**Parental engagement in school-based health promotion and education**

**Abstract**

**Purpose:** Children’s health and life chances are affected by many factors, with parents and schools holding influential roles. Yet relatively little is known about parental engagement in school-based health education and specifically, from the perspectives of health and education professionals. The aim of this paper is thus to examine professionals’ perspectives on parental engagement in school-based health education.

**Design/Methodology/Approach:** An exploratory qualitative study was conducted with ten health, education and local authority professionals from a socio-economically deprived area in England. Semi-structured interviews explored the role of professionals within the school health curricula, roles that parents played in school health, and barriers and enablers to parental engagement in school health education.

**Findings:** Reported barriers to engagement related to assumptions about parents’ own health behaviours , impacts of funding and inspection regimes, and protected time for health within the school curriculum. Enablers included designated parental support workers based in the school, positive role modelling by other parents, consultation and engagement with parents, and a whole school approach to embedding health within the wider curriculum.

**Practical Implications:** Findings from this study suggest the importance of building meaningful partnerships with parents to complement school health education and improve child health outcomes.

**Originality/value:** This paper addresses an important gap in the research on parental engagement in school-based health education from the perspectives of health and education professionals. Effective partnerships with parents are crucial to the success of school health education.

**Key words:** Parents, School Health Promotion, Professionals, Child and Adolescent Health.

**Article Classification:** Research Paper.

**Background**

School-based health education programmes make an important contribution to health and education outcomes for children and young people (Lucarelli *et al*., 2014; Langford *et al*., 2015; Barry *et al*., 2017). Recent research identifies positive benefits across a range of health and education measures, including improvements to nutrition, levels of physical activity, social well-being and bullying, learning and academic achievement (Lucarelli *et al*., 2014; Langford *et al*., 2015; Barry *et al*., 2017). The significant role schools play in health promotion and education is underscored by the World Health Organisation’s (WHO) Health Promoting Schools (HPS) framework, which recognises the value of both the taught curriculum and broader school environment to the achievement of positive health (WHO, 1998).

In many ways, the HPS framework reflects a departure from traditional forms of health education that privilege biomedical understandings of health and take a prime focus on ‘healthy’ behaviour change and risk reduction strategies (Fitzpatrick and Tinning, 2014). In contrast, the HPS approach aims to engage with broader notions of health through highlighting the multiple influences on children’s health and well-being. In line with a socio-ecological approach (Bronfenbrenner, 1979), the focus for health education thus shifts from individual-level factors to acknowledge the complex ways in which socio-economic and political contexts interact to shape health practices and outcomes. Bronfenbrenner’s socio-ecological model provides a useful framework for understanding these multiple influences, which are located across five inter-related systems: the microsystem (individual, proximal factors), mesosystem (interaction between individual and social structures, e.g. school-home relationship), exosystem (social structures such as community, school, parents’ workplace), macrosystem (culture, values, laws), and the chronosystem (life transitions and events). The model emphasises bi-directional influences and interactions between the different systems to illustrate the inter-relationships between the individual and their environments and how these shape health and development. The school setting, and its relationship with the wider community, can be seen to reflect the mesosystem, but which is further influenced by (and influences) other social systems to shape children’s health.

The HPS framework has been widely implemented across Europe, Australia and Northern America. In the US, for example, the Whole School, Whole Community, Whole Child (WSCC) programme (ASCD/CDC, 2014) has aimed to create a school environment that facilitates health education and lifestyles, whilst acknowledging the important role of the wider community – including parents and families. Similarly, in England the National Healthy Schoolsinitiative (Department for Education and Skills/Department of Health [DfES/DH], 2005) has sought to develop a healthy school climate (e.g. through the introduction of healthy school meals), alongside a targeted Personal, Social and Health Education (PSHE) curricula addressing a range of health areas such as diet and exercise, sex and relationships, alcohol and substance use (Warwick *et al*., 2009; Arthur *et al*., 2011). Whilst some critiques suggest these curriculum changes and related initiatives continue to support individual-level responsibility for health (e.g. through the transmission of health information and the upholding risk reduction strategies), the emphasis on a settings-based approach has been broadly welcomed and has triggered the expansion of school-based health promotion.

