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The School Health Approach in Quebec: Perceptions of Students' Parents

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Abstract

In Quebec, the *Healthy School* and *Global Health* approaches, situated at the crossroads of education and health, attract attention for their global and integrated promotion of young people's health. Within the context of these emerging approaches, this questionnaire-based study aims to describe how parents (N=573) perceive health in the school setting, their role with regard to health and the ways they engage with their child in this regard. The collected data have been analyzed using a socio-ecological framework; findings reveal that parents have a positive view of school health, but do not necessarily associate it with the approach recommended in the environment as a whole. Generally speaking, they link health to lifestyles, particularly healthy diet and exercise, and demonstrate their involvement in various ways depending on their socio-economic status. This discussion examines the communication strategies employed to familiarize parents with said approaches in school-family relationships and highlights the importance of developing their critical thinking so that parent-child interactions will prove relevant and constructive in the promotion of health. Concerted action

and a shared vision for health education among stakeholders in the school and family environments are suggested to optimize the impacts on young people's day-to-day life.

Keywords: Parents' perceptions, Health education, School health, Socio-ecological model, Parental involvement.

1. Introduction

With the adoption of the Ottawa Charter for Health Promotion in 1986, the World Health Organization (WHO) recognized that the competencies enabling choices conducive to health must be acquired at the start of schooling. More specifically, numerous authors agree that the school plays a decisive role in developing healthy lifestyles in children, since the habits acquired at a young age often dictate their conduct as adults (Hopper, Munoz, Gruber, & Nguyen, 2005; Rivard & Trudeau, 2006; Virgilio, 1996). Accordingly, the revision of school curricula begun in many countries during the 1990s led to a component that targeted health (Puhse & Gerber, 2005). In 2004, WHO reaffirmed the importance of health in the school setting, with particular emphasis on the promotion of 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 behaviours.* (p. 18).

1.1 Health education

The guidelines issued by the International Union for Health Promotion and Education [IUHPE] (2008) indicate what is expected of the school in terms of health education. Of these, the following are particularly worth noting: 1) promotes students' health and well-being; 2) integrates health into the school's ongoing activities, curriculum, and assessment standards; 3) addresses the health and well-being of the school staff as a whole, and 4) collaborates with parents and the local community. Many researchers concur, since they maintain that health education is not up to the school alone, but is a responsibility that must be shared equally with the families and community. As a result, various stakeholders are being increasingly called upon to participate in school health education activities (Bizzoni-Prévieux, Mérini, Otis, Jourdan, & Grenier, 2011; Deschenes, Trudeau, & Kébé, 2009). The recent work by Bizzoni-Prévieux et al. (2011), conducted in France and Quebec, examines partnership from the angle of teachers' collective work in health education. The school may be the first to motivate collective action, but there are outside participants as well, in this case, the parents, who now find themselves increasingly petitioned in Quebec. Parents are considered key actors - front-line partners even - in the school success of children and teens (Deslandes, 2005; Martin & Arcand, 2005) as well as in health education (Beaudoin, 2010; Ma & Zhang, 2002; Mérini, 2010).

1.2 School health education initiatives

A number of organizations in various countries have developed diverse health-related school initiatives (Allensworth & Kolbe, 1987; St-Leger & Nutbeam, 2000). Examples include the Health Promoting School in Australia, the European Network of Health Promoting Schools, the Center for Disease Control under the name Coordinated School Health Program in the United States and the Healthy School Approach in Canada, all of which are global health education initiatives aimed at improving young people's health and academic achievement (Simard & Deschesnes, 2011). Health education initiatives fall under academic achievement,

since research findings conclude that healthy students tend to learn better (IUHPE, 2008). Despite evidence linking education and health, and the unprecedented growth of health education initiatives in schools, many works reveal that such initiatives meet with a host of obstacles (Simar & Jourdan, 2011), notably a lack of coherent action for promoting health on the part of the various groups of stakeholders (Deschesnes, Martin, & Jomphe-Hill, 2003). The literature, in particular, highlights the consolidation of collaboration among stakeholders inside and outside the school (Grenier & Otis, 2010). This collaboration is particularly well documented for school-family relations, especially as regards the challenge of reaching out to parents and involving them in school health guidelines (Simar & Jourdan, 2011).

