

Collaboration within the Context of the Healthy School Approach (HSA): The Case of a Disadvantaged Elementary School in Quebec

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Author's Note

The authors of this article gratefully acknowledge the educational community of this school for their help with this study, which was made possible by a research grant from the Fonds de recherche sur la société et la culture, New Researcher component (FQRSC, 2007-2010, no. 120671). The research grant was given to the first author named.

Abstract

This case study focuses on the groundwork aiming at developing school-family-community collaboration in the deployment of the HSA in a low socio-economic status elementary school. Two theoretical models - the HSA and Hoover-Dempsey et al. (1997, 2010) models - guided the analysis of five discussion groups (N=31) regarding their perceptions of the place of health in school and of parents' and educators' health related practices to support HSA deployment and to establish the pathway to a better school-family-community collaboration. The school is committed to health despite its low economic status. Encouragement, modeling and teaching are the perceived practices or actions.

Keywords: healthy school, perceptions, practices, collaboration, stakeholders.

Résumé

Cette étude de cas unique s'intéresse à la mise en place de la collaboration école-famille-communauté dans le déploiement de l'AÉS au sein d'une école primaire défavorisée. Les modèles théoriques de l'AÉS et de Hoover-Dempsey et ses collègues (1997, 2010) ont guidé l'analyse de cinq groupes de discussion (N=31), concernant leur perception de la place de la santé à l'école et les pratiques des parents et des éducateurs reliées à la santé susceptibles de supporter le déploiement de ladite approche et de créer une meilleure collaboration. L'école est engagée vers la santé en dépit de son statut défavorisé. L'encouragement, le *modeling* et l'enseignement sont les pratiques les plus fréquemment utilisées.

Mots clés : école en santé, perceptions, pratiques, collaboration, acteurs.

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Introduction

In 2004, *l'Organisation mondiale de la santé* (OMS) reaffirmed the important role of school health promotion and healthy lifestyles:

Schools influence the lives of most children. They should protect the health of children by informing them, by teaching them the basics of health and by promoting a healthy diet and exercise, along with other healthy behaviors. (p. 18)

Since reforms in the 1990's, all provincial teaching programs in Canada include health as one of their components (Rivard & Beaudoin, 2005; Turcotte, Desbiens, Trudel, Demers, & Roy, 2011). Ministerial briefings and the works of numerous researchers have also reaffirmed that the responsibility for health belongs not only to schools, but to families and communities as well. Many school and extracurricular initiatives have been developed to promote health in young people, and the ways of doing it are quite diverse. Both national organizations (e.g., Canadian of School Health, Joint Consortium for School Health) and provincial organizations (e.g., Action Schools BC, Manitoba Healthy Schools) followed this momentum, with the result that nearly a dozen associations have by now designed various school initiatives in their own provinces (Beaudoin, 2011). In Quebec, the school is also called upon in matters of health, and the *Healthy School Approach* (HSA) (Ministère de l'Éducation, du Loisir et du Sport, 2005) is part of this impetus. The present study focuses accordingly on the place of health and health-related practices in schools and in families, in view of better school-family-community collaboration in the deployment of the HSA.

Problem Statement

School-family and School-community Collaboration

There is no doubt in the literature that the school's collaboration with the family and the community is closely linked to school achievement. According to the socio-cognitive perspective of learning, the child who demonstrates expectations of success and values schooling with respect to subject matter and homework will tend to be more motivated, involved, and persevering, which will in turn contribute to his or her school achievement (e.g., Chouinard, Plouffe, & Roy, 2004). Parents' involvement will also play a large role in their child's motivation to learn (Bouffard & Bordeleau, 2002). This first dual collaboration between the school and the family has been studied from many angles, including school achievement and aspirations, the prevention of school dropout, and school adjustment (e.g., Deslandes & Jacques, 2004). We know by now that parental involvement fosters school-family collaboration (Deslandes, 2001) and that school strategies that promote parental involvement are the best predictors of school-family collaboration (Epstein, 2011). According to Beaudoin's (2011) recent review and analysis of the Canadian literature and Rivard, Deslandes, and Collet's (2010) study, the role and the nature of parents' and educators' practices involved in school-family collaboration have not yet been researched with respect to youngsters' health.

The second dual collaboration between the school and the community refers to the links between the school and community individuals, organizations, and businesses that "promote

students' social, emotional, physical, and intellectual development" (Sanders, 2006, p. XI). Although it has been studied to a lesser extent (e.g., Epstein, 2011), the community's contribution has appeared increasingly in ministerial briefings on education since 2001.