Despite such initiatives, health inequities remain across socio-economic indicators and child health outcomes. In England, the Royal College of Paediatrics and Child Health State of Children’s Health report (2017) highlights important discrepancies across socio-economic contexts, with children from deprived groups experiencing some of the worst outcomes in the developed world (p. 6). Evidence of this kind underscores the significance of the multifaceted aspects of children’s health and development, including how individual, community and broader socio-cultural and political factors can work towards, or against, the promotion of children’s health (Marmot *et al*., 2010). As described, the HPS framework aims to move beyond a purely individualistic approach and acknowledges the significance of community and family contexts (Langford *et al*., 2015) and indeed, how parents and the home environment are instrumental in supporting positive health outcomes for children and young people (Sormunen *et al*., 2012). The interaction between the school and family environment (mesosystem) is thus a critical site for supporting children’s health and development.

*Parental engagement*

Increasing recognition of the importance of family engagement has triggered an expansion of research investigating different forms of parental involvement in schools and children’s learning more broadly (see Goodall and Montgomery, 2014 for a discussion). Parental involvement encompasses a range of formal and informal activities, including participation in school health events, assisting with learning and homework, decision-making with school personnel, and engaging with the local community (Lewis *et al*., 2011). Yet, relatively little is known about which types of involvement are most desired (by parents and school staff) or the forms of activity that might be most effective for supporting the achievement of health and education goals in support of children’s well-being. Indeed, varying (sometimes inconsistent) uses of related terms such as ‘involvement’, ‘engagement’ and ‘participation’ across the health and education literature creates difficulties when seeking to draw comparisons with respect to the types and impacts of (differing forms of) parental engagement with school-based agendas, including health. Goodall and Montgomery (2014, p. 399) propose a ‘continuum between parents’ involvement with schools, and parental engagement with children’s learning’. The latter reflects a shift from a focus on involving parents in school-based activities to a broader engagement in learning outside the school context.

Despite conceptual ambiguity, the education literature has reported that parental involvement can contribute to academic success, as well as positive psychosocial adjustment (Kim, 2009). In relation to health, research has tended to focus on parents’ perspectives on, and responsibilities for, specific topic areas such as sex and relationship education (Peter *et al*., 2015; Alldred *et al*., 2016) or bullying (Sawyer *et al*., 2011). A survey of Finnish parents found that many considered a combined home and school responsibility for a range of health issues including human biology and puberty, lifestyle choices such as smoking and alcohol, emotional safety and bullying (Sormunen *et al*., 2012).

However, this same literature also reports barriers to engagement, with parents from challenging social, financial and educational circumstances facing the greatest difficulties (see Kim, 2009; Lewis *et al*., 2011; Condon and McClean, 2017). School-based health intervention studies (see Segrott *et al*., 2016) have reported some of the challenges of recruiting and engaging parents in school initiatives. Explanations for (lack of) involvement have largely focused on individual, rather than school-level (or contextual) factors, and have assumed deficits in parental knowledge, attitudes and confidence in relation to health. This individual focus downplays the significance of broader socio-cultural factors known to determine both health outcomes and differential levels of parental involvement and/or engagement (Kim, 2009; Lewis *et al*., 2011). Indeed, some research has found that parental involvement can be affected by language and cultural barriers, socio-economic status, lack of social networks, parents own school experiences, and perceptions of (negative) attitudes or responsiveness of school staff (Kim, 2009). Research from the US, for example, has highlighted the frustrations experienced by school personnel regarding the lack of parental participation in nutrition programmes, which can result in inconsistent messages between the school and home environments (Lucarelli *et al*., 2014). Other research has shown how school and teacher practices can present obstacles for supporting engagement, particularly for families from lower socio-economic backgrounds (Walker *et al*., 2005; Seitsinger *et al*., 2008).

