 times per day, 20.4% 1 time per day, and 21.3% less than one time per day or not at all. 25.3% consume dairy products 4 or more times per day.
- Soft Drinks: 53.5% drank soft drinks less than 1 time per day and 20.1% did not drink any at all. 13.1% reported drinking soft drinks 1 time per day. 7.3% reported drinking those beverages between 2 to 4 times per day and 1% said they drank soft drinks 5 or more times per day.

During the past 7 days...
- 14.9% did not eat: fast food during the past 7 days. 35% ate fast food 1 day and 10.5% ate fast food on about 2 days. 3.5% on 3 days and 1% on 4 days.

During the past 30 days...
- 95.2% did not vomit or take laxatives to lose weight or to keep from gaining weight during the past 30 days. (3.8% or 12 students reported doing this.)
- 98.7% did not use diet pills, powders, or liquids without a doctor’s advice to lose weight or keep from gaining weight over the past 30 days. (1.3% or 4 students reported doing this.)
Hygiene:
During the past 30 days...
- 39% rarely or never wash hands/use sanitizer before eating at school, 25.8% sometimes do this.
- 59.9% always wash hands/use sanitizer after using the toilet at school, 26.7% do this most of the time, 11.7% sometimes do this and 7.8% rarely or never do this.
- 31.9% always use soap/sanitizer when washing hands at school while 23.2% do this most of the time, 30.6% sometimes do this, while 12.3% rarely or never do this and 1.9% just don’t wash their hands at school.

Mental Health:
During the past 3 months...
- 68.8% of the students rarely or never felt lonely while 23.5% sometimes felt lonely. 7.7% (24 students) reported feeling lonely most of the time or always.
- 67.7% rarely or never were so worried about something that they couldn’t sleep at night while 27.1% were sometimes so worried. 5.6% of students reported they lost sleep because they were worried most of the time or always.
- 66.5% of students were rarely or never so worried that they could not eat or did not have an appetite while 11% reported that they were sometimes. Less than 3% reported feeling this way most of the time or always.
- 52.8% of the students said they never or rarely had a hard time staying focused on their homework or other things they had to do while 30.2% sometimes felt this way. 17.1% reported feeling this way most of the time or always.

<table>
<thead>
<tr>
<th>1. During the past 3 months, how often have you felt lonely?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Rarely</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>answered question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. During the past 3 months, how often have you been so worried about something that you could not sleep at night?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Rarely</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>answered question</td>
</tr>
</tbody>
</table>
3. During the past 3 months, how often have you been so worried about something that you could not eat or did not have an appetite?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>64.2%</td>
<td>199</td>
</tr>
<tr>
<td>Rarely</td>
<td>22.3%</td>
<td>69</td>
</tr>
<tr>
<td>Sometimes</td>
<td>11.0%</td>
<td>34</td>
</tr>
<tr>
<td>Most of the time</td>
<td>1.5%</td>
<td>6</td>
</tr>
<tr>
<td>Always</td>
<td>0.6%</td>
<td>2</td>
</tr>
<tr>
<td>answered question</td>
<td></td>
<td>310</td>
</tr>
<tr>
<td>skipped question</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

4. During the past 3 months, how often have you had a hard time staying focused on your homework or other things you had to do?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>14.5%</td>
<td>45</td>
</tr>
<tr>
<td>Rarely</td>
<td>38.3%</td>
<td>149</td>
</tr>
<tr>
<td>Sometimes</td>
<td>30.2%</td>
<td>94</td>
</tr>
<tr>
<td>Most of the time</td>
<td>14.5%</td>
<td>45</td>
</tr>
<tr>
<td>Always</td>
<td>2.6%</td>
<td>5</td>
</tr>
<tr>
<td>answered question</td>
<td></td>
<td>311</td>
</tr>
<tr>
<td>skipped question</td>
<td></td>
<td>5</td>
</tr>
</tbody>
</table>

Regarding close friends, the majority of the students (84.8%) report having 3 or more close friends. Nine percent of students said they had 2 close friends, 2.9% had 1 close friend and 3.2% or 10 students said they had 0 close friends.

Regarding eating lunch alone at school, the majority of the students (75.5%) have never done this while 12.9% have rarely eaten lunch alone and 4.8% have sometimes done this. 6.7% or 21 students report that they eat lunch alone most of the time or always.

5. How many close friends do you have?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>3.7%</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td>2.5%</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>9.0%</td>
<td>28</td>
</tr>
<tr>
<td>3 or more</td>
<td>84.8%</td>
<td>263</td>
</tr>
<tr>
<td>answered question</td>
<td></td>
<td>310</td>
</tr>
<tr>
<td>skipped question</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

6. Since the beginning of this semester, how often have you eaten lunch alone at school?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>75.5%</td>
<td>234</td>
</tr>
<tr>
<td>Rarely</td>
<td>12.9%</td>
<td>40</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4.0%</td>
<td>15</td>
</tr>
<tr>
<td>Most of the time</td>
<td>3.2%</td>
<td>10</td>
</tr>
<tr>
<td>Always</td>
<td>3.5%</td>
<td>11</td>
</tr>
</tbody>
</table>
Regarding missing class or school without permission during the past 30 days, the majority of students (91.3%) have done this on 0 days. Twenty-seven students or 6.7% have done this on 1 or more days.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 day</td>
<td>91.3%</td>
<td>284</td>
</tr>
<tr>
<td>1 or 2 days</td>
<td>7.1%</td>
<td>22</td>
</tr>
<tr>
<td>3 to 6 days</td>
<td>1.3%</td>
<td>4</td>
</tr>
<tr>
<td>6 to 8 days</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>10 or more days</td>
<td>0.3%</td>
<td>1</td>
</tr>
</tbody>
</table>

### Protective Factors:

**During the past 30 days...**

- Most of the students were reported being kind and helpful most of the time or always by 71.3% of the students and sometimes kind and helpful by 20.9% of the students. 7.8% or 24 students reported that their classmates were rarely or never kind and helpful.
- Parents or guardians checked to see if homework was done for the majority of students (54.9%) always or most of the time while 19.5% reported they never checked their homework checked sometimes. 25.6% said that their parents or guardian rarely or never checked their homework during the last 30 days.
- Parents or guardians were reported to have understood their problems and worries most of the time or always by 49.2% of the students and sometimes by 24.3% of the students. 26.5% felt that their parents or guardians rarely or never understood their problems and worries.
- Parents or guardians knew where their student was during their free time most of the time or always according to 52.3% of the students while they sometimes knew for 20.8%. 16.9% said that their parents or guardians rarely or never knew where they were during free time.

Regarding the hours of sleep on a school night, 36.0% report getting 8 or more hours while 39.5% said they get between 7 and 6 hours and 24.5% get 6 hours or less.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>2.9%</td>
<td>9</td>
</tr>
<tr>
<td>Rarely</td>
<td>4.9%</td>
<td>15</td>
</tr>
<tr>
<td>Sometimes</td>
<td>20.9%</td>
<td>64</td>
</tr>
<tr>
<td>Most of the time</td>
<td>49.7%</td>
<td>152</td>
</tr>
<tr>
<td>Always</td>
<td>21.6%</td>
<td>66</td>
</tr>
</tbody>
</table>

**1. During the past 30 days, how often were most of the students kind and helpful to you?**
<table>
<thead>
<tr>
<th>2. During the past 30 days, how often did your parents or guardians check to see if your homework was done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Rarely</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>answered question</td>
</tr>
<tr>
<td>skipped question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. During the past 30 days, how often did your parents or guardians understand your problems and worries?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Rarely</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>answered question</td>
</tr>
<tr>
<td>skipped question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. During the past 30 days, how often did your parents or guardians really know what you were doing with your free time?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>Never</td>
</tr>
<tr>
<td>Rarely</td>
</tr>
<tr>
<td>Sometimes</td>
</tr>
<tr>
<td>Most of the time</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>answered question</td>
</tr>
<tr>
<td>skipped question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. On average how many hours sleep do you get on the nights before school?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>less than 5 hours</td>
</tr>
<tr>
<td>5-6 hours</td>
</tr>
<tr>
<td>7-8 hours</td>
</tr>
<tr>
<td>8-9 hours</td>
</tr>
<tr>
<td>more than 9 hours</td>
</tr>
<tr>
<td>answered question</td>
</tr>
<tr>
<td>skipped question</td>
</tr>
</tbody>
</table>
At my school there is a teacher or some other adult who...

- **Really cares about me:** 50.7% say this is pretty much true or very much true while 49.3 say this is a little true or not at all true.
- **Is mean to me:** 49.5% said that this is not true at all while 28.7% said that this is a little true. 21.8% (67 students) reported this was pretty much true or very much true.
- **Tells me when I do a good job:** Almost all students (80.35) reported that this is pretty much or very much true while 15.5% said it was a little true and 4.3% (13 students) reported that it was not true at all.
- **Notices when I'm not there:** 60.9% of students stated that this was pretty much or very much true while 26.7% revealed that this was a little true and 12.4% reported that this was not true at all.
- **Always wants me to do my best:** The majority of students (87.0%) revealed that this was pretty much true and very much true while 13.1% (39 students) said this was a little true or not at all true.
- **Listens to me when I have something to say:** 75.7% of students said this was pretty much or very much true while 17.5% said this was a little true and 6.8% said it was not at all true.
- **Believes that I will be a success:** 75.3% felt this was pretty much or very much true, 17.6% said it was a little true and 6.8% (21 students) reported this was not at all true.

<table>
<thead>
<tr>
<th>5. At my school, there is a teacher or some other adult who really cares about me.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>Not at All True</td>
</tr>
<tr>
<td>A Little True</td>
</tr>
<tr>
<td>Pretty Much True</td>
</tr>
<tr>
<td>Very Much True</td>
</tr>
<tr>
<td>answered question</td>
</tr>
<tr>
<td>skipped question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. At my school, there is a teacher or some other adult who is mean to me.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>Not at All True</td>
</tr>
<tr>
<td>A Little True</td>
</tr>
<tr>
<td>Pretty Much True</td>
</tr>
<tr>
<td>Very Much True</td>
</tr>
<tr>
<td>answered question</td>
</tr>
<tr>
<td>skipped question</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. At my school, there is a teacher or some other adult who tells me when I do a good job.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>Not at All True</td>
</tr>
<tr>
<td>A Little True</td>
</tr>
<tr>
<td>Pretty Much True</td>
</tr>
<tr>
<td>Very Much True</td>
</tr>
<tr>
<td>answered question</td>
</tr>
<tr>
<td>skipped question</td>
</tr>
</tbody>
</table>
9. At my school, there is a teacher or some other adult who notices when I’m not there.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All True</td>
<td>12.4%</td>
<td>38</td>
</tr>
<tr>
<td>A Little True</td>
<td>26.7%</td>
<td>82</td>
</tr>
<tr>
<td>Pretty Much True</td>
<td>36.5%</td>
<td>109</td>
</tr>
<tr>
<td>Very Much True</td>
<td>25.4%</td>
<td>78</td>
</tr>
</tbody>
</table>

answered question 307
skipped question 9

10. At my school, there is a teacher or some other adult who always wants me to do my best.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All True</td>
<td>3.6%</td>
<td>11</td>
</tr>
<tr>
<td>A Little True</td>
<td>6.5%</td>
<td>29</td>
</tr>
<tr>
<td>Pretty Much True</td>
<td>31.4%</td>
<td>96</td>
</tr>
<tr>
<td>Very Much True</td>
<td>55.6%</td>
<td>170</td>
</tr>
</tbody>
</table>

answered question 306
skipped question 10

11. At my school, there is a teacher or some other adult who listens to me when I have something to say.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All True</td>
<td>6.8%</td>
<td>21</td>
</tr>
<tr>
<td>A Little True</td>
<td>17.5%</td>
<td>54</td>
</tr>
<tr>
<td>Pretty Much True</td>
<td>45.5%</td>
<td>140</td>
</tr>
<tr>
<td>Very Much True</td>
<td>30.2%</td>
<td>93</td>
</tr>
</tbody>
</table>

answered question 308
skipped question 8

12. At my school, there is a teacher or some other adult who believes that I will be a success.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All True</td>
<td>6.8%</td>
<td>21</td>
</tr>
<tr>
<td>A Little True</td>
<td>17.9%</td>
<td>55</td>
</tr>
<tr>
<td>Pretty Much True</td>
<td>45.8%</td>
<td>141</td>
</tr>
<tr>
<td>Very Much True</td>
<td>29.5%</td>
<td>91</td>
</tr>
</tbody>
</table>

answered question 308
skipped question 0
Physical Activity:

During the past 7 days...
- 46.0% reported they were physically active, enough to increase their heart rate so it made it hard to breathe for some time. For a total of at least 40 minutes per day on 5 or more days. 19.5% reported this on 4 days, 15.6% on three days and 12.5% on 1 or 2 days. 7% reported never doing this during the past 7 days.
- Strengthening or toning muscles by doing push-ups, sit-ups, or weight training: 27.4 reported doing this on 5 or more days, 8.3% on 4 days, 11.6% on 3 days, 14.2% on 2 days, 13.9% on 1 day and 24.8% never did this during the past 7 days.
- Stretching exercises such as too touching, knee bending, or leg stretching: 24.4% reported doing this on 5 or more days, 11.6% on 4 days, 14.5% on 3 days, 14.5% on 2 days, 12.5% on 1 day and 12.5% never did this during the past 7 days.

During the past 12 months...
- Sports teams (School, BISAC and/or community teams): 29.1% never played on a team, 27.2% played on one team, 24.6% played on 2 teams and 18.9% played on 3 or more teams.
- Other: Many students listed sports teams for “other” space on “In how many other physical activities did you participate?” Some non-team others listed include: tennis lessons (22 students), ice skating lessons/classes (11 students), horseback riding lessons (7 students), dance troupe (2 students), badminton classes (6 students), physical training/exercise classes, not PE (5 classes).

<table>
<thead>
<tr>
<th>Activity</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dance class</td>
<td>31.7%</td>
<td>76</td>
</tr>
<tr>
<td>Martial arts class</td>
<td>5.0%</td>
<td>12</td>
</tr>
<tr>
<td>Thai boxing class</td>
<td>6.7%</td>
<td>16</td>
</tr>
<tr>
<td>Golf club/lessons</td>
<td>7.5%</td>
<td>19</td>
</tr>
<tr>
<td>Fencing club</td>
<td>1.7%</td>
<td>4</td>
</tr>
<tr>
<td>Internships</td>
<td>13.3%</td>
<td>32</td>
</tr>
<tr>
<td>Gymnastics class/club</td>
<td>3.6%</td>
<td>9</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>65.4%</td>
<td>157</td>
</tr>
<tr>
<td>Show replies</td>
<td></td>
<td>answered question 240</td>
</tr>
<tr>
<td></td>
<td></td>
<td>skipped question 76</td>
</tr>
</tbody>
</table>

Most students, 46.8%, spent two hours or less per school day sitting and watching television, playing computer games, talking with friends, or doing sitting activities while 38.7% spent 3 to 4 hours per school day doing this, 16.9% spent 5 to 8 hours per school day engaged in these activities and 3.6% or 11 students said they spend more than 8 hours per school day doing these sedentary activities. On the weekends or holidays, 26.9% reported spending two hours or less per day, 31.6% spent 3 to 4 hours per weekend/holiday day while 41.5% spent 5 or more hours per weekend/holiday day doing these activities. (7.6% or 23 students reported these engaging in these activities for more than 8 hours).
During the past 7 days 29.8% of students said it takes less than 10 minutes per day to go to and from school. 16.2% spend 10-19 minutes per day commuting to and from school and 29.2% spend between 20 and 59 minutes while 16.9% commute for 60-120 minutes. Only 7.9% commute for more than 2 hours.

The majority of students, 33.4%, choose to hang out with their friends during their free time while 22.9% would rather play TV/computer games. 16.3% of students like to spend their free time playing sports or exercising and 16.3% like to chat online/phone with friends. 9.3% of students choose to read or "other" for their free time.

6. How much time do you spend during a typical or usual school day sitting and watching television, playing computer games, talking with friends or doing sitting activities (including homework)?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 1 hour per day</td>
<td>10.3%</td>
<td>51</td>
</tr>
<tr>
<td>1 to 2 hours per day</td>
<td>30.5%</td>
<td>92</td>
</tr>
<tr>
<td>3 to 4 hours per day</td>
<td>38.7%</td>
<td>117</td>
</tr>
<tr>
<td>5 to 8 hours per day</td>
<td>13.9%</td>
<td>42</td>
</tr>
<tr>
<td>7 to 8 hours per day</td>
<td>3.0%</td>
<td>9</td>
</tr>
<tr>
<td>More than 8 hours per day</td>
<td>3.6%</td>
<td>11</td>
</tr>
<tr>
<td>answered question skipped question</td>
<td>302</td>
<td>14</td>
</tr>
</tbody>
</table>

7. How much time do you spend during a typical or weekend/holiday day sitting and watching television, playing computer games, talking with friends or doing sitting activities?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 1 hour per day</td>
<td>6.6%</td>
<td>20</td>
</tr>
<tr>
<td>1 to 2 hours per day</td>
<td>20.3%</td>
<td>61</td>
</tr>
<tr>
<td>3 to 4 hours per day</td>
<td>31.6%</td>
<td>95</td>
</tr>
<tr>
<td>5 to 6 hours per day</td>
<td>23.9%</td>
<td>72</td>
</tr>
<tr>
<td>7 to 8 hours per day</td>
<td>10.0%</td>
<td>30</td>
</tr>
<tr>
<td>More than 8 hours per day</td>
<td>7.8%</td>
<td>23</td>
</tr>
<tr>
<td>answered question skipped question</td>
<td>301</td>
<td>15</td>
</tr>
</tbody>
</table>

8. During the past 7 days, how long did it take for you to get to and from school each day? Add up the time you spend going to and from school.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 minutes per day</td>
<td>29.8%</td>
<td>90</td>
</tr>
<tr>
<td>10 - 19 minutes per day</td>
<td>18.2%</td>
<td>49</td>
</tr>
<tr>
<td>20 - 29</td>
<td>4.0%</td>
<td>12</td>
</tr>
<tr>
<td>30 - 39</td>
<td>6.3%</td>
<td>18</td>
</tr>
<tr>
<td>40 - 49</td>
<td>6.6%</td>
<td>26</td>
</tr>
<tr>
<td>50 - 59</td>
<td>10.3%</td>
<td>31</td>
</tr>
<tr>
<td>60 - 120</td>
<td>15.9%</td>
<td>51</td>
</tr>
<tr>
<td>More than 2 hours</td>
<td>7.9%</td>
<td>24</td>
</tr>
<tr>
<td>answered question skipped question</td>
<td>302</td>
<td>14</td>
</tr>
</tbody>
</table>
9. What do you choose to do with your free time? (Choose the activity you mostly do.)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>TV/computer games</td>
<td>22.0%</td>
<td>69</td>
</tr>
<tr>
<td>Sports or exercise</td>
<td>16.2%</td>
<td>55</td>
</tr>
<tr>
<td>Chatting online/phone with friends</td>
<td>16.2%</td>
<td>40</td>
</tr>
<tr>
<td>Hanging out with friends</td>
<td>33.4%</td>
<td>104</td>
</tr>
<tr>
<td>Reading Other?</td>
<td>9.3%</td>
<td>26</td>
</tr>
</tbody>
</table>

answered question: 302
skipped question: 14

Unintentional Injury:
During the past 30 days, how often did you...
- Use a seatbelt when in a car? 26.8% never or rarely used a seatbelt, 19.1% sometimes used one, 20.4% used one most of the time and 31.1% always used one. (2.7% had not ridden in a motor vehicle during the past 30 days).
- Ride in a car or motor vehicle driven by someone who had been drinking alcohol? 90.3% did not do this, 6% did this one time, 0.7% did this 2 or 3 times, 1% did this 4 or 5 times and 2% report doing this 6 or more times.
- Wear a helmet when riding a bicycle or other non-motorized vehicle? 41.6% rarely or never wore a helmet (of that 36.2% never), 4% sometimes and 4% did most of the time while 10.1% always did this. (40.3% did not ride a bike or other non-motorized vehicle during the last 30 days.)
- Wear a helmet when riding a motorcycle? 82.9% never rode a motorcycle during the last 30 days, 9.0% rarely or never wore a helmet, 2.3% sometimes wore a helmet, 1.3% wore one most of the time, and 5% always wore one.

During the past 7 days 4.7% of the students rode on a motorcycle with 2 or more people on 1-2 occasions, 1% did this on 3-4 occasions and 0.7% did this on 4 or more occasions.

Bullying:
During the past 30 days...
- 75.2% of the students reported that they were not bullied, 16.1% (46) were bullied on 1 or 2 days, 5% were bullied on 3 to 5 days, and 1.7% were bullied on 6 to 9 days. Three students (1%) reported being bullied on all 30 days.