Nevertheless, the community's perceptions of HSA deployment and educators' and parents' health-related practices need to be studied in greater depth (Rivard & Beaudoin, 2009). Knowing that HSA and health issues are important in the school and the family curriculum, and that it is demonstrated by the educators' and the parents' practices will play in favor of a greater commitment from the community (Sanders, 2006).

Collaboration of Disadvantaged Families

Although numerous studies have demonstrated the family's contribution to school achievement and perseverance (e.g., Dail & Payne, 2010; Deslandes, 2010; Jeynes, 2005), the situation of families from low socio-economic status (SES) backgrounds is an increasing concern. Indeed, these families are often characterized by poverty, low literacy, and often negative school experiences, which generate a weak sense of competence, and can lead to less involvement in their child's schooling (e.g., Deslandes & Rivard, 2011; Harris & Goodall, 2007). At the same time, parents including low SES and immigrant parents — argue that some educators don't know anything about what they do at home (Graue & Hawkins, 2010). To fully support children's education, school-family relationships must encompass a bidirectional flow of information, such that parents know about educators' educational practices and educators are informed of parents' needs, interests and practices. It is the same for school-community relations. It is then easier for the school, parents, and the community to be on the same page and develop a shared vision of what is being done and what should be improved if they can arrange a school-family-community collaboration. This is in fact one of the crucial conditions for successful school-family-community partnerships, in particular in low SES environment (Deslandes, 2010).

Low-income Families and Health Issues

Several researchers have explored health issues regarding mainly eating habits and physical activity within low SES families. Dubois et al.'s (2011) longitudinal study conducted with 1200 Quebec children indicated a link between household food insecurity and obesity in among 10-to-11-years-old children. It seems that obesity is due to an increased consumption of low-nutrient, energy-dense food. For his part, Poisson (2008) reports study results that show low intake of fresh products like fruit, vegetables, and milk products — as well as a high intake of fat/salted and fat/sweet products — among low SES families. According to some American studies reviewed by Czaplicki (2009), there is no association between children and teenagers' physical activities and the economic status of their families. On the contrary, Canadian studies identify the latter as one of the strongest predictors of physical activities among youngsters (e.g., Mo, Turner, Krewski, & Mo, 2005). Stalsberg and Pedersen's (2010) recent review of literature supports the hypothesis that teenagers from privileged backgrounds are more active. Other works report major concerns regarding safety in sports, such as cycling activities (Blais, Lavoie, & Maurice, 2010), especially with reference to low SES families. According to Farley (2001), a Quebec program aimed at promoting the use of helmets when cycling is three times less effective in low-income areas than in high-income ones. Other studies, moreover, have explored social competencies closely linked to conflicts and violence that occur mainly in schoolyards (e.g., Dionne, Lavoie, Morency, & Paradis, 2009). In Quebec, the intervention strategy *New Approaches, New Solutions* (NANS) is a privileged means of preventing violence in disadvantaged areas (Ministère de l'Éducation, du Loisir et du Sport, 2009). According to

Bernard, Charafeddine, Frohlich, Kestens and Potvin (2009), smoking is also a bigger problem among youngsters living in poor neighbourhoods, since it is associated with low SES and peer influence. Interestingly, tobacco control interventions in Quebec target teenagers and sixth-graders (children about 12 years of age) from low-income areas (Gouvernement du Québec, 2010).

Relevance and Objectives of the Study

The HSA is at the crossroads of education, health, and school success. The few descriptive studies that have focused on the Quebec Healthy School Approach reveal that stakeholders in the educational community are strongly in favour of it (Deschesnes et al., 2008), while other studies highlight the indisputable contribution of parents and the community in its deployment process (e.g., Deschenes, Trudeau, & Kébé, 2009). The mechanisms and richness of the interactions among the various stakeholders generate new collaborations, which are still rarely documented (e.g., Deslandes, Rivard, Joyal, & Trudeau, 2010; Rivard & Beaudoin, 2009). *Perceptions* guide, in a certain fashion, the interactions between individuals which, in turn, refer to the various manifestations linked to mobilization, notably *practices*, whether in connection with the school or the family (Larose, Lenoir, & Karsenti, 2002). On their side, practices refer to activities aiming at specific goals (Epstein, 2011). To our knowledge, no research has yet been one on these two variables as characteristics of low SES school-family-community collaboration environment within the HSA framework. The current study, which has been conducted at a microscopic level — that is, within the context of a local initiative — offers access to these two variables and allows us to identify and elaborate on the various *perceptions* and *practices* of the stakeholders engaged in deploying the HSA that seem most likely to lead toward collaboration.