Understanding health and education professionals’ perspectives on parental engagement is thus critical to the identification of both the school and home influences on parents’ participation in school-based health education and promotion and may help advance understanding of the relationship between the home and school environments (mesosystem) and how these interactions shape responses to health education. To that end, this paper reports findings from an exploratory study that aimed to examine the perceived (individual and school-level) barriers and facilitators to parental engagement – and importantly, from the perspectives of different health and education professionals. Following Goodall and Montgomery (2014), the term engagement is used here to reflect the differing forms of participation and involvement may take, including how parents may engage with health education in varying ways and in differing contexts. Findings from this study help to advance much-needed knowledge of how professionals’ perspectives may support (or hinder) engagement, including the identification of relevant and effective strategies to recognise and enhance parents’ contributions to school-based health education and promotion – thus providing insights into the interactions of the mesosystem as one possible site for advancing health education in support of children’s health.

**The study**

This exploratory qualitative interview study was conducted in a socially and economically deprived inner-city area in England. As evidenced, deprivation not only determines health and education outcomes (Marmot *et al.*, 2010), but has been found to influence engagement in health education and related practices (Kim, 2009) for both children and adults. The urban area selected was below regional and national indicators on all health and social care indicators, including life expectancy, level of development at age five, and the number of children living in poverty (Public Health England [PHE], 2016). 71.5% of the population identified as white British, compared to the England average of 89.3%. The area includes a proportionately higher number of looked after children than regional or national averages (PHE, 2016) and 41.8% of primary age pupils in the study locality were eligible for the pupil premium (Department for Education [DFE], 2016). The pupil premium is government funded and provides free school meals for eligible pupils, as well as extra funding to schools on a per capita basis.

The study locality had a proportionate universal approach to delivery of interventions via the Healthy Child Programme (HCP) from 5 to 19 years (Department of Health/Department of Children, Schools and Families [DH/DCSF], 2009). This programme provides a framework for universal services to be delivered in schools, with additional services for those considered to be most in need. The framework is multi-disciplinary and includes health, education and wider services to support the multifaceted aspects of children’s health. The HCP 5-19 is implemented via the HSP and national curriculum and commences at school entry (4/5-year olds) with a broad health assessment that encompasses children’s emotional and psychological wellbeing, in addition to promoting healthy weight and areas of safeguarding.

To reflect the underpinning multi-disciplinary approach identified in the HCP, a purposive sample of participants included local authority public health commissioners, primary school teachers with responsibility for personal social and health education, school public health improvement workers and school nurse (see table one). Participants were identified by leads within specific workplaces as having experience of school health promotion and being key informants in the locality under consideration. The study was conducted during 2015 and focused on one geographical area within the target local authority. The decision to recruit participants from the primary school setting was guided by the HCP 5-19 programme, which commences at this stage. Potential participants thus would be aware of, and involved in, health education at this important phase in children’s health and development. Nine schools were initially invited to participate in the study, with two responding positively to the offer of staff interviews. This low uptake can be seen to reflect the well-known challenges of undertaking school-based research and the competing commitments of many schools and staff.

[Insert table one here]

*Data collection*

Due to the paucity of information concerning parental engagement from the perspectives of professionals, a small-scale exploratory enquiry using semi-structured qualitative interviews was conducted. Qualitative research enables a more detailed understanding of parental engagement from the perspectives of professionals; insights from which can be used to improve the effectiveness of programmes and support efforts to widen parental engagement in health promotion. The main purpose of the interviews was to elicit the perspectives of health and school staff on the role parents and carers take in health promotion and education initiatives in schools. A semi-structured interview schedule was devised based on a comprehensive review of the existing literature on parental engagement in health and education. The guide was sufficiently flexible to enable participants to identify and discuss the issues most relevant to their area of work and/or experience of working with parents. Discussion topics focused on the following areas to elicit responses around the study’s main aims:

* The professional role of the participant in delivering health education and promotion
* Experiences of working with parents and carers
* Facilitators and barriers to parental engagement in school-based health education and promotion
* Strategies used to encourage parental engagement, including thoughts on the relative success of such strategies.

Ethical approval was obtained from a University Faculty Ethics Committee. Written informed consent was obtained individually from all participants at the time of interview. Participation was entirely voluntary, and respondents were free to withdraw from the study at any point without giving reason. Interviews took place in the participants’ workplace or via telephone. All data were securely secured in anonymised format in line with data protection and ethical requirements.