2. During the past 30 days, how were you bullied most often?

<table>
<thead>
<tr>
<th>Bullying Incident</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was not bullied during the past 30 days</td>
<td>73.2%</td>
<td>218</td>
</tr>
<tr>
<td>I was hit, kicked, pushed, shoved around, or locked indoors</td>
<td>0.7%</td>
<td>2</td>
</tr>
<tr>
<td>I was made fun of because of my race or color</td>
<td>4.0%</td>
<td>12</td>
</tr>
<tr>
<td>I was made fun of because of my religion</td>
<td>1.8%</td>
<td>3</td>
</tr>
<tr>
<td>I was made fun of with sexual jokes, comments, or gestures</td>
<td>3.7%</td>
<td>11</td>
</tr>
<tr>
<td>I was left out of activities on purpose or completely ignored</td>
<td>4.0%</td>
<td>12</td>
</tr>
</tbody>
</table>
I was made fun of because of how my body or face looks | 3.4% | 10
I was made fun of because of my sexual orientation | 0.3% | 1
I was bullied in some other way. | 9.7% | 29

<table>
<thead>
<tr>
<th>3. If you have been bullied where does the bullying usually occur?</th>
<th>Response</th>
<th>Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have not been bullied</td>
<td>08.2%</td>
<td>267</td>
<td></td>
</tr>
<tr>
<td>at school</td>
<td>25.4%</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>on the bus to/from school</td>
<td>0.7%</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>speaking over the phone</td>
<td>0.6%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>online (internet)</td>
<td>2.7%</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>SMS messages on mobile</td>
<td>0.0%</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2.0%</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>answered question</td>
<td>299</td>
<td></td>
<td></td>
</tr>
<tr>
<td>skipped question</td>
<td>17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Alcohol and Other Drug Use:

**Alcohol:**
- 81% of students reported that they have never had an alcoholic drink (more than a few sips) while 19% (97) students have had an alcoholic drink.
- Most (83% or 16 students) of the students who had an alcoholic drink were 12 or 13 when they had their first drink of alcohol (other than a few sips) and 26.7% (16) were 10 or 11 years old.
- Most (51.7% or 31 students) had this first drink at their home and some (26.7% or 16 students) had their first drink at a restaurant. 5% (3) reported the first drink out on the street, in a park or in some other open area and only 1 student (1.7%) reported that their first drink occurred at a bar, pub or disco. (9.3% (6 students) had their first drink at someone else’s home).
- Most (44.1% or 26 students) of these students only drank once. Of those drinking more than one time, 18.6% (11) reported drinking at home and 26.3% (12) reported drinking in a restaurant the last time they had a drink of alcohol. (6.5% (5) had the last drink at someone else’s house, 3.4% (2) had it at a bar, pub or disco and 1.3% (1) had it on the street, in a park or in some other open area.
- During the last 30 days, 62.7% (37 students) did not have any drinks containing alcohol. 30.5% (16 students) reported having at least one drink containing alcohol on 1 or 2 days and 6.8% reported this happening on 3 to 5 days.
- During the past 30 days, the days they drank alcohol, 69% (40) of the students had less than one drink. 17.2% (10) had about 1 drink, 8.6% had about 2 drinks, 5.4% reported 3 drinks and only one student (1.7%) reported drinking 4 drinks.
- Students reported obtaining alcohol during the past 30 days, by getting it some other way (49% or 25 students), getting it from home (37.3% or 19 students), buying it at a store (7.8%) or getting it from friends (5.9%).
- During the past 30 days, the majority of the students (89.8% or 53 students) did not drink so much alcohol that they were really “drunk”. 8.5% reported getting “drunk” 1 or 2 times and one student reported this behavior 10 or more times.
- The majority (72.3% or 34 students) of students reported drinking alcohol with their family and 19.1 said they drank with their friends. 8.5% or 4 students said they usually drink alone.
Most students reported that they rarely (37.5%) or never (37.5%) are allowed to drink alcohol at home while 19.6% are sometimes allowed. 5.4% report that they are always allowed to drink alcohol at home.

The majority (73.1% or 38 students) of the students say that their parents or guardians know that they drink alcohol while equal numbers (7% or 13.5%) report that their parents don’t know they drink or they are not sure if their parents know they drink.

**Drug Use:**
- Most of the students (95.6% or 285 students) report never being offered drugs at school while 4% or 12 students report being offered drugs once or twice at school. Only 1 student (3%) reported being offered drugs 3 or more times at school.
- The majority (98.7% or 294 students) reported never using drugs and 4 students or 1.3% reported using drugs.
- Of these four students, one did not use during the past 12 months, one used 1 or 2 times during this time, one student reported using 3 to 9 times and one student used 10 or more times.
- Concerning drug use during the past 30 days, three students reported using 0 times and one student used 1 or 2 times.
- Of these four students, one tried drugs for the first time at 8 years old or younger, one tried when they were 10 or 11, and two reported their first age of use was 12 to 12 years old.
- Of these four students, one reported using marijuana or hashish most often while another reported using methamphetamine the most often. One student said they used “some other drug” the most often and the other student left this question blank.
- The students all reported different ways of obtaining their drugs: one bought drugs from a friend, one was given drugs at a night club, one said the drug was available at their home and one obtained their drugs some other way.

**Tobacco:**
- Most of the students, 94.3%, reported that they have never tried or experimented with cigarette smoking (including shisha), even one or two puffs while 5.7% (17 students) have.
- Of these 17 students, 17.6% (3) tried their first cigarette when they were 10 years or younger, 23.6% (4) when they were 10-12 and 17.6% (3) when they were 13-14. 41.2% (7) have never tried a cigarette.
- Most of the students have never tried shisha (62.5%) while 25% (4) tried it at age 10-12, one student (6.25%) tried it at 10 years or younger and one (6.25%) student tried it at 13-14 years old.
- While 41.2% (7) of these students have never tried a cigarette, 2 (11.8%) first tried a cigarette at home, 2 (11.8%) as someone else’s house, 2 (11.8%) at a bar, pub or disco and 3 (17.6%) students first tried a cigarette at some other place.
- Sixty percent of these students have never tried shisha while one student (6.7%) tried it at home, 2 students (13.3%) tried it at someone else’s house, one (6.7%) at a bar, pub. or disco. and 2 (13.3%) tried it in a restaurant.
- 76.5% (19) of these students have not smoked during the last 30 days. One student (5.8%) reports smoking one cigarette per day during this period, one student (5.8%) smoked 11-20 cigarettes per day and 2 students (16.8%) smoked more than 20 cigarettes per day.
- 87.5% of students report not smoking cigarettes during the last 30 days, while 6.25% report smoking on 1 or 2 days or 3 to 5 days.
- 76.5% report not smoking shisha during the last 30 days, while 5.8% smoked on 1 to 2 days, 5.8% smoked on 3 to 5 days, 5.8% smoked on 20-29 days and 5.8% report smoking shisha on all 30 days.
• Of these students, 58.5% don’t smoke, 5.9% smoke at friend’s houses, 11.8% smoke at social events, 5.9% smoke in public areas such as parks, shopping centers, and street corners, and 17.6% smoke in other places.
• Of these students, 53% (9) would definitely not smoke if their best friend offered them a cigarette while 25% (4) definitely would. 11.8% (2) probably would or probably would not.
• Of these students, 58.9% (10) would definitely not smoke shisha in one of their best friends offered it to them, while 11.8% (2) definitely would. 23.5% (4) probably would not while 5.9% (1) probably would.
• 41.7% say their parents don’t know that they smoke while 35.3% (6) say their parents do know. Four students. 23.5%, don’t know if their parents know or not.

Sexual Behavior:
• The majority of students, 97%, have not engaged in sexual activity (including sexual intercourse or oral sex) while 3.0% (9 students) report that they have.
• Of these 9 students, four (40%) report they have participated in oral sex more often, two (22.2%) said sexual intercourse more often and 3 (33.3%) said they engage in both oral sex and sexual intercourse most often.
• Half (4) of the students first participated in sexual activities when they were 11 years or younger and half when they were 12 years old.
• During the past 12 months, two of the students (22.2%) did not participate in this sexual activity at all while 1 student each participated 2 or 3 times, 4 to 9 times, and 10 to 29 times. Four students (44.4%) report participating in this activity 30 or more times during the past 12-month period.
• Six (66.7%) of the students report that neither they nor their partners used a condom the last time they participated in this reported sexual activity while 3 (33.3%) students did.
• Students were asked about using any method of birth control during sexual intercourse and the majority 55.6% (5) reported never using any method of birth control. One said they sometimes used birth control, two always use birth control and one never had sexual intercourse. Likewise, the majority (66.7%) reported not using a condom the first time they had sexual intercourse/oral sex. In addition, 44.4% reported never using a condom during the past 12 months while only one student (11.1%) always used a condom.
• When asked about how many people they had sexual intercourse or oral sex with during the past 12 months, 4 students (40%) reported being with 5 or more people, 1 with 1 person, 1 student reported being with 2 people and 1 student reported being with 3 people. Two of the students have had sexual intercourse/oral sex, but not during the past 12 months.
• 33.3% (3) of the students said they knew how to tell someone that they do not want to have sexual intercourse/oral sex with them unless a condom is used. 77.8% (7) of students said they do know how to tell someone that they did not want to have sexual intercourse/oral sex with them.

Internet Use:
• 76.5% of students do not put private information online that could identify them to strangers while 23.3% (70) do put private information online.
• 92.7% of students do not put others’ private information online, while 7.3% (21) do put this type of information online.
• 64.6% of students report that someone else has not put private information about them online, however, 15.4% (44) report that this has happened to them.
• 75.9% of students say that their social networking account is set so only their friends can view their profile while 24.1% (69) say they do not do this.
• 89.3% of students report that they communicate online in a way that is respectful of the privacy for themselves and others, while 10.8% (31) report that they do not do this.

• 76.4% of students report that they have not logged on to someone else’s online account using their login information (that they knew or was provided to them) during the last 12 months, however, 23.6% (68) of the students report that they have done this.
Appendix 4: Leadership Health Awareness Survey

School Leadership Survey

The following questions are designed to gauge your general feelings regarding health education. The survey may be used as part of a research project.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health education should be provided in school.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. Health education impacts on the academic performance of the students.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. Schools and parents share responsibility for providing health knowledge and skills.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. The school has a role to play (beyond health classes) in addressing the health needs of the students.</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. The school has a role to play in addressing the health needs of the staff (beyond providing health insurance).</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

6. How do you think living in Thailand impacts health behaviours? (eg: substance use, diet, social support, road safety)

7. Have you heard of "Health Promoting Schools"?  yes no

8. If yes, what is your understanding of what a health promoting school is?

Many thanks for sharing your thoughts and your time. Would you be available for a follow-up interview to discuss school health programs further? If yes please provide your name and e-mail address below.
Appendix 5: Leadership Team Process Interview Questions

This is a confidential interview. The tape is coded and will be transcribed away from the school and then locked away.

The interview today will be focused on the decision to implement a HPS model at ISB and your reactions to the change message and model.

1. How was the decision to include health/wellness on the SLP made? Who made the decision to include wellness on the SLP?
2. In what way did you contribute to that decision?
3. Why was/do you think wellness was included on the SLP?
4. B mentioned that the school had a ‘morale purpose’ in implementing the change. What do you think he meant by that?
5. Do you agree with that?
6. The model involves using multiple strategies to address the priorities we identified. Any comments about the model? What parts of the model do you like? Are there parts of the model that you don’t understand or find challenging?

Change Message

7. In delivering a change message there are 5 key beliefs that are recommended to be addressed; In what ways do you think these were addressed: Discrepancy – Appropriateness –Efficacy – Principal Support - Valence
8. In what ways was the change message delivered? If need prompts
   LT presentations
   Newsletters, meetings
9. What message had the most impact on you?

10. Was there ‘health jargon’ that was difficult to understand? – comprehensive approach, developmental assets, connectedness,

11. What educational journals do you read regularly? Can you recall any health related articles?

**Survey**

12. The survey assessed these 5 belief’s, and your responses indicated that there were some reservations in each of these areas. Appropriateness of the model seemed to be the main area. What message would have been important in your belief that the model would address the identified discrepancy? In the other areas? D, E

13. In what way do you think the context (setting, staff, community) of our school affects the appropriateness of using the HPS model?