The objectives of the present article are: 1) to describe the perceptions of the stakeholders (students, educators, parents, and community members) with regard to the place of health in the school setting, and 2) to identify health-related practices or actions conducted by educators and parents in view of better school-family-community collaboration in the deployment of the HSA.

Theoretical Framework

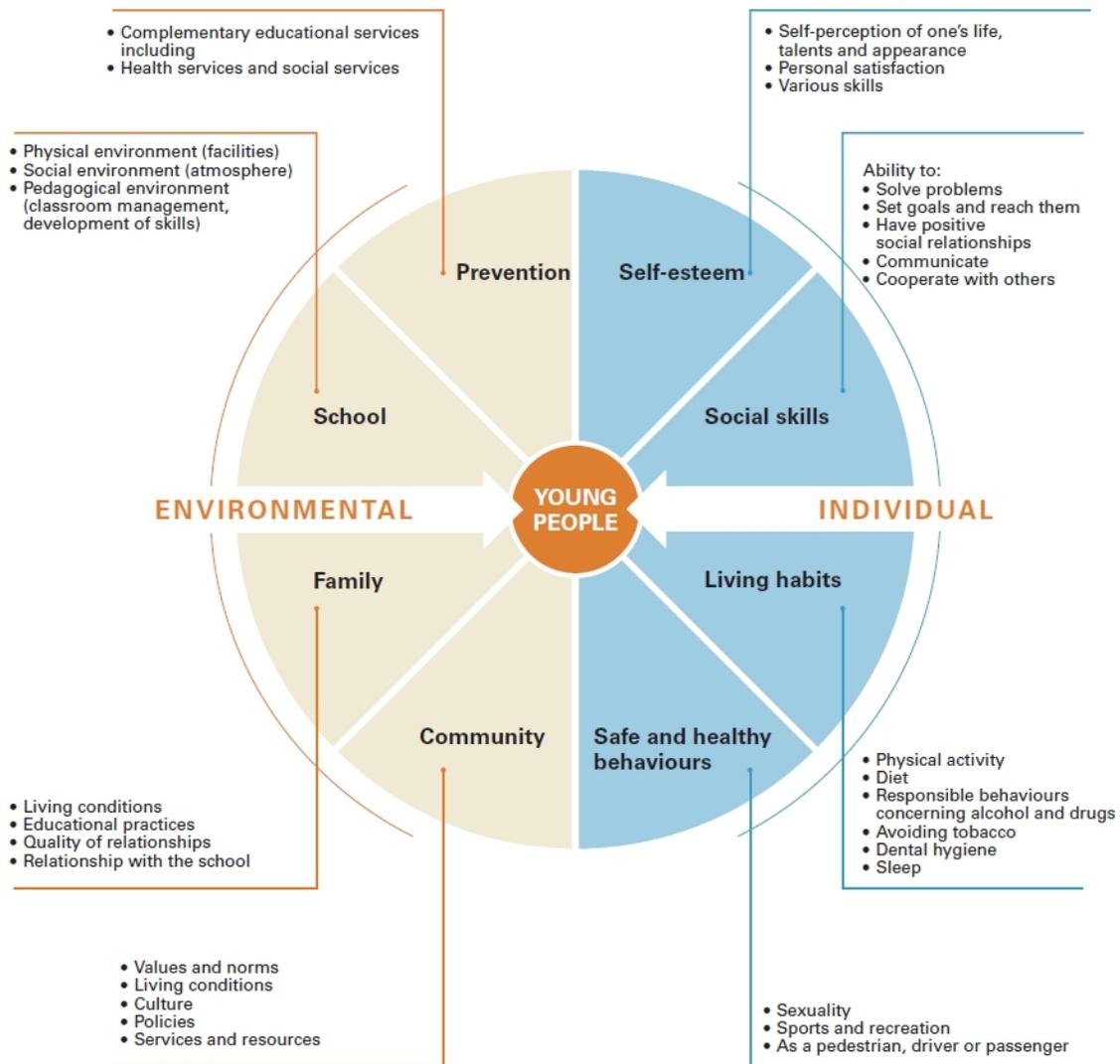
The HSA model (Ministère de l'Éducation, du Loisir et du Sport, 2005) and the Hoover-Dempsey parents' and educators' involvement model (1997, 2010) are the two theoretical anchors for this study. Both models served as a guide for establishing links among the objectives, methodological choices, results analyses, and elements of the discussion.