*Data analysis*

Interviews were digitally recorded and transcribed verbatim by a professional transcription service. Data were analysed thematically based on the approach described by Braun and Clarke (2006). Transcripts were first checked against the audio-files for accuracy. Next, transcripts were read and re-read to identify descriptive codes and interrogate emergent categories. Inductive coding was undertaken by [SA and CP] and involved attaching descriptive labels to each line or section of the text. Codes were compared and discussed by the authors to highlight emergent categories from the data. This stage of the analysis involved drawing together similar codes into categories, which were then considered in relation to the study’s main aim, namely: to examine professionals’ perspectives on parental engagement in school-based health education. The final stages of the analysis involved the interrogation of categories to highlight key themes; defined as an idea or concept that ‘captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set’ (Braun and Clarke, 2006, p.10). Identified thematic areas were then discussed and compared by the authors to identify consistency across interpretations, as well as explore alternative perspectives on the data. Key themes and related sub-themes are given in table two.

[Insert table two here]

**Findings**

Ten professionals participated in interviews all of whom were female. Table one provides the professional backgrounds of participants. Interviews ranged from 16 to 39 minutes with a mean interview time of 30 minutes. Three main themes were identified from interviews: 1) topical health issues for school aged children; 2) successes and enablers to school health education and promotion; and 3) challenges and barriers to parental engagement.

*Topical health issues for school aged children*

Perhaps unsurprisingly, and in line with recent health education initiatives (Arthur *et al*., 2011), all respondents foregrounded the relevance of dominant public health priority areas when discussing their respective roles and the contribution of health education to children’s health. During interviews, participants’ discussed a number of topical health issues for school-aged children including healthy eating, physical activity and oral health. Participants’ concerns about healthy eating often centred on children’s consumption of foods high in sugar and salt, which they reported to be a frequent part of children’s lunchboxes – thus implying some home-level influences on children’s diet when at school. Participants also signalled concerns about the impact of ‘mixed messages’ between the healthy eating curriculum and the broader school environment.

*Healthy eating is a big problem, because often children are consuming lots of fizzy drinks and convenience food and not having a balanced diet…At pretty much all the schools that you go in have highlighted that lunchboxes are an issue. Children have got lots of sugary snacks, they’ve got salted snacks (Participant 9).*

*We’ve had children turn up with lollipops for breakfast (Participant 5).*

Similarly, the importance of physical activity as part of a broader focus on diet and obesity featured heavily in participants’ accounts but was more often discussed as a positive contribution of the school setting to children’s health and their related health behaviours. Ensuring timetabled opportunities for physical activity was seen by participants as a positive component of the school curriculum. Both school nurses and teachers spoke favourably about the renewed emphasis on physical activity within the curriculum.

*The physical activity side of things isn’t too bad, because school provides a lot of that…there’s two hours’ physical activity teaching time. Then there would be extra-curricular clubs after school. There are lunchtime clubs. There are activities at playtime (Participant 10).*

We've got a well-equipped PE [physical education] shed. My year 2s this week for example did archery. We had a couple of people come in and they brought all the archery bows and arrows and that was really fun for the kids ...Today in the hall we've got, I think it's Taekwondo, martial arts (Participant 6).

Despite positive reports of the ways in which the school curriculum supported opportunities for children to participate in physical activity, participants also highlighted the difficulties of engaging some children in sports, particularly for those children who were reported to be overweight.

*I don’t think in terms of PE [physical education] children are doing enough...but actually what I know from support workers and some staff...is that children who are carrying the weight will not join in as much (Participant 1).*

We've had school clubs for those kids that are very sedentary and are clearly overweight, to try and get them active (Participant 6).

Interestingly, the role of parents and home environment more broadly was not discussed in relation to children’s physical activity, despite evidence suggesting the influential role families can play in supporting children’s willingness to engage in exercise (Zecevic *et al*., 2010).

A third key health issue identified by professionals was dental or oral health, including concerns about (lack of) oral hygiene and the need for enhanced dental treatment and care for many children – thus reflecting the recent focus and concerns about children’s oral health as a key public health priority (Marmot *et al*., 2010), but also highlighting the potential absence of home health practices.