14. Do you feel that there has been any change within the school already in regard to wellness?

15. Do you have any concerns about the future of the program?

16. In future jobs as a school administrator do you think you would adopt a HPS approach? Why?

If not the whole program are there any parts of the program you would like to adopt?

Or as your job as part of a school leadership team would you support the implementation of a HPS approach? Why?

Do you want to make any other comments?
Appendix 6: Leadership Team Change Agent Questions

A change agent is a person who leads a change in an organization in order to attain a higher degree of output or an improved outcome. Ultimately, the goal of the change agent is to make the change stick. With Belinda as the change agent, the change message was the adoption of the Health Promoting School model. The change recipient was the Leadership Team with you (the interviewee) as a member of that team.

1. I would like to ask you to think of and perhaps write down a few attributes or characteristics that you believe a change agent would need in order to be effective and successful. Now, which of these attributes that you are thinking of do you believe the change agent portrayed when she guided the school in the adoption of the Health Promoting School model?

2. For each attribute listed, can you give me a specific example?

3. If more than one characteristic is mentioned and written down…Which attribute do you believe was the most important? The second most important? Third? Etc…And why?

4. Here is a list of characteristics of an effective change agent taken from several sources. How does the list you made compare to this list? Would you add anything to your list?

5. In which of the below areas do you think the change agent is strong (expert)? In which areas could she improve (novice)?

6. For each attribute that they identify, have them give an example….If they believe she had a strong, clear vision…what do they think the vision was?

7. Is there anything that she could have done differently?

8. In guiding this change she used an Ecological or Whole System Model (Dooris, 2004). (Show the picture of the model) This model recognizes the interplay
between environmental, behavioral, and organizational factors. The LT’s adoption of the HPS program reflects the top-down managerial commitment to this change and is part of the organizational factors which will in turn influence other components in the model. Are you aware of other efforts that she has been involved in to include the other components of the whole system in order to facilitate change? (Staff, students, parents, health fair, etc).

9. What steps were taken in leading the change? What is your opinion on the length of time from introducing the model to the LT adopting the model? Too long? Too fast? Should more time have been spent or more emphasis been placed on any of the areas below? (First presentation to BOT May 2008….full LT presentations-3, many mtgs with LT members)

10. In your (the interviewee) role do you consider yourself a successful change agent? An expert? How often do you lead system wide changes?
Appendix 7: Parent Questions

1. How long have you been associated with the school?

2. In what way/s have you been involved with health and wellness at the school?

3. What Wellness related committees/activities have you been involved with, see below for some examples? Please outline your role.

Substance Abuse Committee
Wellness Survey Committee
Live Well Learn Well (parent committee)
   Logo Development – Live Well. Learn Well @
   Fridge Magnets and To-Do list
   Newsletters
   Health and Fitness Fair
   Action Plans (nutrition, physical activity):
   Nurses Audit/action plan:
Other
   a) How do you feel your involvement in the committee or activities affected your awareness, support of or interest in the wellness program. (Or any other reflections).

   b) Do you feel the committee/s gave you a sense of ownership and/or empowerment to effect change?

4) What have you enjoyed about your involvement?

5) What have you not enjoyed? Or what has frustrated you?
6) What do you think the successes of the Wellness initiative have been?

7) Do you see any failings?

8) Do you think ISB needs a wellness program? And why?

9) Do you think the model (see below) we have is the right one? Why?

10) Do you think the school can implement a Wellness program?

11) Do you feel like the administration is supportive?

12) Do you feel like the program would help you personally?

13) How would you describe the decision-making process at ISB?

Other comments:
Appendix 8: Staff Questions

1. How long have you worked at ISB? In what roles?

2. In what way/s have you been involved with health and wellness at the school?

3. What Wellness related committees/activities have you been involved with, see below for some examples? Please outline your role.

   Substance Abuse Committee
   Wellness Survey Committee
   Staff Guiding Coalition
   Learning Evidence Team

   a) How do you feel your involvement in the committee or activities affected your awareness, support of or interest in the wellness program. (Or any other reflections).

   b) Do you feel the committee/s gave you a sense of ownership and/or empowerment to effect change?

4. What have you enjoyed about your involvement?

5. What have you not enjoyed? Or what has frustrated you?

5. What do you think the successes of the Wellness initiative have been?

6. Do you see any failings?

7. Do you think the school needs a wellness program? And why
8. Do you think the model (see below) we have is the right one? Why?

10. Do you think ISB can implement a Wellness program?
11. Do you feel like the administration is supportive?
12. Do you feel like the program would help you personally?
13. How would you describe the decision-making process at the school?

Other comments:
Appendix 9: Organizational Change Recipients’ Beliefs Scale

Organizational Change Recipients’ Beliefs Scale

Please read the statements, on both sides of this paper, and fill in the circle that represents your response.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. This change will benefit me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Most of my respected peers embrace the proposed organizational change.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I believe the proposed organizational change will have a favorable effect on learning.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. The school has the capability to implement the change that is proposed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. We need to change the way we do some things in this organization to support student learning more comprehensively.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. With this change in the school, I will experience more self-fulfillment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. The top leaders in this organization are “walking the talk”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. The change in our operations will improve the performance of our organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I can support this change in the school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. We need to improve the way we operate in this organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I will earn higher pay from my job after this change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. The top leaders support this change</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Statement</td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>13.</td>
<td>The change that we are implementing is correct for our situation</td>
<td>0</td>
</tr>
<tr>
<td>14.</td>
<td>I am capable (have the knowledge) of being an advocate for the proposed organizational change</td>
<td>0</td>
</tr>
<tr>
<td>15.</td>
<td>We need to improve our effectiveness by changing our operations in regard to providing a supportive and nurturing environment</td>
<td>0</td>
</tr>
<tr>
<td>16.</td>
<td>The change in the school will increase my feelings of accomplishment</td>
<td>0</td>
</tr>
<tr>
<td>17.</td>
<td>The majority of my respected peers are dedicated to making this change work</td>
<td>0</td>
</tr>
<tr>
<td>18.</td>
<td>When I think about this change, I realize it is appropriate for our organization</td>
<td>0</td>
</tr>
<tr>
<td>19.</td>
<td>I believe we can successfully implement this change</td>
<td>0</td>
</tr>
<tr>
<td>20.</td>
<td>A change is needed to improve our operations</td>
<td>0</td>
</tr>
<tr>
<td>21.</td>
<td>My immediate manager is in favor of this change</td>
<td>0</td>
</tr>
<tr>
<td>22.</td>
<td>This organizational change will prove to be best for our situation</td>
<td>0</td>
</tr>
<tr>
<td>23.</td>
<td>We have the capability to successfully implement this change</td>
<td>0</td>
</tr>
<tr>
<td>24.</td>
<td>My immediate manager encourages me to support the change</td>
<td>0</td>
</tr>
</tbody>
</table>

Thank you for participating.

Developed by: Ashok A. Arora, Auburn University, Jeremy R. Bernhardt, Washington, D.C., Jennifer M.⎠πς Columbus State University, H. Jack Walker, Utah State University.
Appendix 10: Health Promoting Schools Model Checklist

<table>
<thead>
<tr>
<th>Principles of a HPS</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
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<tbody>
<tr>
<td>The ISB Health Promoting School Model</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Promotes the health and wellbeing of students</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Upholds social justice and equity concepts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Involves student participation and empowerment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Helps to provide a safe and supportive environment</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Links health and education issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Addresses the health and wellbeing issues of staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Collaborates with the local community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Integrates into the school's ongoing activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Sets realistic goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Engages parents and families in health promotion</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following Essential Elements of a HPS are included in the model:

a) Healthy School Policies: Such as policies or accepted practices which enable physical activity, healthy eating or prevent bullying.

b) Individual Health Knowledge and Skills: Including the curriculum and associated activities such as the health fair, physical activity/log where students gain age-related knowledge and understanding.

c) Community Links: These are the connections between the school and the students’ families and other key local groups.

d) The School’s Physical Environment: Includes facilities, shade provision, hand washing facilities etc.

e) The School’s Social Environments: Combination of the quality of the relationship among and between staff and students. It is influenced by the parents and the wider community.

f) Health Services: including nursing, counseling and any other health services to ISB.

Many thanks for your time.
### Appendix 11: Node Structure Report

#### Node Structure

**PhD**

11/18/2014 12:42 PM

<table>
<thead>
<tr>
<th>Hierarchical Name</th>
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Nodes\Characteristics of change agent\Weaknesses or Improvements\raise profile No None

**Reports**\Node Structure Report

11/18/2014 12:42 PM

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Nodes\Concerns, reservations\Conc. re Efficacy No None
Nodes\Concerns, reservations\Conc. re Principal Support No None
Nodes\Concerns, reservations\Conc. re Valence No None
Nodes\Concerns, reservations\Sustainability No None

**Nodes**\Decision Making Process

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Nodes\Describing Context\large No None
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Nodes\Describing Context\Mission driven No None
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Nodes\Describing Context\Stuck in ways No None
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No | None

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Nodes | Key Beliefs | broad reach 5 elements
--- | --- | ---
No | None
Nodes | Key Beliefs | cultural layer
--- | --- | ---
No | None
Nodes | Key Beliefs | good for kids
--- | --- | ---
No | None
Nodes | Key Beliefs | Linked to school mission
--- | --- | ---
No | None

Reports | Node Structure Report
--- | ---
Page 2 of 4

Hierarchical Name | Nickname | Aggregate | User Assigned
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Nodes | Key Beliefs | Appropriateness | Makes sense
--- | --- | --- | ---
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Nodes | Key Beliefs | Appropriateness | Supportive policies and procedures
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Nodes | Key Beliefs | Discrepancy
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Nodes | Key Beliefs | Addresses identified need
--- | --- | ---
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Nodes | Key Beliefs | Addresses identified need | Health data
--- | --- | --- | ---
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No | None

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Nodes | Key Beliefs | Visionary leadership
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Nodes | Key Beliefs | Personally valuable
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### Nodes/Readiness for Change/Process

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<td>Managing Information</td>
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<td>Vision</td>
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<td>Whole package logo</td>
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### School Characteristics

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<th>Negative or Barriers</th>
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### Social Justice and Equity References

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</table>

### Time Frame

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<th>Right Time</th>
<th>Time not an issue</th>
<th>Too Slow</th>
</tr>
</thead>
<tbody>
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<td>No</td>
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<td>No</td>
<td>No</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
Appendix 12: Confirmation of Ethical Approval

DEAKIN UNIVERSITY

Human Ethics Research
Office of Research Integrity
Research Services Division
70 Edgar Road Burwood Victoria
Postal: 221 Burwood Highway
Burwood Victoria 3125 Australia
Telephone 03 9251 7123 Facsimile 03 9244 6801
research-ethics@deakin.edu.au

Memorandum

To: Prof Evelyne de Leeuw
School of Medicine

Cc: Ms Belinda Gardner

From: Deakin University Human Research Ethics Committee (DU-HREC)

Date: 16 May, 2010

Subject: 2010-009

The Health Promoting School Framework in an International School (Part A)

Please quote this project number in all future communications.

Exemption from Ethics Review was granted for this project on 18/05/2010.