1.3 School-family relationships and health

School-family relationships have been examined from various angles including academic achievement, school aspirations and dropout prevention, among others (Deslandes, 2010). For Christenson & Sheridan (2001), the school-family collaboration is central to academic, social and emotional learning for children and teens. Accordingly, beliefs - even positive perceptions of the importance of educational goals and parental involvement at school and at home - are among the indicators of the relations surrounding this collaboration. There are relatively few studies on school-family collaboration and health promotion (Ciliska, Miles, O'Brien, Turl, Tomasik, Donovan, & Beyers, 2000; Ornelas, Perreira, & Ayala, 2007). What's more, some researchers (Ma & Zhang, 2002) feel that the school staff must enlist the aid of parents to obtain positive health-related outcomes and behaviours in students. In a similar vein, Denman (1998) points out that many school partners view the parents as essential collaborators in school health education, while Cramer and Iverson (1999) believe that parents are interested in health education in the school and judge that the teacher is well placed to help students adopt a healthy and active lifestyle. While others indicate that parental involvement appears critical for implementing strategies aimed at promoting exercise (Ornelas et al., 2007) and healthy eating habits in school-age children (Ciliska et al., 2000), the contribution of parents from low income environments presents additional challenges (Deniger, Abdoulaye, Dubé, & Goulet, 2009). To be more precise, disadvantaged families are often characterized by poverty, little schooling and a history of negative experiences in the school context, all of which leads to a low sense of competence, less involvement in their child's schooling and an instrumental concept of the school (e.g., Harris & Goodall, 2007). The result is that many of these parents feel less equipped and capable of assisting their child (Deslandes, Rousseau, Rousseau, Descôteaux, & Hardy, 2008). There is no research, to our knowledge, on the collaboration of low-income families and the school in terms of health. Relatively few studies discuss the family context, and these few either conclude that a disadvantaged status influences the practices of school partners and the targeted objectives of health education (Simar & Jourdan, 2011) or corroborate the findings of other studies linking the single-parent status of families, especially those where the mother is head of the family, to deprivation (Rivard, Deslandes, & Beaudoin, 2011).

1.4 Health education initiatives in Quebec

Health education initiatives in Quebec are based on guidelines issued by the *États généraux sur l'éducation* in 1996, which officialized this field of study in every school system (Beaudoin, Rivard, Grenier, & Caty, 2008). There are two key components to health education in the school curriculum (Ministry of Education of Quebec [MEQ], 2001). The first, *Health and well-being,* focuses on general training. This component calls for all stakeholders in the educational community to empower students to manage their health and, particularly, to adopt healthy lifestyles. The second, *Adopting a healthy and active lifestyle,* is about physical education and health. This component aims to help students choose behaviours that support health and well-being.

Health education initiatives can be implemented directly in keeping with the school curriculum, or they may be based on emerging approaches in health education. At the moment, there are two major structural approaches in Quebec schools: *Healthy School* and *Global Health.*

The *Healthy School* approach derives from a complementarity agreement between the MEQ and Ministry of Health and Social Services (MSSS) in Quebec, which united their shared objectives of "education and health" to serve young people's educational achievement (MEQ & MSSS, 2003). The *Healthy School* approach is based on this agreement and is anchored, notably, in the educational system via the *Programme de formation de l'école québécoise* (Quebec School Training Program) (MEQ, 2001), an approach viewed as promising, notably because it is grounded in a global and unified conception (Martin & Arcand, 2005). This conception is *global* in that it includes 6 key factors of the child's development at the individual and environmental levels. The individual level involves: 1) self-esteem (personal satisfaction); 2) social competence (experiencing quality social relations); 3) safe, healthy behaviours (in sports and recreational activities), and 4) healthy lifestyles. The environmental level relates to: 5) the school setting (i.e., the physical layout), the family (i.e., relations with the school) and the community (i.e., services and resources in the neighbourhood) as well as 6) preventive services (i.e., health and social services). The conception is *unified* in that it calls for all stakeholders having a role in the child's schooling - namely, school, family and community members - to assist in promoting the child's academic achievement, health and well-being (Martin & Arcand, 2005).