The HSA model was inspired by ecosystemic theories postulating that children are influenced by the multiple environments in which they live (e.g., Bronfenbrenner, 1986). Deployed in the Quebec school system since 2005, the HSA was motivated by a threefold objective — the school achievement, health, and well-being of young people — and was anchored to the *Quebec Education Program* (Ministère de l'Éducation du Québec, 2001). According to Roberge and Choinière (2009), one of the efficiency criteria for school initiatives is based on this compatibility with *Pedagogical Renewal*. This approach is deemed innovative and promising because it is both a global and concerted conception. It is global in that it groups together the key factors of youth development — which are individual and environmental in nature — and concerted in that actions are performed at different levels and with different stakeholders: the child, school, family, and community (Ministère de l'Éducation, du Loisir et du Sport, 2005) (Figure 1). In keeping with the HSA, the members of the school team consist of educators (teaching and non-

teaching staff) and community members, who include individuals from different organizations considered influential by educators in the context of this approach. The variables of this model will be useful to document the content covered in the health approach and are relevant to the involved stakeholders and concerned environments.

Figure 1.

The key factors of young people's development (Ministère de l'Éducation, du Loisir et du Sport, 2005, p. 25).



The Hoover-Dempsey et al.'s (1997, 2010) model stipulates that the involvement of parents and educators impacts the student's grades and behaviors. This model offers a highly

unique method for examining the health-related practices or actions used by these adults regarding the deployment of the HSA. Four groups of practices or actions are identified in the model: modeling, reinforcement, teaching, and encouragement. When they are exposed to some models, young people acquire skills and competencies (Bandura, 1997). Indeed, the more that the models (e.g., parents and educators) are perceived to be powerful and competent, the more they influence young people's behaviours and attitudes. Reinforcement is associated with the theory of behaviours based on their consequences (Skinner, 1989). This theory of reinforcement predicts that young people will be more likely to adopt behaviours if they are rewarded. In other words, involvement by parents and educators through reinforcement impacts school achievement and the adoption of healthy lifestyles. Teaching, in the sense of instruction, involves the action of communicating knowledge, which in turn influences the targeted results. Open or interactive teaching appears to foster greater autonomy and reasoning ability in young people than direct or authoritarian teaching. Finally, encouragement corresponds to the use of practices or actions that can potentially stimulate young people's motivation to adopt the desired behaviours. The present model will shed more light on parents' and educators' practices that are more likely to set the baseline for school-family-community collaboration promotion in the HSA.

Methodology

Research Design

The qualitative research design proposes an in-depth study of a case (Gagnon, 2005) involving the implementation of the HSA in a low SES elementary school and is based on Merriam's (1998) four fundamental characteristics : particularistic, descriptive, heuristic, and inductive.

Environment and Participants

As proposed by Yin (2003), we targeted a school showing the optimal conditions necessary for meeting our research objectives. The targeted school is recognized as a leader in the following community based criteria: HSA in place for about six years; openness to and collaboration in research projects; mobilization of school, family, and community stakeholders; combined goals of achievement and health anchored to the school's achievement plan; and presence of a follow-up committee for the achievement plan. The school is involved in the NANS and is rated 9/10 on the socio-economic environment index (EEI) as calculated by the Minister (2003)¹. Table 1 presents the main characteristics of the four categories of participants that took part in the study.

Data Collection

Group discussion was the chosen method for collecting data. This method has the advantage of not only of obtaining the personal viewpoint of participants, but also of calling on the attitudes and norms expressed and articulated socially (Kitzinger & Barbour, 1999), an asset in the world of school-environment collaboration. In order to describe the perceptions of the various

¹ According to the Ministère de l'Éducation du Québec (2003), a third of the EEI calculated represents the proportion of parents who are unemployed, while two-thirds correspond to the proportion of mothers who did not graduate from high school.

groups of stakeholders about the place of health in the school setting and educators' and parents' health-related practices, we conducted five separate discussion groups as follows: 2 x 6 students; 1 x 7 educators; 1 x 6 parents; 1 x 6 community members. The interviews lasted for about 60 minutes and took place at the targeted school. A unique interview canvas, with some adjustments depending on the age group of participants, was developed based on the two theoretical models and the relevant literature.

Table 1.

Participants in the study.