Authorisation has been given for Ms Belinda Gardner under the supervision of Prof Evelyne de Leeuw, School of Medicine, to undertake this project for the life of the project from 18/05/2010.

This Exemption from Ethics Review is given only for the project as stated in this memo. It is your responsibility to contact the Human Research Ethics Unit, immediately regarding any of the following:

- Any adverse events or events which might affect the continuing ethical acceptability of the project
- All modifications to the research relating to the data or records must be submitted to the Human Research Ethics Unit for review prior to being implemented

In addition, you will be required to report on the progress of your project at least once every year and at the conclusion of the project. You are furthermore required to retain auditable records of the project demonstrating compliance with the National Statement on Ethical Conduct in Human Research (2007) (paragraph 5.2.9) and to produce these if required.

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Memorandum

To: Prof Evelyne De Leeuw
School of Health & Social Development

cc: Ms Belinda Gardner

From: Deakin University Human Research Ethics Committee (DU-HREC)
Date: 23 February, 2010
Subject: 2010-010
The Health Promoting School Framework in an International School (Part B)

Please quote this project number in all future communications

The application for this project was considered at the DU-HREC meeting held on 22/02/2010.

Approval has been given for Ms Belinda Gardner, under the supervision of Prof Evelyne De Leeuw School of Health & Social Development, to undertake this project from 22/02/2010 to 22/02/2013.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HREC’s.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DU-HREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
## Appendix 13: Model from National Health Education Standards

**Characteristics of Effective Health Education**

**Effective Health Education:**
- Focuses on specific behavioral outcomes
- Is research-based and theory-driven
- Addresses individual values & group norms that support health-enhancing behaviors
- Focuses on increasing personal perception of risk and harmfulness of engaging in specific health risk behaviors and reinforcing protective factors
- Addresses social pressures
- Builds personal and social competence
- Provides functional health knowledge that is basic, accurate, and directly contributes to health-promoting decisions & behaviors
- Uses strategies designed to personalize info & engage students
- Provides age- and developmentally appropriate information, learning strategies, teaching methods & materials
- Incorporates culturally inclusive learning strategies, teaching methods & materials
- Emphasizes adequate time for instruction
- Provides opportunities to reinforce skills & positive health behaviors
- Provides opportunities to make connections with other influential persons
- Includes teacher information & plans for professional development & training to enhance effectiveness of instruction and learning

### Coordinated School Health Programs (CSHP)

**National Health Education Standards**

**Performance Indicators**

**State Frameworks/State Standards**

**Concepts**
- Skills
- Attitudes
- Values
- Norms

**Behavior**

Appendix 14: Whole School, Whole Community, Whole Child Conceptual Model

Appendix 15: Comparison of General Principles of a Health Promoting School and Statements from the School’s Vision and Guiding Principles

<table>
<thead>
<tr>
<th>School’s Mission/Vision</th>
<th>Principles and Values of a health-promoting school</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding and guiding their own learning.</td>
<td>Facilitate students to help themselves.</td>
</tr>
<tr>
<td>Set priorities with respect to their body, mind and spirit.</td>
<td>Focus on mental, emotional and social health as well as physical health</td>
</tr>
<tr>
<td>Feel supported and encouraged.</td>
<td>Feel they belong, feel cared for, valued and safe.</td>
</tr>
<tr>
<td>Connections between disciplines and the real world</td>
<td>To make a difference in real-life situations</td>
</tr>
<tr>
<td>Skills mentioned in the vision: Goal-setting, group learning and leadership, cross-cultural understanding</td>
<td>Decision-making, assertiveness, goal-setting, listening and responding effectively to others, reading and interpreting social cues, being co-operative, resolving conflicts.</td>
</tr>
</tbody>
</table>

(Gray et al., 2006)
Appendix 16: The Initial Plan Presented to Senior LT

A supportive and nurturing learning environment.

Target: Design and implement a sustainable Learner Wellbeing program that supports the social, emotional, mental and physical health of students and staff.

A healthy school promotes the health and well-being of its students and staff through a well-planned, taught curriculum in a physical and emotional environment that promotes learning and healthy lifestyle choices.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>➢ Clearly articulated vision of a supportive and nurturing environment which is not represented by a strategic plan and assessment criteria</td>
<td>➢ A clear process of accountability for the supportive and nurturing vision</td>
<td>Stage 1: Diagnosis, Vision, Plan</td>
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<tr>
<td>➢ Many segregated/fragmented activities and efforts that could have a much greater impact and be more efficiently implemented eg: - Bullying prevention - Sleep deprivation - Breakfast survey - Committees –substance use, food, safety</td>
<td>➢ People from across the school community working together to plan and deliver school activities.</td>
<td>➢ Develop the coordinating process</td>
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<td></td>
<td>➢ The development of a sustainable, coordinated approach utilizing the existing structures in the school 6.</td>
<td>9. Plan for the data collection and analysis</td>
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<td></td>
<td>10. Record and develop partnerships and links to the community</td>
</tr>
<tr>
<td></td>
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<td>Stage 2: Support and</td>
</tr>
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</table>
- Height/weight screening
- Areas that are not represented e.g. protective factors, public health initiatives (vaccinations, smoking cessation)
- Focus in some areas is now on education and skills, need to include other dimensions such as supportive environments, policy, reorientation of health services, community action
- Presently being driven by passionate individuals, needs to be woven into the culture and structures of the school

| Sustainable process of assessment and monitoring of needs - physical, social, emotional |
| Planning process that considers multiple strategies. |
| A health literate community where wellbeing and learning is optimized, (barriers to learning are reduced, assets are built) |

**Implementation**
- Endorsement by Leadership Team and/or School Board
- Presentations to each school division
- Implement the plan (develop processes, establish planning tools, assessment criteria, priorities)

**4. Program Assessment:** How will we know we have been successful?

**Short-term:**
- Coordinated model built from a democratic process
- Assessment and monitoring process established in the school structure
- Health-promoting school principles/theory built into existing and new programs in school and community
- Key Partners (Community – PTA, Booster Club, Companies) advocate for the program agreements and policies reflect this
- Resources and staffing provided for overall coordination
- School Board and Administration (Leadership Team) endorse and support the program, agreements and policies reflect this
- Professional Development provided to various educators and partners
### Medium-term:
- Ongoing Professional Development provided to various educators and partners
- Increased health-promoting school activity in school communities
- Increased community involvement/engagement in school health promotion activity
- Curriculum programs reflect the health needs of the community
- Build teachers’ capacity to support and improve the wellbeing of the students’

### Long-term:
- Students reaching their academic potential
- Improved health status of the learning community.
- Staff satisfaction/well-being indicators improve (reduced sick leave, etc ....)

### 5. Challenges: What barriers do we need to overcome?
- Time needed / Takes 3-4 years to establish (equivalent to approximately 1 year already completed)
- Requires personnel and funding
- Requires support from school leaders and staff – need to recognize all advantages offered by a HPS in improving educational outcomes
- Develop shared vision and understanding
- Change in processes – coordination of current fragmented activities using multiple strategies
- Professional growth and development of staff needed

### 6. Resources What is needed to be successful?
- Overall support from board & LT
- Support and volunteers from community
- Collaboration with key partners/companies
  - Personnel with time and resources to plan, implement,
## Appendix 17: Strategic Learning Plan—Health and Wellness

<table>
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<td>1. Our mission does not include health and wellness</td>
<td>A sustainable K-12 process of assessment and monitoring of community well being (physical, emotional and social) will be developed and planning processes will be implemented to reduce barriers to learning</td>
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<tr>
<td>2. Curriculum delivery is inconsistent</td>
<td>1. A 4th bullet is added to our mission addressing well-being</td>
</tr>
<tr>
<td>3. Gaps in health related policies and procedures</td>
<td>2. Pre-Kindergarten to Grade 12 health delivery is consistent for all students</td>
</tr>
<tr>
<td>4. No surveys to routinely monitor</td>
<td>3. ISB has comprehensive health related policies and procedures</td>
</tr>
<tr>
<td>5. Lack of overall coordination of various health related personnel and programs</td>
<td>4. Surveys are in place to monitor well-being and scheduled routinely</td>
</tr>
<tr>
<td>6. Lack of compliance with parts of the audit</td>
<td>5. Coordinating structure is in place with leadership</td>
</tr>
<tr>
<td>7. MS/HS wellness survey indicated concerns regarding sleep, breakfast, obesity, a 'caring adult' and athletics participation rates</td>
<td>6. ISB meets all audit requirements</td>
</tr>
<tr>
<td>8. WASC Recommendation 1</td>
<td>7. Wellness survey shows improvement</td>
</tr>
</tbody>
</table>

1. Ensure well-being is addressed in school mission
2. Make recommendations for health curriculum delivery.
3. Establish policies and procedures.
4. Establish routine surveys to monitor. Pilot a social and emotional well being survey at sampled grades from ES, MS & HS:
   a. Analyze for the underlying issues -- red flags (i.e. depression, social skills) --then do a more targeted analysis
   b. Audit where identified social/emotional needs are being met. Establish where understandings, skills and knowledge will be addressed and/or supported
   c. Prioritize actions based on degree of need.
5. Recommend coordination structure.
6. Ensure compliance with audit (audit to be revised to reflect ISB).
7. Formation of a guiding wellness council to develop an action plan.
8. Formation of priorities for targeted growth evidenced by survey results.
9. Develop strategies in relation to policies, curriculum, community.

10. Examine ways to increase physical environment.

11. Establish student and parent athlete and participation in activity and participation.

Education mechanisms.
## Appendix 18: Plan for Increasing Student Physical Activity 2011–2013

### Priority Area:
Increase physical activity (PA) in students

### Data:
Collect new data reflecting 60 minutes of accumulated PA in 2011, annual monitoring

<table>
<thead>
<tr>
<th>Priority</th>
<th>Data</th>
<th>Who</th>
<th>Fall Completion</th>
<th>Spring Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curriculum</td>
<td>Increase K-9 students and ES parents’ knowledge of recommended levels of PA</td>
<td>HS and MS PE (or Wellness teachers?)</td>
<td>Completed by Oct conferences</td>
<td>Completed by Oct conferences</td>
</tr>
<tr>
<td>Curriculum</td>
<td>Increase K-9 students and ES parents’ knowledge of recommended levels of PA</td>
<td>All MS, HS PE, MS wellness teachers</td>
<td>Completed by Oct conferences</td>
<td>Completed by Oct conferences</td>
</tr>
<tr>
<td>Help students access</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Help students access</td>
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<tr>
<td>Help students access</td>
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</tr>
<tr>
<td>Help students access</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Fall Completion
- Develop Google doc with log, information and link to activities office.
- Discuss with MS admin. re having results discussed by students during conferences (also showing links to activities available).
- Put into Wellness Folios
- Wellness coordinator
- September