The *Global Health* approach is based on work that led to the adoption of the Ottawa Charter for Health Promotion (WHO, 1986) and is also rooted in the Quebec school program. The approach is intended for the school as a whole and proposes initiatives involving three distinct components: 1) a health education program targeting five teaching/learning areas: first aid, nutrition, exercise, stress management and the human body; 2) the creation of a school environment that fosters young people's development, and 3) the creation of a school-community partnership to promote the development of interdisciplinary projects in the school and greater collaboration among the different stakeholders in young people's health education. More specifically, the program's objectives aim to: 1) encourage the development and acquisition of healthy lifestyles; 2) develop the routine practice of outdoor physical activities; 3) combat sedentary behaviour; 4) stimulate motivation and school achievement,

and 5) improve students' socio-affective values and exploit the notions of enjoyment, respect and safety. These objectives can be achieved if the school staff as a whole participates in the various health education initiatives and if members of the family and community are involved in the continuity of the initiatives implemented in the school.

The main difference between the two approaches is that *Global Health* tends to involve educational initiatives that are usually implemented by school authorities and therefore require very few health field workers. The two approaches have several points in common: first, they are rooted in school programs (MEQ, 2001) and second, they rely on health promotion principles for schools (IUHPE, 2008) and a comparable identity base, meaning they encourage overall, concerted action with environments of influence - in this instance, the family - to promote the adoption of healthy lifestyles.

1.5 Relevance of the study

The research on school-family collaboration for promoting young people's health is still in its infancy stage and little documentation exists on the mechanisms and interactions characteristic of school-family collaboration in terms of promoting healthy lifestyles in school-age children (Inchley, Muldoon, & Currie, 2006). A recent review and analysis by Beaudoin (2011) of the Canadian literature on the family's influence on health education highlights the lack of research on parental perceptions and involvement underlying school-family relations in terms of school health education initiatives. Within the frame of this study, we targeted parents viewed as key actors in the educational success of their school-age children (Deslandes, 2005; Martin & Arcand, 2005) and as front-line partners in a health-based school approach (Ma & Zhang, 2002).

2. Theoretical framework and research objectives

The important place of ecological models in the social sciences is based on the fact that they put behavior as being affected by, and affecting the social environment (McLeroy, Bibeau, Steckler, & Glanz, 1988). Sallis, Owen, & Fisher (2008) present four core principles of ecological models: 1) ecological models are most powerful when they are behavior-specific; 2) influences on behaviors interact across different levels; 3) there are multiple influences on specific health behaviors, including factors at the intrapersonal, interpersonal, organizational, community, and public policy levels, and 4) multi-level interventions should be most effective for changing behavior. Furthermore, ecological models can be used to develop comprehensive intervention approaches that systematically target mechanisms of change at each level of influence (Sallis et al., 2008). Sallis and colleagues (2008) consider two different categories of ecological models. The first category regroups models intended mainly to explain behavior, and the second category includes models intended to guide behavioral interventions. Although several models from the literature could be useful and relevant for our type of study (e.g., Bronfenbrenner, 2005; Cohen, Scribner, & Farley, 2000; Fisher, Brownson, O'Toole, Shetty, Anwuri, & Glasgow 2005; Stokols, Grzywacz, McMahan, & Phillips, 2003), we retained the McLeroy et al. (1988) model by virtue of its focus on health education and school-family relations from the perspective of behavioral interventions. The principal purpose of ecological

models of health behavior is to inform the development of comprehensive intervention approaches that can systematically target mechanisms of change at different levels of influence (Sallis et al., 2008).