Students (n=12)	Educators (n=7)	Parents* (n=6)	Community members (n=6)
2 nd division (F=4, H=2)	HPE specialist (H=1)	(F=5, H=1)	HSA respondent associated with the MSSS (F=1)
3 rd division (F=3, H=3)	Generalists (F=3)		Former deputy and parent of children who previously attended the school (H=1)
	Support service (H=1)		Private researcher who supports a health project (H=1)
	Psychoeducator (F=1)		Assistant principal of a secondary school (H=1)
	Daycare director (F=1)		Managing director of the Centre d'actions bénévoles (F=1)
			President of the municipality's Société St-Jean-Baptiste (H=1)

*Single-parent family (F=3); Blended family (F=1); Traditional family (F=1, H=1)

A content validation (subject matter and wording of questions) was first conducted among individuals having similar characteristics with the participants in the study. The final interview canvas included five key headings. The results of only two headings are presented in this article because of their close links to the study objectives. These headings are: 1) health and the school (objectives of the HSA and the achievement plan, programming of services and activities, pedagogical content and practices, and 2) health and the family (parents' roles, responsibilities, and practices). We obtained the ethical approval of the university committee in compliance with the requirements of the funding agency.

Analyses

The qualitative data obtained from the participants' comments during discussion groups were recorded, transcribed, and analyzed using L'Écuyer's method (1990) for mixed content analysis. The procedure consists of calling on predetermined categories in the literature, in this case the key factors of youngsters' development as proposed by the HSA (Figure 1) and the four groups of practices or actions based on Hoover-Dempsey et al.'s model (1997, 2010), while at the same time allowing for the emergence of new categories. The analysis was conducted using a coding scheme (Karsenti & Savoie-Zajc, 2004), which incorporated the categories of both theoretical models. The comments of the participants were classified independently by two members of the research team. Any disagreement was discussed among analysts to obtain a consensus. No new class has emerged from this analysis process.

Limits of the Study

Although the diversity of the sample can be considered an asset in the conduct of this study precisely because it relies on an approach built around various actors, the fact remains that the results thereof may seem specific or idiosyncratic. It is therefore important to describe the findings in details, to interpret results with caution, and especially to take into account the context of this case study.

Results

Stakeholders' perceptions: The place of health in the school

Each group of participants was requested to answer the following question in relation to the first objective: To what extent does school X apply HSA? The factors depicted in the HSA model (Figure 1) were used to categorize the participants' comments. Note that educators', parents', and community members' comments are grouped under the label "adults."

Students

Invited to talk about health at school, the students most often mentioned the living habits factor and — to a very small extent — the social skills factor. Regarding physical activity, some said the school devotes a greater part of the curriculum schedule — sometimes a full half-day — to physical education and bicycle outings, for example. As for eating habits, the students admitted they don't have the right to bring junk food to school. They also said that educators reward healthy snacks and that they organize and prepare school breakfasts with the students four times a year. The safe and healthy behaviors factor is mainly considered with respect to bicycle safety: the students declare being aware of the obligation to wear a helmet. Furthermore, they state that they do not have the right to bring dangerous weapons "like a knife" to school, or that the educators provide a structured environment in the schoolyard, which is fenced off. These

statements are associated to the school environment. With respect to social skills, they affirmed that they are forbidden to fight or to swear, although they admitted engaging sometimes in rather deviant behaviours, such as throwing the ball in each other's face during recess.

Adults

Similar to the students interviewed, the adult participants' responses refer mostly to two living habits: physical activity and diet. The educators said that physical exercises with the students are integrated in the classroom curriculum and that the students' participation is mandatory. They added that integrating health into the school's achievement plan objectives and into the disciplinary competency «*Adopting a healthy active lifestyle*» in terms of physical education and health issues contributes to improving the students' health. For their part, the parents maintain that school promotes engagement in physical activities, not only at school or on sport teams, but also at home. Likewise, they were aware of large-scale activities aimed at getting students involved in extracurricular physical activities at least once a month. Community members recognized that more school time is devoted to physical education and, consequently, that students in this particular school were doing more exercises. Parents and community members evoked the presence of the *Québec en forme* organization in school as an asset for students in relation to the regular practice of physical activities. As for eating habits, the educators raised the importance of the Nutrition Month in March of each year, and parents indicated that the school encourages the development of good habits by rewarding healthy snacks, particularly fresh fruits and vegetables with the program *I challenge j'croque (Défi Moi j'croque)*.