### Spring Completion
- Help students access
- Develop follow-up strategies for data: All staff
- PE meeting
<table>
<thead>
<tr>
<th>PA opportunities available</th>
<th>collating results and how can we help those students under the requirements, can students present a goal at conferences or discuss results?</th>
<th>August</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss the potential role of counselors in the referral of students to access PA.</td>
<td>Wellness coordinator</td>
<td>Dec</td>
</tr>
<tr>
<td>Review class sizes in MS</td>
<td>Review class sizes and discuss with new principal as needed</td>
<td>Wellness coordinator, MS LT</td>
</tr>
<tr>
<td>Policy</td>
<td>Enhance learning through increasing physical activity in the HS by introducing a PA requirement.</td>
<td>Wellness coordinator and all key stakeholder groups</td>
</tr>
<tr>
<td></td>
<td>Develop proposal of adding a 2 credit requirement for PA for Jnr’s and Snr’s (can 10th do during health?)</td>
<td>Wellness coordinator and all key stakeholder groups</td>
</tr>
<tr>
<td></td>
<td>Form a HS working group to meet with reps from counselors, Deans, PE, IB reps., HS Principal, Jnr’s and Snr’s. The proposal to include guidelines of acceptable activities, staffing implications, possible choices.</td>
<td>Wellness coordinator and all key stakeholder groups</td>
</tr>
<tr>
<td>Present the Proposal to Admin./Board</td>
<td>TBA</td>
<td>AV</td>
</tr>
<tr>
<td>Supportive Environments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make hard-top a more user-friendly venue</td>
<td>Prepare proposal for PTA to fund shade covering for hard-top</td>
<td>ES LT</td>
</tr>
<tr>
<td>Increase PA</td>
<td>Train staff on physical activity class breaks</td>
<td>ES PE and</td>
</tr>
<tr>
<td>opportunities during the day</td>
<td>LT</td>
<td></td>
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<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>Explore option with admin. of student play leaders in the ES and MS. (Review after-school activities)</td>
<td>BG</td>
<td>N/A</td>
</tr>
<tr>
<td>Discuss PA fund-raisers with (skip-a-thons, walk-a-thons etc)</td>
<td>Community service rep</td>
<td>BG</td>
</tr>
<tr>
<td>Increase PA opportunities after school for non-athletes</td>
<td>Develop plan for intramurals for new facilities</td>
<td>HS, MS LT Athletic</td>
</tr>
<tr>
<td>Discuss the promotion of student-run PA clubs with coordinator</td>
<td>Intramural coordinator</td>
<td></td>
</tr>
<tr>
<td>Provide opportunities for students being cut from JV to continue participating during the season.</td>
<td>Athletics director</td>
<td></td>
</tr>
<tr>
<td>Health Services</td>
<td>Ask counselors/SS to add PA to the list of things they discuss with students, generally and in response to stress, depression and provide the counselors with the available options for PA.</td>
<td>Wellness coordinator</td>
</tr>
<tr>
<td></td>
<td>Explore opportunity for general healthy body weight, PA, to be distributed from nursing office.</td>
<td>Wellness coordinator, Parent Committee</td>
</tr>
<tr>
<td>Data – Collect new</td>
<td>Collate the responses from the PA log</td>
<td>Wellness</td>
</tr>
</tbody>
</table>
| Develop avenues for information dissemination | - Noticeboards  
- Webpage | Wellness coordinator  
CFO | Sept/Oct |
| Increase awareness in the community of: | - Link between PA and learning  
- Recommended levels of PA  
- Avenues in community available for PA  
- School data | LWLW committee | Oct/Nov |
| Community Action | Brainstorm other ways we can encourage PA, provide incentives or support. Work with PTA on bike/walking to school with incentives and prizes that coincide with Earth Week. | Wellness coordinator, PTA | Oct  
Feb-April |

**Priority Areas:**  
- Increase reported consumption of fruit and vegetables in all students.  
- Increase breakfast consumption in HS.  
- Increase awareness of the effects of blood glucose on learning.

**Data:**  
- Collect new data reflecting daily servings of fruit and veg, annual monitoring  
- Collect new data in ES on number of offerings of high GI foods.

<table>
<thead>
<tr>
<th>Curriculum</th>
<th>Who</th>
<th>Spring Completion</th>
<th>Fall Completion</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase knowledge and awareness of recommended levels of fruit and veg. consumption</td>
<td>Health, Wellness and ES teachers</td>
<td>Meeting held – not feasible this year, hope to start to integrate next year.</td>
<td>March</td>
<td>Curriculum office</td>
</tr>
<tr>
<td>Identify where in the ES, MS and HS fruit/veg. consumption is taught and develop curriculum if gaps are identified</td>
<td>Classroom teachers</td>
<td></td>
<td>March/April</td>
<td></td>
</tr>
<tr>
<td>Complete a weekly log of breakfast and fruit and veg. in the ES so students record, assess and reflect on their intake</td>
<td>Wellness coordinator</td>
<td></td>
<td>Feb.</td>
<td></td>
</tr>
<tr>
<td>ES – Discuss the Food log with ES admin and implications for the classroom teacher</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Task</td>
<td>Description</td>
<td>Responsible Party</td>
<td>Deadline</td>
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<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Develop follow-up strategies for data: (collating results, goal setting)</td>
<td>Wellness coordinator</td>
<td>Feb.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase knowledge and awareness of blood glucose and learning.</td>
<td>Identify where in the ES, MS, HS blood glucose and the brain is taught.</td>
<td>Health, Wellness and ES teachers</td>
<td>March</td>
<td></td>
</tr>
<tr>
<td>Policy</td>
<td>Develop a framework for an ISB food policy.</td>
<td>Nutrition expert on BOT</td>
<td>May</td>
<td></td>
</tr>
<tr>
<td>Provide an environment that reinforces healthy messages and enhances learning by developing a food policy.</td>
<td>Present Policy Framework to LT and to the Board</td>
<td>Wellness coordinator</td>
<td>Sept 2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop full policy document depending on feedback from framework.</td>
<td>Committee with BOT, staff, parent, student, cafeteria input</td>
<td>Feb. 2013</td>
<td></td>
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<tr>
<td></td>
<td>Present the Proposal to Admin./Board for ratification</td>
<td>TBA</td>
<td>March 2013</td>
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<td></td>
<td>Develop phased policy implementation plan if ratified</td>
<td></td>
<td>May/June</td>
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<tr>
<td>Supportive</td>
<td>Present sample of a healthy ES plate to the</td>
<td>Wellness</td>
<td></td>
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<tr>
<td>Environments</td>
<td>LT for approval to trial</td>
<td>coordinator</td>
<td>Feb.</td>
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<tr>
<td>Reinforce message of</td>
<td>Introduce healthy plates</td>
<td>Wellness</td>
<td>August</td>
<td></td>
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<tr>
<td>a balanced diet</td>
<td>in the ES</td>
<td>coordinator</td>
<td></td>
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<td></td>
<td>Present to staff meeting</td>
<td>Wellness</td>
<td>Feb/March</td>
<td></td>
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<tr>
<td></td>
<td>and develop guidelines</td>
<td>coordinator</td>
<td>ES Staff Meeting</td>
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<td></td>
<td>on healthy messages to</td>
<td></td>
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<td></td>
<td>be reinforced in the</td>
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<td></td>
<td>cafeteria and classroom</td>
<td></td>
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<tr>
<td>Improve healthy</td>
<td>Ask local shops to</td>
<td>Wellness</td>
<td>Nov/Dec</td>
<td></td>
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<tr>
<td>snack options after</td>
<td>provide some healthier</td>
<td>coordinator</td>
<td></td>
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<tr>
<td>school</td>
<td>choices after school or</td>
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<td></td>
<td>restrict the number of</td>
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<td></td>
<td>afternoons they sell the</td>
<td></td>
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<tr>
<td>Community Action</td>
<td>Provide new community</td>
<td>Wellness</td>
<td>Nov/Dec</td>
<td></td>
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<tr>
<td></td>
<td>sports coordinator with</td>
<td>coordinator,</td>
<td></td>
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<td></td>
<td>snack guidelines to</td>
<td>BOT rep</td>
<td></td>
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<td></td>
<td>send out to sports</td>
<td></td>
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<tr>
<td>Health Services</td>
<td>Ask counselors and SS</td>
<td>Wellness</td>
<td>Dec</td>
<td></td>
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<tr>
<td></td>
<td>staff to screen for</td>
<td>coordinator</td>
<td></td>
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<tr>
<td></td>
<td>breakfast consumption</td>
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<td></td>
<td>in the HS.</td>
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<td></td>
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<tr>
<td></td>
<td>Ask nurse to screen for</td>
<td>Wellness</td>
<td>Dec</td>
<td></td>
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<tr>
<td></td>
<td>breakfast consumption</td>
<td>coordinator</td>
<td></td>
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<td></td>
<td>for students presenting</td>
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<td></td>
<td>with headaches in the</td>
<td></td>
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<tr>
<td></td>
<td>morning.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data</td>
<td>Collect new baseline</td>
<td>Wellness</td>
<td>May</td>
<td></td>
</tr>
<tr>
<td></td>
<td>data for fruit and veg.</td>
<td>coordinator</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Collate the responses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>from weekly log</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Collect information on high GI food exposure in the ES</td>
<td>Conduct a one-month audit on high GI food offerings in the ES classroom (cakes, chips, soda, candy etc)</td>
<td>ES teachers volunteer to be involved</td>
<td>March or May</td>
<td></td>
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</tr>
</tbody>
</table>

**Parent Committee – Educating the Community, Initiating Community Action**

| Increase community awareness of: | - New plate guidelines from US  
- Fruit and veg. consumption  
- Link between GI and learning  
- ISB data | LWLW committee |  |
|---|---|---|---|
Appendix 20: Draft Plan for Staff Wellness 2011–2013

**Priority Areas:** See data below.

**Data:**

| Reported Behaviours | • 67% disagreed that they rarely feel stressed  
|                     | • 51% reported getting less than 7-8 hours sleep most nights  
|                     | • 37% drink less than 6-8 glasses of water daily  
|                     | • 56% staff agreed counseling referral was available for staff, 33% didn't know and 11% disagreed (re grief and loss counseling: 67% agreed it was available, 28% didn't know) |

| Areas of Interest | • 42% planning for retirement  
|                  | • 40% developing a personal fitness plan |

**General Feedback**

• Many initiatives, expectations and requirements are coming from different directions resulting in the feeling of a lack of time to do all things well.
• Added expectations that are sometimes done at 'district level' such as curriculum development.
• Need to respect each other – the important roles we all play, the need for time and an efficient work space as well as informal space to connect and develop bonds and collegiality (faculty lounge suggested)

<table>
<thead>
<tr>
<th>Health Domain</th>
<th>Strategy</th>
<th>Who</th>
<th>Fall Completion</th>
<th>2012/13</th>
</tr>
</thead>
</table>
| Mental /Emotional Health | Counseling Services  
<p>|                  | Clarify with staff the opportunities for counseling -email | Psychologists |       |        |</p>
<table>
<thead>
<tr>
<th>Department</th>
<th>Task</th>
<th>Responsible Party</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>-staff handbook</td>
<td>- staff notice board (with a list of contacts, numbers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-orientation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning for Retirement</td>
<td>Information sessions for expats, locals and from different countries (Stephen Bush)</td>
<td>CFO</td>
<td></td>
</tr>
<tr>
<td>Set-up staff Alumni on FB to help feedback to staff</td>
<td>some of the lessons learned through retirement and transitioning</td>
<td>TBA</td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td>Physical activity and stress management: Form sub-committee to develop guidelines for staff physical activity policy to support staff that want to work out/ do stress management during the school day.</td>
<td>Wellness coordinator and staff wellness subgroup</td>
<td>Completed</td>
</tr>
<tr>
<td></td>
<td>Provide free consultations with trainers</td>
<td>Athletics director</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provide free sessions after school</td>
<td>Athletics director</td>
<td></td>
</tr>
<tr>
<td>Social Health</td>
<td>Provide environment supportive of collegial interaction.</td>
<td></td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>- Clarify needs and level of support for a staff meeting room either within schools or one school - wide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Staff wellness notice boards in each school</td>
<td></td>
<td>TBA</td>
</tr>
<tr>
<td>Data</td>
<td>Change question relating to faculty training for child protection.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health Promoting School Update