What makes McLeroy's model more interesting than the others in the same category is its focus on health education and its multi-level specificity, which allows for a better comprehension of the reality observed in the present study. One of the problems with a number of the other ecological models of social behavior is that they lack adequate specificity to guide conceptualization of a specific problem or to identify appropriate interventions (McLeroy et al., 1988). The McLeroy model has sufficient specificity because it doesn't confuse many factors in a single source of influence, which makes it possible to identify and apply appropriate interventions of many current health problems, particularly those related to health promotion (McLeroy et al., 1988). Another specificity of this model is its special consideration for behavior: behavior is considered as an outcome, an "in-model variable", and not just a contributing host characteristic. Indeed, this model allows targeting a specific health behavior to be improved in order to identify the best approach relative to the needs of the person. In addition, the model takes into account the interactions between different influences of health behaviors, such as school-family interactions. The model is also divided into five levels, corresponding to the different influences of specific health behaviors. An implicit assumption of these levels of analysis is that health promotion interventions are based on our beliefs, understandings and theories of the determinants of behavior, and the five levels of analysis reflect the overall strategies currently available for health promotion programming (McLeroy et al., 1988). Even if they are more time consuming and difficult to implement, multi-level studies are the only way to generate knowledge that will lead to effective multi-level interventions (Sallis et al., 2008).

For the purposes of this study, the socio-ecological model (McLeroy et al., 1988) includes three levels: the *individual* (student), the *interpersonal* (family) and the *organizational* (school). These levels were selected because they allowed us to operationalize our two research objectives, namely to describe: 1) how parents perceive health in the school setting, their role with regard to health, and 2) the ways they engage with their child in this regard. The two other levels of McLeroy model (*community* and *public policy*) were excluded because they could not be integrated in terms of the targeted objectives.

The McLeroy model therefore served as the theoretical framework for the proper execution of this study, in terms of theory and methodology as well as data analysis. More specifically, this model recognizes the intertwined nature of the relationship between individuals and their environment. Healthy behaviors can be achieved through the combined efforts of all stakeholders, at all levels. A tailored version of the model will be proposed in our discussion of the findings.

3. Methodology

To enable parents to describe how they perceive health in the school setting, their role with regard to health and the ways they engage with their child in this regard, the research

methodology privileges case study principles (Yin, 2009). Here's an overview of the methodology.

3.1 Sample

The first case focuses on 3 elementary schools (*Healthy School* approach), and the second on 2 *(Global Health* approach). The key characteristics of the 5 schools are presented in Table 1. In our study, only school 2 (Case #1: *Healthy School*) has a low socio-economic environment index[1] (EEI), that is, a high index (8/10), because a score of 1 indicates a well-off school and a score of 10 a very poor school. The same table depicts a total sample of 573 families and includes the parents (F=486, H=87) of children from grades 1 to 6 (i.e., ranging from 6 to 12 years of age). The following criteria were used in selecting the parents: parents of children in the six teaching levels, of both sexes and signed a formal authorization to take part in the study because our project was approved by the ethics committee of both universities. Although we would have liked a more balanced participation of women and men, the gender-based percentage seen is typical for this type of study (e.g., Czaplicki, Laurencelle, Deslandes, Rivard, & Trudeau, 2012).

Table 1. Key characteristics of the 5 schools

Schools	EEI	Size of school (number of students)	Participating families		
Case #1: *Healthy School*					
School 1 (2007-2008)	3/10	335	F=67	H= 7	Total= 74
School 2 (2007-2008)	8/10	217	F=91	H=15	Total=106
School 3 (2008-2009)	4/10	423	F=135	H=27	Total=162
Total:					*N=342*
Case #2: *Global Health*					
School 4 (2008-2009)	3/10	173	F=54	H=13	Total= 67
School 5 (2008-2009)	3/10	316	F=139	H=25	Total=164
Total:					*N=231*
Grand Total:					*N=573*

3.2 Methods

The data analyzed in the present article were taken from a questionnaire[2] administered in 2008 or 2009, depending on the cases and schools in the study (see Table 1). The

[1] In Quebec, the socio-economic environment index (EEI) is calculated by the Ministry of Education of Quebec (MEQ, 2003). The index takes into account the mother's schooling (weighted at 66%) and the proportion of parents who were not employed the previous year (weighted at 33%), without considering the family's income. This information, obtained from Statistics Canada, was compiled for the 2001 census from a sample number of households (families).