Likewise, the adults' comments corroborate some of the students' regarding the school environment. Educators emphasized school supervision in terms of "pairs of guardian eyes," safe play modules, and limited access to the schoolyard. Parents know that there are always supervisors during recess time and note the important support provided by the educators. More specifically, they appreciate that younger students are kept separated from students in upper grades during recess time. Moreover, they added that visitors must go to the secretary's office before being allowed to circulate freely in the school. The community members' statements are along these same lines: strong educators support adequate supervision, sharing of recess areas based on common grade levels, and zero tolerance for violence.

Concerning safe and healthy behaviours, educators state the mandatory use of a helmet when cycling. They pointed to a contract signed by some students and their parents to incite the child to respect the safety rules during sports outings. Members of the community referred to self-esteem when reminding the initiative that invites students to write letters to each other (*courrier des jeunes*). In their view, this activity allows children to express their joy or pain, and to verbalize their experience by writing about it.

Perceptions of Educators' and Parents' Practices

In relation to the second objective, two questions were formulated: In what ways do educators become involved in their students' health and adoption of healthy lifestyles? And what do the parents do? The following section describes the perceptions of the four groups of stakeholders who participated in the study, that is: students and community members' perceptions of educators' and parents' practices, as well as parents' and educators' perceptions about their own practices. Practices are classified according the Hoover-Dempsey et al.'s (1997, 2010) model and in relation to the identified factors in the HSA model (Ministère de l'Éducation,

du Loisir et du Sport, 2005), which is discussed later in view of better school-family-community collaboration in the deployment of this approach.

Students

With respect to educators, students talk about physical activity and diet as contexts that offer various opportunities to illustrate the practices put into place: teaching, modeling, reinforcement, and encouragement. They describe some *teaching* and *modeling* strategies, like when educators participate with them in sports activities addressing security during recess time, outside of school time (e.g. rabaska), or when doing some cycling together. Educators are reported to reward students who bring snacks to school made of fresh fruits and vegetables (*reinforcement*). Other educators broadcast messages over the school's intercom that emphasize the importance of having healthy breakfast to start off the day and healthy snacks that are more likely to improve students' concentration power (*encouragement*). Again, according to the students, some educators verify students' knowledge about the four food groups of the *Canadian Food Guide* (*teaching*) while others, mostly physical education specialists, assign homework that requests from the students to make a list of unhealthy lifestyles for the purpose of replacing them with new and healthier ones (*encouragement*).

Regarding the parents, students' comments dwell also on physical activity and diet, referring to practices like joining children in outdoor sports (*modeling*), inviting them to play outside when homework is done (*reinforcement*), and registering them in a sports activity or making available healthy food (*encouragement*). Echoing the home environment, students also point out some parental practices aiming to discourage passive activities like imposing a 30-minute time limit at the computer. This control appears to be a way of encouraging them to be more active. On the other hand, some students deplore their parents' lack of encouragement by bringing up the fact that their parents do not purchase any fresh fruits and vegetables or do not often go to sports practices with them. Students from upper grades (8-to-10 years old), moreover, believe that smoking is a very bad habit and, therefore, they try to convince their parents or other adults in their family to put an end to this bad habit. Lastly, students report some parental practices in relation to social skills in the following way: "They tell us not to fight," which echoes a form of teaching.

Adults

In this section, we discuss educators' and parents' responses regarding their own practices with students and children. Also included are community members' perceptions regarding the educators' and the parents' practices in the deployment of the HSA. As for physical activity and diet, educators mention some school projects with the objective of making students more active, such as trips by bicycle, cross-country running, and the Christmas circus. They also talk about organizing recreational sports activities for students to meet challenges or a fruit food counter (*Compagnie Mix-O-Fruits*) to help students develop their sense of responsibility. All of the above examples provide educators with the opportunity for modeling, reinforcing, teaching, and encouraging children to stay active and eat well. Concerning social skills, educators refer mostly to practices linked to conflict prevention and resolution because there are numerous crises at their school (*teaching, reinforcement, and encouragement*). Speaking more personally, educators acknowledge the fact that health being a priority in their school requires them to act as models for their students: "If I don't practice what I preach, I'd probably have trouble getting my health message across the students" (*modeling*). On their part,

parents and community members recognize that educators put in a lot of effort to engage students in physical activities, such as during morning exercises in class or in end-of-the-year sports activities. The parents specify that they are also aware of the “healthy breakfasts” organized at school (*teaching, reinforcement, encouragement, and modeling*) and of the readings on fruits and vegetables that educators discuss in class with the students and incorporate in other disciplines (*teaching*).