Ms Belinda Gardner presented background on the proposed health-related fourth bullet on the schools’ mission. The “Live Well Learn Well” program is accountable for students’ wellness in the strategic plan. This initiative began in 2008 after a health review was conducted. Ms Gardner discussed the link between protective factors (caring relationships with an adult at school, high expectations, and messages that students can succeed) and physical activity, nutrition, sleep, and substance abuse on quality of learning. The school has conducted student wellness surveys since 2007 to assess needs of this population. The surveys historically have very high response rates. This data feeds into a planning framework with the goal of realizing students’ cognitive potential and removing barriers to learning. Current priorities for the school are adequate sleep, physical activity, nutrition, and connectedness. Ms Gardner stated that a comprehensive approach is the best model for ISB and uses multiple strategies including policy, education (curriculum), supportive environments, and partnerships. The fourth bullet of the mission statement will propel efforts to implement a plan.

MOTION: To approve the fourth bullet so the mission statement reads as follows:

Through outstanding teaching in a nurturing environment, [the school] inspires students to:
- achieve their academic potential
- be passionate, reflective learners,
- become caring global citizens
- lead healthy, active and balanced lives

The motion passed unanimously
Appendix 22: Parent Live Well Learn Well Committee Introduction

WELLNESS

As parents, educators, friends and neighbors being supportive and nurturing is a wonderful characteristic of the ISB community. To help inform this incredibly important process a new group of parents and staff are working to share the latest research relating to learning, health and providing support. Whether it’s our understanding of how to perform at our best in the classroom, playing field or in the playground or understanding the protective factors that help steer our children away from substances, we hope there will be valuable information for everyone.

Over the months of February, March, April and May new topics will be covered in newsletters, flyers and presentations. The committee is presently represented by the following people, but others are welcome to attend and those of you with special skills and knowledge in health, marketing and technology please join us.

Female from Survey Committee, BSc. is a full-time Mum with previous experience in pharmaceuticals.

Female from Survey Committee (future BOT member), MPH, RD, is a Registered Dietitian with a Master's Degree in Public Health. She has been working as a dietitian for over 15 years, most recently at a hospital devoted to the care of patients undergoing cancer treatment.

Female new to committee, BA, CPA. Presently, full-time mom. In prior life, COO-banking, Sr. Consulting Mgr., Deloitte.

Female from Survey Committee, MSc, PA, is a pediatric physician assistant currently working on clinical trials of HIV vaccines. She previously worked on pediatric AIDS and maternal-child health research in Uganda.

Female new to committee, MSN. Previous experience as a Women’s Healthcare Nurse Practitioner. Currently working towards Master's in Public Health (MPH) with Walden University.

LT member who attended HPS conference [leave following June], is the K-12 Physical Education Head; member of school Leadership Team, working with (change agent) to establish a health-promoting environment at ISB.

Researcher and change agent, MED, BEd. Is a HS Health teacher with previous experience working in the Australian Health Department (policy, planning and health promotion) and at Sydney University (Health and Research Centre).
THE 5 DIMENSIONS OF WELLNESS

Social aspects include parent-child relationships, sibling relationships, peer relationships, positive social behavior, empathy and sympathy.

Physical aspects include nutrition, physical activity, physical safety, preventive health care, reproductive health and substance abuse.

Emotional aspects are closely linked with social aspects and include emotional development and control, coping, autonomy, positive self-development, trust and attachment.

Cognitive aspects include information processing, memory, curiosity, mastery, motivation, persistence, thinking and intelligence.

Spiritual aspects include beliefs, values, morals and ethics; a sense of meaning and purpose; altruism; and a sense of connectedness to something larger than oneself.

Contact us at: wellness@
Appendix 23: LWLW Nutrition Newsletter

Balance Your Food

January 2013

New Plates in the Elementary School Cafeteria

Proudly supported by the ISB PTA and Epicure

From 21st January 2013, the Elementary School will have 3 new plate designs! The plates, designed by Kylie Harper, were purchased from a PTA grant with further support provided by Epicure. Their support is greatly appreciated. There is also a new poster on the wall leading into the ES cafeteria.

The plates and poster convey an important message being shared across the school about the importance of balancing the food we eat over the course of a day. The messages on the poster are:

- Balance your food: Have a variety of nutrients at every meal
- Make half your plate fruit and vegetables
- Make at least half your grains whole
- Protein: Variety is key (meats, eggs, fish, nuts, beans)
- Get your vitamins from fruit everyday
- Choose a rainbow of colors
- Healthy bones and teeth need calcium

The messages on the plates are reminding students to choose both fruits and vegetables at lunch. The aim is to try to make half of their meal fruit and vegetables and a total of 5 servings of fruit and vegetables per day.

Inside this issue:

- New Plates in ES: 1
- New Plate Designs: 2
- Fuelling the Brain: 3
- Nutrition for Teens: 3
- Consequences of Unhealthy Food: 4
- Unhealthy Food as a Reward: 4
- Family Tips: 4

Links for ideas and information on balancing your food:
http://www.choosemyplate.gov/food-groups/
http://www.nutritioninteractive.com/

Make half your plate fruits and vegetables.
The New Designs

Aim for 5 servings of fruits and vegetables every day!

For healthy physical, emotional and social development your body needs the right type of energy.

Choose a variety of colors of fruits and vegetables.
Fueling the Brain

Brain cells need twice the energy than other cells in your body because they are always busy – even while we are sleeping!

Glucose is the only fuel normally used by brain cells. Because neurons cannot store glucose, they depend on a constant supply of this precious fuel.

Low blood glucose can lead to attention difficulties as well as a decline in auditory and visual processing abilities.

Blood glucose is generally obtained from carbohydrates: the starches and sugars you eat in the form of grains and legumes, fruits and vegetables. (The only animal foods containing a significant amount of carbohydrates are dairy products.)

Too much sugar or refined carbohydrates at one time, however, can actually deprive your brain of glucose – depleting its energy supply and compromising your brain’s power to concentrate, remember, and learn.

Refined carbohydrates like soda drinks, cakes, cookies and candies release sugar too quickly into the bloodstream, which the body stores, and ultimately leads to low blood sugar levels. Many sugary, refined breakfast cereals also do this.

Complex carbohydrates from whole grains, legumes and some vegetables and fruits have long-chain molecules of sugar that are broken down slowly by the liver, like a slow release capsule. This keeps a nice steady supply of blood sugar just what your brain needs.

http://www.fl.edu/learn/brain/carbs.html

Start the day with breakfast

Eating breakfast renews the energy stores that have been depleted overnight. If a child or teen’s body is not refreshed in the morning, it has to draw fuel from alternate energy stores, until lunchtime. The stress hormones required to mobilize these energy reserves may leave the hungry child or teen feeling irritable, tired, and unable to learn or behave well.

The most nutritious breakfasts include:

- Carbohydrates (and fiber) from whole grains, fruits and vegetables
- Protein (dairy, meat, fish and poultry, eggs, beans, nuts, and seeds, soy products)
- Calcium (dairy, soy products, canned fish)

From Annie Caccillo’s Teen Talk Breakfast article

Nutrition for Teens

The teens are a time of rapid growth and development. Usually appetites match needs, but some teens are attracted to bad diets.

- Teenagers express their newly found independence by giving up some of the family food habits and developing their own styles.

- Education and information about the best choices of snacks and takeaways are important at this time

- Remember it is the total diet that counts. Teenagers will eat some of the high-fat snacks and takeaways, but encourage them to balance these with healthy food.

- Emphasize good food as part of a healthy lifestyle, which includes regular exercise, enough sleep, and time spent socializing with family and friends.

Have healthy snacks in the fridge. For example, cut up fruit or vegetables with a healthy dip such as hummus or yogurt, toast, or vegetable soups ready to heat.

303
Consequences of Using Food as a Reward

Food is commonly used to reward children for good behavior. It’s an easy, inexpensive and powerful tool to bring about immediate short-term behavior change. Yet, using food as reward has many negative consequences that go far beyond the short-term benefits of good behavior.

- **Contributes to poor health.** Foods commonly used as rewards (like candy and cookies) can contribute to health problems for children, i.e., poor learning, obesity, diabetes, hypertension and cavities. Food rewards provide unwanted calories and displace healthier food choices.
- **Encourages overconsumption of unhealthy foods.** Foods used as rewards are typically “empty calorie” foods — high in fat, sugar and salt with little nutritional value. Decreasing the availability of empty calorie foods is one strategy parents and schools can use to address the current childhood obesity epidemic.
- **Contributes to poor eating habits.** Rewarding with food can interfere with children learning to eat in response to hunger and satiety cues. This teaches kids to eat when they are not hungry as a reward to themselves, and may contribute to the development of disordered eating.
- **Increases preference for sweets.** Food preferences for both sweet and non-sweet food increase significantly when foods are presented as rewards. This can teach children to prefer unhealthy foods.

Tips to Promote Healthy Childhood Eating....

- **Have regular family meals.** Knowing dinner is served at approximately the same time every night and that the entire family will be sitting down together is comforting, which also enhances appetite, and provides a perfect opportunity for your children to share what’s on their minds. If time permits, breakfast is another great time for a family meal, especially since kids who eat breakfast tend to do better in school.
- **Cook more meals at home.** Eating home cooked meals is healthier for the whole family and sets a great example for kids about the importance of food. Restaurant meals tend to have more fat, sugar and salt. Save dining out for special occasions.
- **Get kids involved.** Some children enjoy helping adults grocery shop and preparing dinner. It’s also a chance for you to teach them about the nutritional values of different foods, and (for older children) how to read food labels. Aim to have your children leave home able to cook 10 healthy recipes!
- **Make a variety of healthy foods available and keep your pantry free of empty calorie snacks.** Keep plenty of fruits, vegetables, whole grain snacks and healthful beverages (filtered water, milk, herbal tea, occasional fruit juice) around and easily accessible so kids become used to reaching for healthy snacks when they’re hungry instead of empty calorie snacks like sodas, chips, or cookies.
Appendix 24: Nutrition Banner in the ES

BALANCE YOUR FOOD

1. Fruits
2. Vegetables
3. Grains (Whole)
4. Grains (Refined)
5. Proteins

ENJOY YOUR LUNCH!
And always try to make half your plate fruits and vegetables.