[2] The questionnaire is available upon written request to the first author.

questionnaire was beneficial in that it reached a large number of participants who could respond freely to questions on a specific subject (Fink & Kosecoff, 1998). The contents are based on another questionnaire that was validated and used in a previous study (Trudeau, Czaplicki, Laurencelle, Deslandes, Rivard, & Blais, 2008), then repeated in part by Czaplicki (2009). In the latter' study, items referring to parental practices have a high internal coherence (a Cronbach's alpha of 0.725). The contents also take into account the theoretical foundations of the emerging health approaches (Martin & Arcand, 2005). Following the instructions in the introduction, the questionnaire offers three types of answers: answer scales, lists of items to select, or short development answers. All in all, it includes 34 questions divided into six sections. Here, we focus on 14 questions under three headings. The first, *School and health,* has two aspects to clarify the relationship between the two, namely: 1) health in the school setting and 2) health in terms of the school-family relation. The second, *You and the school*, concerns parent-school relations and examines the parents' role and involvement in school activities. The third, *Your child and health,* concerns parents' perceptions of their child's state of health and well-being. The three sections correspond to the three levels of the theoretical framework (McLeroy et al., 1988).

3.3 Procedures

Before the questionnaire was handed out, it was checked by two university experts in the field of health education, and then administered to six parents (1 parent/grade level) to ensure comprehension and estimate time of completion, about twenty minutes. A few corrections, mainly in relation to terminology, were made before the questionnaires were sent out, either in winter 2008 or winter 2009, in each of the 5 schools.

3.4 Data collection and analysis

The questionnaire was placed in an envelope addressed to the parents and given to each child by the homeroom teacher. The envelope also contained a letter introducing the study, a consent form and a return envelope. The questionnaire was therefore self-administered. Qualitative data from open-ended questions were analyzed using L'Écuyer's (1990) mixed content analysis. Closed-ended answers, on the other hand, were analyzed using SPSS software to perform a descriptive statistical analysis of elements such as frequencies and percentages.

4. Findings

The findings allowed an interrelation to be established between the three levels of the socio-ecological model: the *individual* (student), the *interpersonal* (family) and the *organizational* (school). They are represented schematically in Figure 1, which serves as a background for the findings in each section: *School and health, You and the school,* and *Your child and health.* Findings for the first two sections enabled us to achieve the first goal of our research, namely, to describe parents' perceptions of health in the school setting and their role in implementing an approach to health education; findings for the third section helped with our second goal: to shed light on parental involvement in health education.

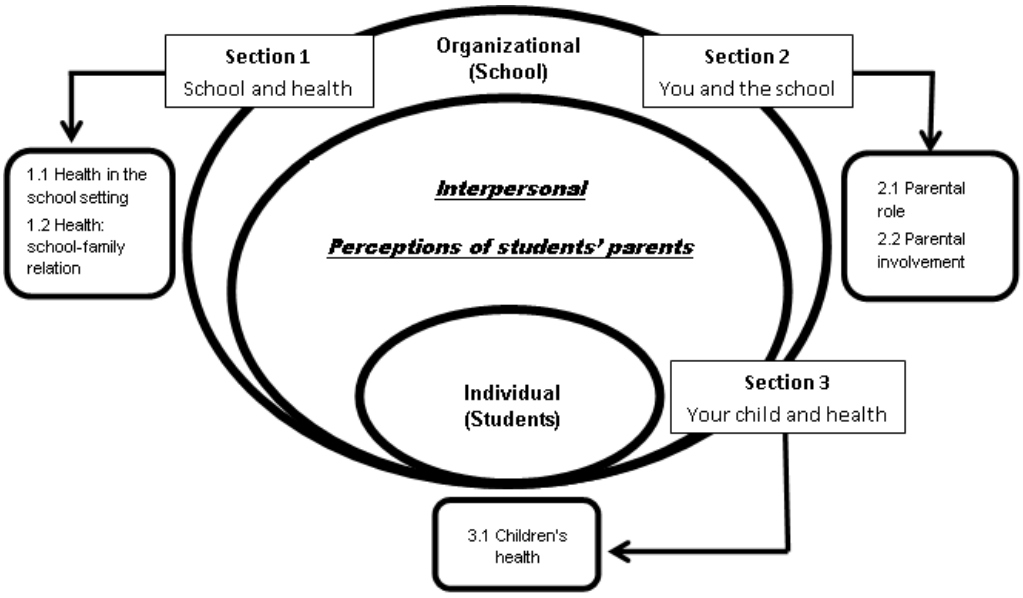

Figure 1. The socio-ecological model of the Global Health Approach (McLeroy et al.,1988), adapted by Rivard and Turcotte (2013)

4.1 School and health

The findings briefly presented in this first section link the levels *interpersonal* (family) and *organizational* (school) using the school as the main point of analysis based on parental perceptions (McLeroy et al., 1988). See no. 1.1 and 1.2 in Figure 1.