*We find that there’s a lot of children that have poor oral health. I was at a school where I think it was like only 50% of the children were cleaning their teeth once a day (Participant 10).*

 *[W]e had 70% of kids not cleaning their teeth in the morning (Participant 6).*

# *Successes and enablers to school health education and promotion*

Despite reporting concerns about children’s health, notable successes in current working practices were also highlighted by participants during interviews. In line with HPS framework, adopting a ‘whole school approach’ to health was described positively by participants. This approach was seen to provide both a ‘vision for health’, as well as equipping staff and students with practical skills to support the enactment of healthy practices.

*[The] school has put health first, they've got gardens where they grow their own food and they cook their own food. Into the curriculum they've woven cookery skills, gardening skills, life skills…(Participant 9).*

The HPS framework underscores the value of school leadership for promoting health in schools and reflects the broader education literature that calls for strong school leadership to support partnerships with parents (Goodall, 2018). The value of strong and sustained leadership for a whole school approach was widely echoed by participants as being critical not only to help truly embed health issues within the curriculum, but also to ensure school practices supported health. Examples of such ‘embedding’ included controlling portion size for school meals and introducing fun, enjoyable and relevant forms of physical activity to children, such as the inclusion of cheer-leading as an exercise class. In addition, the introduction of the healthy school awards (see DfES/DH, 2005) was identified as a key motivator for staff to promote health in schools.

Routine integration of staff across the sphere of health and education was further emphasised by participants. School personnel were considered to play important role models and advocates for health, which in turn was reported to support parental engagement. Parental support workers and teaching assistants were particularly valued for their positive contribution to, and effect on, both parental involvement and engagement. These roles had an outreach element that supported one-to-one interactions with parents– thereby acting as a vital bridge between the school and family and home environment. The active and consistent consultation and engagement with parents was further seen to trigger positive changes to parents’ attitudes towards health messages – and how engaging with parents may support their involvement in school-based health education classes.

*We have a Senior High-Level Teaching Assistant who has direct responsibility for parental engagement and involvement; she's the person persuading parents to come into school and help support in classes (Participant 5).*

*One of the parents we did a case study on recently came from [study locality], and she actually works in a school…she came to the [cookery] course with, and she was one of those people that was really negative when she first came, and just turned it around completely and is a fantastic spokesperson now for all the other parents because she went through all the courses (Participant 2).*

*We’ve had one child who lost two stone in three months…Her mum is outstanding in the way she helped her and she said, I’m quite happy…to go and tell anybody about this and talk to them above what we’ve done (Participant 1).*

# *Barriers and challenges to parental engagement*

Despite providing many positive examples of successful health promotion and engagement with parents, all respondents described challenges. Changes that had taken place to the commissioning of health services in schools and availability of school nurses, financial austerity and the dominant target setting approach (e.g. focus on obesity measures such as recording children’s body mass index) was viewed as having a deleterious effect on the ability to build and maintain partnership arrangements with parents.

*We've been squeezed with the government cut backs. The nurse used to be in every Friday and she used to have various children that she would weigh. She would talk to various kids for one reason or another and they were brilliant at coming in and giving a talk (Participant 6).*

*What we're finding when we go into schools and we say, ‘Well who's your school nurse?’, ‘Well I haven't a clue, I don't know who the school nurse is, they've not been in’. Or Heads get very cross because they'll say, ‘We've not seen them for ages, we have no idea what they're doing. They might drop in, but we don't know they're coming…(Participant 9).*

Statutory requirements placed on schools such as end of Key Stage testing and the OFSTED (The English Office for Standards in Education inspection body)inspection framework created tensions and made it difficult for head teachers to prioritize health in the curriculum. In addition, schools in socially and economically deprived areas were considered to bring specific challenges for inspection regimes, but also as children experienced multiple forms of disadvantage – with negative consequences for their health and education.

*Pressure from Ofsted which is the biggest stick hanging over schools for assessments… maths, English, science, which they [children] do need, but that sometimes gets pushed to the detriment of health education (Participant 9).*

In England, the lack of a statutory basis for PSHE was also seen as being a critical barrier to supporting the integration of health within the curriculum. School respondents (which included PSHE coordinators) commented on the lack of time allocated to the PSHE role. These challenges to the school health curriculum also prompted discussions around responsibilities for health and the respective roles of the school and family environment. During interviews, respondents highlighted a tension between the role of the school and the role of parents in providing health education and related guidance. Participants discussed the difficulties they experienced when seeking to engage with parents and often cited parents’ own health practices as a barrier to school-based health promotion efforts.