Brought to you by

Healthy eating awareness program
and the ES PTA.
Appendix 25: The Health Ambassadors Program

Goal
To spread good, healthy habits to the ISB community, with a specific focus on elementary school children. The Health Ambassadors Program would aim to enrich the ES Health Curriculum by delivering healthy messages that are aligned with the Strategic Learning Plan and identified health objectives.

Rationale
Healthy students learn better. Physical activity, nutrition, staff health, balance and connectedness are priorities identified at ISB based on data that has been collected. This program would help the ES teachers to build knowledge and skills in the students by having passionate HS students teach the ES students in a fun, engaging way (similar to the Health Fair 2 years ago). Children can be encouraged to stay healthy if a health-based program can be incorporated as an important school activity. The target group is, more specifically, elementary school children, who are in their habit-formative stage. Hence, they can be guided to make the right choices for a healthier life.

2013-2014 Focus
The goal during next year would be to impart knowledge and skills regarding healthy eating choices as well as the importance of regular physical activity. It is proposed to initially focus on nutrition and build on the messages that have begun with the plates and poster in the ES cafeteria and also build on the physical activity messages that were delivered last year.

Physical exercise on a daily basis in childhood is generally associated with good health. In spite of this known fact, a large proportion of children do not participate in regular exercise. Also, the easy availability of tasty junk foods like burgers, pizzas and highly sugared fizzy drinks, makes it hard on kids to make the correct choices.

Methodology:
The HA could mainly comprise of High School students (9-12 graders), possibly Varsity Council members, NHS members, etc. who are role models for younger children to learn from, in leading healthy lives. These High School student volunteers of the Health Ambassadors Club would visit classrooms (possibly grades 1, 2, 3, 4 or 5) for a 15-20 minute talk or activity/game. They would be using visuals such as slide shows, animated video clips, enacting of a small skit, etc. Games could also be organised, particularly for grades 4 and 5, using activity cards with pictures/information on food groups. Short quizzes would make it a fun game too. Younger children from grades 2 and 3 could move to music such as the birdie dance as a warm up or games like bean bag toss as a fun way to for them to learn about healthy choices.
Potential Topics covered by HAC members:
Ideal food choices: Junk Food
Good Nutrition; A Balanced Diet
Snacking: The Correct Way
Importance of Sleep
Personal Hygiene for a Healthier Body
Laughter for a Healthier Mind
Video Gaming: Everything in Good Measure
Internet Usage
Dealing with Bullies

Some Potential Activities:
Younger students
nutrition plate bean bag toss
food tasting
warm up dance activity
printable nutrition/food colouring pages
Older students
how much sugar is in a Coke can demonstration
food pyramid/groups
printable crossword challenge
seeing germs under UV light

Logistics:
During the High School lunch break, groups of 2 or 3 students committed to the cause would visit individual classrooms for 15-20 minute sessions.

Suitable Time Slots: 10.25 - 10.45 am
10.45 – 11.05 am

School is the ideal environment for the promotion of healthy habits since each and every child can be reached. Thus, educating young minds about lifelong healthy habits will result in a happy and active community practising a healthy lifestyle.

Support Required

HS Health teacher: To ensure activities are linked to school plan, are sending the right message and are appropriate.

ES Liaison: To help organise sessions and communicate with the ES teachers as well as ensure activities are appropriate

Thank you, and hope you consider this proposal! :)
Appendix 26: Program Logic for the Hong Kong Healthy School Award Scheme

Source: Centre for Health Education and Health Promotion, The Chinese University of Hong Kong (Program logic formulated by Erin Armstrong, Visiting Health Promotion Practitioner, October 2011)
Appendix 27: Staff Survey Report

Staff Wellness Survey Results
Summary from May/June 2011

The staff survey was conducted during May and June of 2011, returning staff were asked to answer a series of questions under the following headings. This summary represents the most significant findings of the survey. Of the 189 returning staff, 133 responses were received (70%). The responses were distributed across the 3 schools with 37% ES, 28% MS and 45% HS (this totals more than 100% as some of the staff work across all three schools and checked more than one box). OR ANDY we can just say …the responses were distributed across the three schools with approximately 41% HS, 25% MS and 34% ES.

Health Related Absences
- 26% of staff are not absent for health reasons
- 50% of staff absences are due to infectious illness
- 22% of staff absences are from work-related stress

School Environment
See below for the actual responses. The most significant area was in regard to a manageable annual calendar/schedule.

This school:

<table>
<thead>
<tr>
<th>Question</th>
<th>Agree strongly</th>
<th>Agree somewhat</th>
<th>Disagree somewhat</th>
<th>Disagree strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>is a supportive and inviting place for staff to work</td>
<td>22.9% (30)</td>
<td>53.4% (70)</td>
<td>19.1% (25)</td>
<td>4.6% (6)</td>
</tr>
<tr>
<td>promotes trust and collegiality among staff</td>
<td>7.6% (10)</td>
<td>61.1% (80)</td>
<td>26.7% (35)</td>
<td>4.6% (6)</td>
</tr>
<tr>
<td>allows me time/freedom to do my planning and work</td>
<td>19.1% (25)</td>
<td>55.0% (72)</td>
<td>20.6% (27)</td>
<td>5.3% (7)</td>
</tr>
<tr>
<td>has a manageable annual calendar/schedule</td>
<td>10.6% (14)</td>
<td>46.2% (61)</td>
<td>35.6% (47)</td>
<td>7.6% (10)</td>
</tr>
<tr>
<td>makes reasonable demands outside my job assignment</td>
<td>12.4% (16)</td>
<td>62.0% (80)</td>
<td>20.9% (27)</td>
<td>4.7% (6)</td>
</tr>
<tr>
<td>provides a good physical environment in which to work</td>
<td>42.4% (56)</td>
<td>41.7% (55)</td>
<td>14.4% (19)</td>
<td>1.5% (2)</td>
</tr>
<tr>
<td>has reasonable targets, deadlines</td>
<td>10.7% (14)</td>
<td>50.4% (66)</td>
<td>30.5% (40)</td>
<td>8.4% (11)</td>
</tr>
</tbody>
</table>
values me and recognizes my contribution  

<table>
<thead>
<tr>
<th></th>
<th>26.5% (35)</th>
<th>42.4% (56)</th>
<th>18.2% (24)</th>
<th>12.9% (17)</th>
</tr>
</thead>
</table>

Staff Support
There appears to be a lack of awareness of avenues of support available to staff in regard to counseling services. There were also some general comments in regard to the need for more confidential avenues for counseling and making these avenues known to staff. Opportunities for stress relief and relaxation were not recognized or perceived as available.

- 56% staff agreed counseling referral was available for staff, 33% didn’t know and 11% disagreed (re grief and loss counseling: 67% agreed it was available, 28% didn’t know)
- 75% agreed collaborative decision-making was used in their dept., 23% disagreed
- 63% staff disagreed that there were opportunities for relaxation and stress relief, 24% agreed
- 38% of staff didn’t know, 34% disagreed, if staff and volunteers had undertaken Child Protection training.
- 72% agreed support was available if needed, 21% didn’t know

Reported Behaviours
Exercise
- 26% of staff reported exercising at recommended moderate intensity.
- 27% of staff reported exercising at recommended vigorous intensity.

Alcohol (note this was during the last 2 weeks of the school year when many farewells were held)
- 59% of staff reported 0 or 1-2 day/week consumption
- 24% 3-4 days
- 17% more than 3-4 days
- 67% reported drink 1-2 drinks on the days when they drank, 12% 3-4 and 2% more than 4

Other Reported Behaviours
- 96% of staff don’t smoke
- 75% avoid excess sugar, fat and eat 2 servings of fruit and 3 or veg.
- 82% eat breakfast regularly
- 73% have an annual physical exam
- 79% wear seat belts
- 95% can access health care with ease
- 33% agreed that they rarely feel stressed
- 51% reported getting less than 7-8 hours sleep most nights
- 37% drink less than 6-8 glasses of water daily

Possible Priorities
- Exercise, sleep, water consumption and stress management are possible priorities.
Topics of Interest (top 4 strong interest responses)

- 42% planning for retirement
- 40% developing a personal fitness plan
- 40% managing stress
- 30% Tai Chi/Yoga

Summary of open-ended questions to work-related stress

- Many initiatives, expectations and requirements are coming from different directions resulting in the feeling of a lack of time to do all things well.
- Added expectations that are sometimes done at ‘district level’ such as curriculum development.
- Need to respect each other – the important roles we all play, the need for time and an efficient work space as well as informal space to connect and develop bonds and collegiality (faculty lounge suggested)
Appendix 28: Draft Staff Wellness Plan

**Plan for Staff Wellness 2011-2013**

<table>
<thead>
<tr>
<th>Priority Areas:</th>
<th>See data below.</th>
</tr>
</thead>
</table>
| **Reported Behaviours** | • 67% disagreed that they rarely feel stressed  
• 51% reported getting less than 7-8 hours sleep most nights  
• 37% drink less than 6-8 glasses of water daily  
• 56% staff agreed counseling referral was available for staff, 33% didn't know and 11% disagreed (re grief and loss counseling: 67% agreed it was available, 28% didn't know) |
| **Areas of Interest** | • 42% planning for retirement  
• 40% developing a personal fitness plan |
| **General Feedback** | • Many initiatives, expectations and requirements are coming from different directions resulting in the feeling of a lack of time to do all things well.  
• Added expectations that are sometimes done at ‘district level’ such as curriculum development.  
• Need to respect each other – the important roles we all play, the need for time and an efficient work space as well as informal space to connect and develop bonds and collegiality (faculty lounge suggested) |

<table>
<thead>
<tr>
<th>Health Domain</th>
<th>Strategy</th>
<th>Who</th>
<th>Fall Completion</th>
</tr>
</thead>
</table>
| Mental /Emotional Health | **Counseling Services** Clarify with staff the opportunities for counseling  
- email  
- staff handbook  
- staff notice board (with a list of contacts, numbers)  
- orientation | Psychologists |  |
<p>| Planning for Retirement | <strong>CFO</strong> |  |  |</p>
<table>
<thead>
<tr>
<th>Information sessions for expats, locals and from different countries (Stephen Bush)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Set-up staff Alumni on FB to help feedback to staff some of the lessons learned through retirement and transitioning</td>
<td>TBA</td>
</tr>
<tr>
<td>Physical Health</td>
<td></td>
</tr>
<tr>
<td>Physical activity and stress management: Form sub-committee to develop guidelines for staff physical activity policy to support staff that want to work out/ do stress management during the school day.</td>
<td>Wellness coordinator and staff wellness subgroup</td>
</tr>
<tr>
<td>Provide free consultations with trainers</td>
<td>Athletics director</td>
</tr>
<tr>
<td>Provide free sessions after school</td>
<td>Athletics director</td>
</tr>
<tr>
<td>Social Health</td>
<td></td>
</tr>
<tr>
<td>Provide environment supportive of collegial interaction. -Clarify needs and level of support for a staff meeting room either within schools or one school - wide</td>
<td>TBA</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Staff wellness notice boards in each school</td>
<td>TBA</td>
</tr>
<tr>
<td>Data</td>
<td></td>
</tr>
<tr>
<td>Change question relating to faculty training for child protection.</td>
<td></td>
</tr>
</tbody>
</table>