With respect to parental practices (family environment), parents argue that they continually encourage their youngsters to practice sports at home, enrol them in physical activities (*encouragement*), and take walks with them every night (*modeling*). Their comments also relate to healthy eating habits such as preparing good breakfasts or healthy snacks, or putting a vegetables plate on the table before and between meals (*encouragement*). On the other hand, educators view parents’ practices as consisting mainly of activities with their children such as “playing sports and going to the park” (*modeling*) and “buying fruits and vegetables” (*encouragement*). A few educators wish parents were more involved and dislike that they don’t engage in sports activities with their children often enough and they don’t encourage them enough. Educators feel that some parents do too little : “I think it could be helpful if more parents would encourage children to be active and if more of them would do outdoors activities with them ... the problem is that there are parents who just do not have the habits of doing that.” Finally, community members recognize that parents are concerned about healthy eating habits, since they provide good and healthy food for their children (*encouragement*). They know that some parents do not follow the school recommendations but they nevertheless believe that parents should set a good example for their children (*modeling*). Essentially, parents’ practices consist of encouragement and, to a lesser extent, modeling.

Discussion

Findings were presented first in response to the two study objectives. Now, we will discuss, among other things, the possible links between stakeholders’ perceptions and reported practices when put in relation to the pathway to a better school-family-community collaboration.

Stakeholders’ Perceptions: The Place of Health in the School

Findings reveal that the participants’ comments cover all of the factors related to the HSA, with the exception of community environment and preventive services (Figure 1). The importance given to physical activity and eating habits is the common denominator for all participants. Such importance is consistent with the OMS (2004) and may be explained by recent ministerial guidelines (Ministère de l’Éducation, du Loisir et du Sport, 2007) and media campaigns, including Kino-Québec’s *Vas-y* campaign and the *5 / 30 Health and Wellness Challenge*. Other lifestyle habits such as alcohol and drug intake have not been addressed probably because the study targeted students aged between 8 and 12 years who are too young to be affected by these issues.

Factors related to safe environment, social skills, and healthy and safe behaviours regarding the practice of sports also draw the attention of stakeholders. Their concerns and the efforts they deploy to assure a safe and healthy environment for students echo the work of Dionne et al. (2009) that suggests increasing the supervisor/student ratio. The NANS measure deployed in low SES areas has certainly had a hand in this. As for the factor of bicycle safety, the mandatory use of a helmet seems a habit of all stakeholders engaged in this school. Our

findings support Farley's conclusion (2001) that suggests legislating the use of helmets to influence cyclists' behaviours, a coercive measure that appears to be an effective solution in low SES environment.

Only community members mention the self-esteem factor. Since some members sit on committees, their presence in the school may explain their knowledge of teaching activities that affect student's self-esteem. It may be that these members from outside the school, recruited on the basis of their influence, are acting not only as fundraising and liaison agents between the school and the community, but also as resource-people dedicated to achieving the school's objectives. This reality appears to support Quebec schools' new perspective of openness to community (e.g. Deslandes, 2009), regardless of the socio-economic environment. That neither parents nor educators mention self-esteem as a factor related to health in the school setting appears to be a cause for concern. These results particularly challenge us. According to Ornelas Pereira, & Ayala (2007), this factor has a key significance because when it is valued within the family, it contributes to self-efficacy associated with active behaviours in children, especially in low SES communities.

An important question remains: Why are factors related to family and community environments and preventive services ignored? Perhaps the foundations of the HSA have not been sufficiently shared with stakeholders and, consequently, a common vision of the students' needs has not been well-developed. It is possible that some parents and community members may adhere to values and hold expectations that differ from those of the school, resulting in divergent perceptions (Thin, 1998). Furthermore, that prevention services are ignored is not surprising because government financial support for those types of services, as opposed to treatment services, has always been very scarce (Deslandes, under press). Stakeholders' viewpoints are being examined in this article using the HSA model for the purpose of moving beyond what are currently evoked as healthy lifestyles and expanding the health concept in the global sense of the HSA, which includes all factors, both individual and environmental.

Perceptions of educators' and parents' practices

The educators' and parents' practices are discussed in relation to the practices or actions suggested by Hoover-Dempsey et al.'s (1997, 2010) model, which stipulates that stakeholders privilege practices in terms of encouragement, modeling, teaching, and reinforcement, as well as in relation to the key factors of young people's development (Ministère de l'Éducation, du Loisir et du Sport, 2005).