*[I]t's the same as alcohol, a lot of parents obviously drink, they get the kids to go to the pub, they tell you that they've been to the pub (Participant 6).*

*Obesity is probably the one that is the most difficult with regards to parents because a lot of parents are either obese themselves or they're in denial about their children (Participant 6).*

 *Smoking, drugs, particularly skunk, cannabis…Many of our parents will smoke cannabis and skunk, and often the kids will come in reeking of it, so that's a big issue (Participant 5).*

Despite often locating the ‘problem’ of parental engagement with parents themselves, professionals did acknowledge the influence and impact of the broader social determinants of health on parents’ participation. Poverty was recognised as being a key factor preventing parents from engaging with school health programmes. During these discussions, participants highlighted the challenges experienced by both families and schools when seeking to mitigate the negative impacts of (multiple forms of) socio-economic disadvantage.

*I think the nature of working in a city like [study locality] that has got high levels of deprivation, it is harder to engage with some parents than it is with others and you sometimes have to start quite small (Participant 1).*

**Discussion**

Findings from this study provide insights into the perspectives of health and education professionals on parental engagement school health education and promotion and highlight the main priority areas professionals identify for supporting children’s health. The results indicate similar issues and concerns across professional groupings, particularly in relation to key health challenges for children and families. Many of the identified issues reflect dominant public health discourse and the wider social determinants of health for school-aged children, including concerns about healthy eating and physical activity (Marmot *et al.* 2010; PHE, 2015).

The tendency to prioritise areas such as diet and exercise indicate professionals’ broader concerns about childhood obesity, and the introduction of strategies such as the monitoring of children’s body mass index in schools. Professionals working with children are increasingly required to monitor children’s health and support the transmission of knowledge about healthy eating and physical activity (Gard and Schee, 2014). Such strategies illustrate how professionals often continue to work within traditional health education frameworks that centre on individual-level factors to support ‘healthy’ behaviour change (Fitzpatrick and Tinning, 2014), and which may account for participants’ readiness to privilege these forms of health education within their accounts. Of interest is the apparent absence of broader notions of health, including the importance of children’s mental, emotional and social well-being. Furthermore, interviews offered few insights into what professionals considered to be parents’ main concerns for their children’s health, which may differ from the areas identified by professionals. This absence may be a product of the interview guide, and the known tendency to uphold dominant discourse within the context of a ‘formal’ interview. Yet such findings also highlight the crucial importance of tapping into parents’ perspectives and understandings of health (and comparing these to the perspectives of professionals). Differential identification and prioritisation of health areas is likely to influence engagement – particularly if health promotion efforts do not resonate with parents’ own health perspectives and priorities. Indeed, research with young people has indicated how their discourses on health can differ significantly from professionals and how such perspectives shape their uptake (or not) with dominant health promotion messages (Spencer, 2013).

Tapping into parents’ understandings of health may help to develop an appreciation of how parents’ own health status and practices can influence children’s practices – a concern echoed within interviews. Parents’ own health-related behaviours are themselves shaped by socio-economic factors (Kim, 2009; Marmot *et al*., 2010; Lewis *et al*., 2011), once again highlighting the multiple and complex influences on children’s health and life chances. Understanding health from a socio-ecological model may be useful here to illustrate the complex and multiple influences on health, including possible impacts on the relative success of school-based health education efforts, particularly if the latter does not resonate with the social worlds and backgrounds children and families occupy.

Whilst privileging a number of topical concerns about children’s health, participants did highlight some of the multiple influences on children’s health and parental engagement, crucially underscoring the effects of poverty and social disadvantage. Of importance was the expansion of parental support workers, who were believed to offer positive role modelling for other parents and encourage successful integration and promotion of parental engagement in school health education and promotion efforts. Findings of this kind reflect evidence from the broader education literature that signals the value of enhanced communication and partnerships with parents to support their engagement (Goodall and Montgomery 2014, Barbour *et al*., 2018). However, as findings also suggest, extending such roles may be compromised by the increasing financial and statutory constraints that shape the school curriculum and environment.