4.1.1 Health in the school setting

Almost all parents questioned, irrespective of approach, state that health in the school setting is *very important* and *important* (97% to 100%). About 92% believe that the top health priorities in their child's school are healthy eating habits and the practice of sports and physical activities. When asked to elaborate on their answers, parents specify that the school emphasizes nutrition by offering information on food and suggestions for healthy meals, lunches and snacks. Another top priority is the ban on fast food. With respect to physical activities, parents underscore the variety of offerings and school-scale sports events. Only those in case study #2 specifically identify the *Global Health* approach to describe health in the school setting. To the question of whether they are familiar with the approach privileged by the school, about 38% say they learned about the *Healthy School* thanks to information provided by the school itself; some 85% are familiar with *Global Health* and also state they received their information from the school.

4.1.2 Health: school-family relation

About two-thirds of the parents questioned say that the school contacts them in reference to health issues. The means of communication are many and varied within the 5 schools and include school-organized activities (21%), memos sent to the home (20%), the school

newspaper or website (16%), the child's homework (16%), specific information (14%), the school bulletin (7%), exchanges with the teacher (5%) and miscellaneous (1%).

In short, the findings in this section show that parents (*interpersonal* level) had a positive view of action for educational health in the school setting *organizational* (school) for both approaches. Diet and exercise are closely associated with health in each school. The parents' perceptions also reveal the school's different ways of communicating with families. They are mainly familiar, however, with the *Global Health* approach which, they find, is decisive in demonstrating the school's role in relation to health and well-being.

4.2 You and the school

In a similar vein, the findings for this section aim to link *interpersonal* (family) and *organizational* (school) levels (McLeroy et al., 1988). Contrary to the previous section, the main point of analysis is no longer the school, but the parents' perceptions of their involvement in implementing the school's health approach (see no. 2.1 and 2.2 in Figure 1). Note that the school-family relation in this context is examined in reference to parental role and involvement.

4.2.1 Parental role

Convincingly enough, a large majority of parents in the 4 schools (about 65%) view themselves as key actors in school health., although the percentage for school 4 (case study #2), is less than 44.8% regarding this issue.

When parents are asked if they wish to participate more in school activities, over a third reply in the affirmative, while the percentage for those in school 2 with a low EEI (case study #1) is somewhat higher (44%). In the two *Global Health* schools (case study #2), fewer parents express a desire for more involvement in the school (31.3% and 30%).

4.2.2 Parental involvement

Parental participation in various school activities is, on the whole, quite high since over 90% of parents take part in parent-teacher meetings and 85% accept classroom invitations. There is a participation rate of 64% in family activities, while participation in school outings hovers around 50%. Parents in both case studies say they seek greater involvement in school activities, although this is more so for parents in the *Healthy School* than those in the *Global Health* approach (average 46% *vs* 36%). The parents in only one *Global Health* school participate in parent committees on school health (6%).

In the section *You and the school*, most parents questioned (*interpersonal* level) feel they play a key role in school health (*organizational* level) and want their child's school to call on them more often; this is particularly so for school 2, which has a high deprivation index. The parents, therefore, wish to participate further in the school's health education activities. Nevertheless, their involvement in school activities is shown in several ways: parent-teacher meetings and classroom invitations are the most popular irrespective of socio-economic environment index.

4.3 Your child and health

The findings in this section mirror the links between the *interpersonal* (family) and *individual* (student) levels based on parents' perception of their children's state of health (McLeroy et al., 1988). See no. 3.1 in Figure 1.