Adult encouragement is the practice most frequently reported and can be demonstrated in a host of ways. All participants recognize the importance of accompanying young people in their physical activities to motivate them to adopt active behaviours. For example, educators' implementation of themed school activities is also a form of encouragement mentioned by students. The parents, for their part, enroll their children in sports, provide a structure for reducing passive recreational activities, and buy healthy food, all of those being examples of encouraging practices reported by students. Some students, however, feel their parents do not accompany them often enough during sports practices and, consistent with this, some educators say that parents do little or are not sufficiently involved. Is this a reliable picture of reality, or does it reflect a certain kind of prejudice or stigma towards low-income parents? Is parents' contribution in the home misunderstood, underestimated, and under-appreciated by educators, or are the latter simply unaware of what parents do in the home? At this stage, it appears important to refrain from any generalizations. Regarding healthy diet, some students admit that their

parents do not buy the recommended fruits and vegetables. One reason may be that healthy foods often have high cost, which makes them less accessible to low SES families (Hart, 2010). Just as Graue and Hawkins (2010) address the collaboration, we suggest bringing the parents and the school together by implementing strategies that have proven effective and that are related to other health topics, such as workshops and discussion tools (Deslandes & Rivard, 2011) to facilitate the flow of information and to value the complementary and essential nature of each one of these actors' contribution.

Modeling is a practice that is widely used by adults, who frequently mention the need to "set an example." This concern also echoes the work of Rivard and Trudeau (2006), which highlighted the importance of the teacher as a model for health in the school setting. On the other hand, it is interesting to point out that some students seek to influence the adults in their family to decide to stop smoking, which can also be seen as a form of modeling. This tendency has also been reported by Czaplicki, Laurencelle, Deslandes, Rivard, and Trudeau (in press), where the child is considered as an agent for change for adults. Some of our results suggest that it may also be the case in the low SES environment where the actual study took place. As shown in Deslandes and Cloutier's (2002) study, young people are key players in the development of school-family collaboration. It is thus important to pursue advanced studies in that direction.

The teaching practices evoked by the students and the adults refer to those of educators. Indeed, the various strategies that were mentioned fall within the spirit of the competency approach (Joannert, 2002), which calls upon the child's reasoning ability and refers to open or interactive teaching. Educators' use of this practice appears legitimate insofar as they carry out the educational mission of the Quebec school. One may wonder whether the teaching practice is exclusively reserved for educators rather than for parents, or at least low SES parents. Past research tends to indicate that some parents — and more importantly low SES parents — tend to relegate the responsibility for teaching to the school system (e.g., Deslandes, Joyal & Rivard, accepted; Deslandes & Rivard, 2011).

Reinforcement corresponds to the practice that participants mention the least. In fact, its meaning is quite close to the encouragement practice. It is also plausible that parents give priority to reinforcement as compared to school achievement and perseverance, judging that the adoption of healthy lifestyles is less imperative than the academic concern. As for the educators, it is possible that the teaching conditions prevailing in Quebec, like large class groups, lend themselves more to reinforcement than encouragement practices.

Conclusion

In summary, this study based partly on the HSA model has given us the opportunity to identify the different actors' perspectives on the place of health in school. The four groups of participants seem to be unanimously in favor of physical activity and healthy eating habits included in the formal and informal curricula and recess supervision. On its part, the Hoover-Dempsey et al.'s (1997, 2010) model also used in this study has highlighted parents' and educators' practices that aim to influence students, such as having them involved in physical activities, providing them with encouragement, and exercising their role as models. Topics covered through encouragement and modeling are mainly focused on physical activity and diet, two lifestyle habits that are associated with school health.

It is therefore plausible to hypothesize that, in a certain way, perceptions guide the adults' practices and, in particular, challenge the narrow spectrum of their views to expand the range of

their practices. Having identified a common vision of the importance of health within the school, and the diverse practices that are being used by educators and parents to influence students, we in fact have been reviewing the steps of exploring (stage 1) and initiating (half-way in step 2) a school-family-community project development (Deslandes, 2010). Even though we have mentioned that the targeted school is at the implementation stage (step 3: planning; step 4: implementation), it is always necessary to reassess and readjust in the pursuit of greater school-family-community collaboration. The school team working on the HSA deployment must now find ways to reach more parents who seem to have little interest in their child's healthy lifestyles, to communicate with them, and to motivate them to become involved. The same actions must be carried out with community members and organizations before readjusting or pursuing the actions undertaken at the implementation stage. Obviously, the health theme is of vital importance and, more specifically, the HSA deployment is a promising avenue for developing school-family-community collaboration.

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