Despite such challenges, our results do offer some insights into possible facilitators that may aid varying forms of parental participation and their broader engagement in school health promotion, including strong and sustained leadership and management; the creation of a whole school approach; and the development of effective engagement strategies with parents and school staff. These identified facilitators are in line with the areas identified in the Public Health England (PHE, 2015) review and underscore the importance of integrated action across multiple levels and the value of rethinking parental involvement in schools to that of parental engagement in broader forms of (health-related) learning (see Goodall 2017). In the discussion that follows, we highlight some of the key implications of this study before concluding with a consideration of some of the possibilities for (and challenges to) school-based health education, including the ways in which parental engagement in school health may be effectively enhanced. The first two areas underscore the ongoing role schools play in health education and crucially, in ways that deliver consistent messages about health. The final area suggests some ways to engage with parents and facilitate critical perspectives on health promotion that extend beyond a prime focus on individual-level factors. We close by returning to our main aim and consider some future directions for research and practice, while acknowledging the limitations of the present study.

*Leadership and management for embedding a whole school approach*

Strong school leadership and management are well recognised in the health and education literature as being pivotal to the uptake of a whole school approach to health promotion, which includes broader engagement with families and local communities (Warwick *et al*., 2009; Arthur *et al*., 2011). Findings reported here underscore the ongoing relevance and role of designated schools leads for health. Importantly, these roles need to address the ways in which learning about health takes places in different contexts, including the home environment, and how ‘health at home’ can support key learning from health education lessons. In recent times such roles are often ‘at risk’ due to competing curriculum priorities and lack of specialist staff in such roles (Lynch, 2015). As findings here demonstrate, developing strong school leadership for health is critical to support staff in the delivery of consistent health messages across the school environment (e.g.by ensuring canteen staff provide nutritious meals for children). In addition, fostering a culture of health in schools requires adequate training and funding of staff across agencies that work in and with schools, to ensure an integrated approach to health education. Without consistency across different learning spaces, children may well continue to receive ‘mixed messages’ about health and best ways to promote it.

*Integration of health promotion and education into the broader curriculum*

Embedding health promotion into the curriculum is crucial (Barry *et al*., 2017) and this study identified areas of good practice where this had been achieved, such as designated time for physical activity (see also Svendsen, 2015). Public Health England (PHE, 2015) highlights the importance of ensuring health education is practical and relevant to both staff and students to facilitate successful uptake of health messages. However, the current curriculum challenges in many government schools in England may set limits to how much and when health is prioritised in students’ learning. The prioritisation of subjects such as English and mathematics lesson, often results in health education being marginalised. Yet opportunities for integrating health (including the social determinants of health) into key subjects could be developed; e.g. by drawing on health-related examples, such as calculating the cost of healthy meals as part of a maths lesson or writing a health diary as part of English. Once again, these forms of health learning could be extended to the home environment and to help children open-up critical discussions with parents about the place of food and exercise in their everyday lives.

*Developing effective working with parents, carers and families*

As we have argued, parents and families play a key role in a child’s current and future health (PHE, 2015). Strategies to improve health education in schools need to further consider how they are taken-up (or not) within other contexts, such as the home environment without attributing blame to parents’ apparent disengagement or regard for health. A deeper appreciation of the limits to some families’ opportunities to engage in health is thus imperative. Developing effective engagement strategies with parents are often compromised by socio-economic factors and the challenges presented by the broader social determinants of health. In Canada, research highlights that parents from low socio-economic backgrounds do participate when encouraged and are offered ‘real life’ education messages and modelling (Rivard and Deslandes, 2012). The importance of role modelling was echoed by professionals in this study and provides one possible effective strategy when working with parents. However, concerns about parents’ own health practices and the discrepancies between health educators’ priorities have been found to hinder relationships (Ross and Mirovsky 2011; Vale *et al*., 2013), with parents reporting feelings of discrimination and judgement (Kim, 2009). Developing effective partnerships and communication strategies with parents will continue to be hindered if a culture of ‘blame’ remains or where responsibilities for health between the school and home environment are conflicted or confused (Patino-Fernandez *et al*., 2013). Evidence of this kind underscores the importance of developing a critical pedagogy with educators and indeed, educating educators about the social determinants of health and how these complex factors manifest in both health practices and outcomes (Marmot *et al*., 2010).