4.3.1 Children's health

Regarding the question *In your opinion, what is a healthy child*? An analysis of parents' comments revolves around three key aspects: 1) school learning; 2) general well-being and 3) lifestyles. Indeed, their comments on good health reveal some common concerns, to wit: improve children's concentration, learning - even their grades - "He's a child well prepared to do what it takes at school on the academic" (free translation). Also, the good health influence the child's overall mood and attitudes "He's well and happy in his skin" (free translation). As well, parents in the 5 schools mention lifestyles such as a healthy diet "A child who eats well (vegetables, fruit, meat, dairy products) with minimal fat foods" (free translation) and exercise "He makes sport instead of staying inside to play video games or on the Internet" (free translation) in particular, followed by sleep and factors such as happiness, energy and absence of illness.

Parents were asked to rate their child's health, well-being and lifestyles on a 5-point Likert scale, where 1 = *very poor* and 5 = *very good*. These questions concerned psychological and overall health as well as diet, exercise, sleep, and dental and personal hygiene. Although most parents' responses are either *very good* or *good*, mainly in reference to exercise, those from the low EEI school (school 2) answer *very good* most often to questions on eating habits, physical activities, and sleep. Do you encourage your child to adopt healthy lifestyles? Over 94% of all parents questioned say *Yes*.

According to the parents (*interpersonal* level), children's health (*individual* level) is reflected in their school learning, overall well-being and lifestyles. Generally speaking, they rate their own child's health, well-being and lifestyles to be *good* or *very* good, and almost all encourage their child to adopt healthy habits.

5. Discussion

The following discussion is based on our findings consistent with the theoretical model employed. Accordingly, it is divided into three sections: 1) School and health; 2) You and the school, and 3) Your child and health.

5.1 School and health

Using the levels of the theoretical model (McLeroy et al., 1988), we discussed *interpersonal* (family) and *organizational* (school) interactions on school health based on the perceptions and communications in these two environments. It is clear that parents have a highly positive view of health in the school setting for both approaches. The findings show they are more familiar with the *Global Health* approach, leading us to conclude that the dissemination strategies (Rogers, 2003) used to familiarize parents with the *Global Health* approach have been effective. There can be no doubt that parents informed of the aims and orientations of

school health will be better equipped to ensure continuity in the home (Grenier & Otis, 2010). The various types of school-family communications, on the other hand, vary among the 5 schools in the sample, although parents specifically identify the *Global Health* approach as a contributing factor in school health. Accordingly, we pose the hypothesis that the use of diverse means of communication may serve to consolidate the relations surrounding school-family collaboration (Deschesnes et al., 2003; Grenier & Otis, 2010).

School health education initiatives such as the *Healthy School* and *Global Health* approaches are emerging in Quebec; they are a lever for implementing real global health objectives based on the contributions of all members of the educational community. Toward this end, two IUPHE (2008) guidelines are useful insofar as they address issues relating to the health and well-being of the school staff, parents and local community. Our study's findings support the undeniable role of the parents in health education, although parents' concept of health tends to be limited to diet and exercise. This being the case, we suggest that schools continue to use a diversity of communication strategies to familiarize as many parents as possible with the school's specific approach.

5.2 You and the school

This section examines *interpersonal* (family) and *organizational* (school) interactions based on parents' role and involvement in the school setting. On one hand, most parents feel they play a decisive role in their child's health and express a wish to become further involved in the school; this is particularly true for that in the low EEI (school 2). A recent survey (497 parents of children aged 5 to 16 years) indicates that Canadian parents demonstrate strong support for physical and health education (Physical Education Canada, 2013). Furthermore, the same survey reports that 3 of 4 parents agree they are responsible for their child's overall health. From the perspective of school educators, Ma & Zhang (2002) highlight parents' role in achieving health education targets. On the other hand, parents demonstrate their involvement in various ways, such as parent-teacher meetings or classroom invitations, with parents from the disadvantaged environment participating to a lesser extent. As well, these different findings regarding socio-economic status are in line with research indicating that low income families require greater accompaniment in order to provide improved support for their child's learning (Deniger et al., 2009). Likewise, parental participation in school activities such as classroom invitations illustrates the decompartmentalization of Quebec schools and their greater openness to the outside community (MEQ, 2001). In this sense, Bell (as cited in Bédard, Couturier, Larose, Lenoir, Potvin, & Terrisse, 2009) points out that educational policies in many countries guide school-family partnerships with a view to enhancing young people's academic performance. However, one must question if the parents in our study really are committed to the school staff and their educational targets, insofar as their classroom participation regarding children's learning and development tends to be passive rather than active (Epstein, 2001). Regarding this problem, we find it would be useful to investigate the level of parental involvement on a scale of passive to active in schools with a health-based program, for example, from the perspective of the participants' modes of relationship - from mutual information to co-management to a coalition even - as proposed by Comte and Picard (2004). In the same vein, there is only one school that underscores parental