*Implications for school-based health education*

Findings from this study suggest several important practical implications for school-based health education. First, and as described, the strategic development and mapping of health promotion and education across the curriculum and school environment is needed. Strong leadership is required to facilitate this, along with sustainable funding for staff and the school. Developing a sustaining ‘health culture’ in schools requires all school staff to be sufficiently trained across a range of health issues, and crucially how the social determinants of health influence child health outcomes, but also shape the nature and forms of engagement with parents and communities. Developing teachers’ and other school staff’s engagement with critical health education approaches may help to support a more thorough engagement with the socially-located influences on health (such as deprivation) and how these influence children’s and families’ uptake of health education messages (Fane and Schulz, 2017; Wright *et al*., 2018).

Combined training for health and education professionals may help to identify possible strategies for engaging parents in school activities, such as healthy eating and exercise classes. Indeed, the importance of multi-disciplinary and collaborative approaches to successful health education across agencies and parents has been widely documented in the literature (Lam *et al*., 2014, Kolbe *et al*., 2015). Ensuring health education is both accessible and engaging for parents – as well as locally and culturally relevant and sensitive is imperative to the delivery of consistent health messages across the home and school environments for children. Lack of consistency between the school and home will set inevitable limits to children’s own engagement with health education messages.

Second, working with parents for the promotion of children’s health will remain challenging in contexts of multiple disadvantages and where social and economic factors shape life chances and practices. In this study, engaging parents in school health may be aided by designated ‘health workers’ who develop longer-term relationships with parents – indeed, these types of longer-term relationships have been found to be successful for engaging families facing multiple disadvantage in health-related programmes (Boddy *et al.*, 2016; Noonan *et al*., 2017). These health role models can support the building of links between the school and home (mesosystem). Of interest is the idea of engaging with parents to take on these health advocate roles and who themselves may be well placed to provide non-judgemental, informative support for parents. Developing socially critical approaches to health education (Fane and Schulz, 2017; Wright *et al*., 2018) may help to further support an advanced appreciation of the socio-economic challenges some parents face, including how health educationalists and teachers can move beyond traditional behaviour change models and instead, challenge existing health and social inequities through the uptake of critical pedagogies.

Finally, schools could be instrumental in lobbying local and national governments to provide sustained funding and related curriculum support to ensure the longer-term maintenance and embedding of health within the school environment – thereby challenging macrosystem influences. Our findings provide evidence of the importance of integrating health throughout the school setting and to ensure health promotion is prioritised across and through the curriculum and wider school environment in support of children’s health and well-being.

*Study limitations*

Findings reported here provide important implications for the promotion of school-based health education and engagement with parents. This study was carried out in one locality, using a small sample and thus findings may not reflect other localities and perspectives. The perspectives of professionals working within secondary school or high school settings may reveal quite different insights into the opportunities and difficulties of supporting parental engagement in health education. Recruitment of school staff proved to be problematic and we acknowledge that their views may not be wholly reflective of other staff groupings. Some interviews were short in duration, reflecting the competing demands on professionals’ time to devote to ‘non-essential’ activities. In addition, the study did not explore parents’ own views on health education and their related engagement practices and thus, the study provides only a partial account of the issues. Furthermore, and as argued, children and young people’s health perspectives differ from those of adults – both parents and professionals (Spencer, 2013), yet more work is needed to ascertain how children and young people view their parents’ roles and contribution to health promotion. Despite these short-comings, the study demonstrates the importance and centrality of parents and the home environment to successfully school-based health education and promotion and draws attention to the need to develop close partnerships with parents in support of children’s health. Findings reported here provide important foundations for building future enquiry into this much needed area of health education.

**Conclusions**

This study underscores the importance of engaging parents in school health education to promote better child health outcomes. Professional perspectives on parental engagement signal both challenges and opportunities when working with parents and families, particularly in contexts of multiple disadvantage and poverty. Sustained financial and strategic leadership are needed to foster partnerships with parents and to demonstrate a commitment to the improvement of child health practices and outcomes.

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