involvement in committees, whereas the literature on the subject stresses various forms of parental participation, notably decision-making (Epstein, 2001). Since only 6% of the parents are involved in school committees (school 4), we may well ask the following question: Does the formation of decision-making committees with parents constitute a genuine lever for creating new relations aimed at improving family-school collaboration vis-à-vis health education?

5.3 Your child and health

This section offers a brief discussion of *interpersonal* (family) and *individual* (student) interactions. Although all parents recognize the benefits of good health, they tend to associate it with a few lifestyles, namely diet and exercise. Could this mean they don't understand the concept of health in the broader sense of the term? Caution is advised here. Sedentariness and unhealthy diets are among today's most worrisome lifestyles, and affect Quebec's school-age children as well. In an effort to combat the problem, WHO (2004) has rightly encouraged schools to promote good nutrition and exercise. In only the last few years in Quebec, the universal concept of *global health* has gradually shifted to that of *healthy life habits,* because the latter are particularly associated with diet and exercise (Rivard, 2011). Quebec's Policy framework for healthy eating habits and a physically active lifestyle, *Going the Healthy Route at School* (MELS, 2007) retains our attention and is an inspiration for the school system as well. While targeting academic achievement, the Policy encourages schools to establish partnerships aimed at promoting health and implementing specific measures to foster healthy lifestyles; the emphasis on diet and exercise may be the reason for parents' preoccupation with these two areas of health.

It is obvious, furthermore, that parents, particularly those in the low EEI school (school 2), overestimate the level of their child's physical activity. We can plausibly assume that, since disadvantaged parents have a low level of schooling (Harris & Goodall, 2007), they are less critical in evaluating their children's daily lives. Some 86 per cent of Canadians feel that children generally do not get enough exercise (Physical Education Canada, 2013). As well, a study (Corder, Van Sluijs, McMinn, Ekelund, Cassidy, & Griffin, 2010) indicates that fully 80% of parents of inactive children wrongly thought their child was sufficiently active, this in a context where school-age children fail to meet the recommended standards (Cameron, Craig, & Paolin, 2005). In reference to exercise, these experts suggest that the proportion of physically active youth has increased over the past decade, yet the activity levels of Canadian children and teens continue to be far from sufficient. Along with Deslandes et al. (2008), there's reason to wonder whether parents are less equipped and less capable of engaging with their child in terms of health. It appears that structural approaches for developing parents' critical thinking are necessary to render all parent-child interactions constructive and relevant in health promotion.

6. Conclusion and avenues for research

Emerging approaches in Quebec call for a renewed relationship between all the stakeholders involved in their deployment, including the school and the families. The key challenges facing school and family environments in health education concern the quest for a shared

vision and concerted action among stakeholders to optimize the impacts on students' day-to-day life. Family characteristics must be handled sensitively to avoid all forms of prejudice and stigma towards disadvantaged parents. The importance of health-based approaches in Quebec schools is undeniable insofar as such approaches foster renewed school-family relations around a component that is less sensitive than academic performance and just as necessary for student success.

We believe that an examination of parental engagement is a privileged research path for the future. In addition to the model of Comte and Picard (2004), which recognizes a continuum of modes of relationship between actors, the model by Hoover-Dempsey, Whitaker, & Ice (2010), which underscores that parents' involvement influences the student's results and behaviours, seems just as relevant to us for use in a health-oriented school. This second model involves four types of actions: modeling, reinforcement, teaching and encouragement. The exploration of health education - and of healthy life habits in particular – suggests the possibility of various modes of relationships and actions capable of shedding shed light on parents' involvement in the optimal development of their children and on their undeniable contribution to today's educational systems.

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