



Published in final edited form as:

*J Sch Health*. 2014 November ; 84(11): 687–689. doi:10.1111/josh.12204.

## Challenges in and Strategies for the Surveillance of School Health Policies and Practices: A Commentary

Nancy D. Brener, PhD<sup>a</sup>, Howell Wechsler, EdD, MPH<sup>b</sup>, and Laura Kann, PhD<sup>c</sup>

Nancy D. Brener: nbrener@cdc.gov; Howell Wechsler: howell.wechsler@healthiergeneration.org; Laura Kann: lkk1@cdc.gov

<sup>a</sup>Team Lead, Survey Operations and Dissemination, Division of Adolescent and School Health, Centers for Disease Control and Prevention, Mailstop E-75, 1600 Clifton Road NE, Atlanta, GA30329

<sup>b</sup>Chief Executive Officer, Alliance for a Healthier Generation, Formerly Director, Division of Adolescent and School Health, Centers for Disease Control and Prevention, Mailstop E-75, 1600 Clifton Road NE, Atlanta, GA30329

<sup>c</sup>Chief, School-Based Surveillance Branch, Division of Adolescent and School Health, Centers for Disease Control and Prevention, Mailstop E-75, 1600 Clifton Road NE, Atlanta, GA30329

---

Since 1994, the Centers for Disease Control and Prevention (CDC) has been monitoring policies and practices across multiple components of school health through 2 surveillance systems: the School Health Policies and Practices Study (SHPPS), a national survey periodically conducted at the state, district, school, and classroom levels, and the School Health Profiles (Profiles), a system of surveys assessing school health policies and practices in states, large urban school districts, territories, and tribal governments. CDC has encountered several challenges in implementing these systems. In this commentary, we describe the most common challenges encountered and the strategies that CDC has identified to address them. We hope our experiences will be helpful to others interested in monitoring school health policies and practices.

### CHALLENGE #1: DATA ARE NEEDED AT MULTIPLE LEVELS TO HELP SUPPORT DECISION MAKING

State and local education and health agencies require data on school health policies and practices in their jurisdictions to help plan and monitor programs, support health-related policies and legislation, seek funding, and assess professional development needs.<sup>1</sup> Data also are needed at the national level to monitor the nation's progress in these areas. For example, 15 national health objectives from *Healthy People 2020*<sup>2</sup> are related to school health.

---

Address correspondence to: Nancy D. Brener, TeamLead, (nbrener@cdc.gov), Survey Operations and Dissemination, Division of Adolescent and School Health, Centers for Disease Control and Prevention, Mailstop E-75, 1600 Clifton Road NE, Atlanta, GA30329.

#### Disclaimer

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

## Strategies

The need for national, state, and local data on school health policies and practices led CDC to develop and implement 2 complementary surveillance systems, SHPPS and Profiles. Data collected through these systems meet different needs. SHPPS provides nationally representative data, whereas Profiles provides data representative of individual states, large urban school districts, and territories. However, although all states and territories have participated in at least one Profiles cycle, only large urban school districts receiving CDC funding have done so. Other school districts could benefit from data on school health policies and practices in their jurisdictions, however. Therefore, those wishing to monitor progress in school health might consider adapting CDC's data collection instruments and protocols for their own use. They might also consider developing their own instruments using other resources, such as those available from local universities or survey/evaluation research companies.

## CHALLENGE #2: NOT ALL INFORMATION CAN BE COLLECTED USING SURVEYS OF STATE, DISTRICT, AND SCHOOL STAFF

Both SHPPS and Profiles are limited by the knowledge of the respondent. Often, these respondents are not the best source of the information of interest. For example, to understand the quality of health education curricula and instruction, it is not sufficient to ask classroom teachers what topics they are covering in their courses. Knowing only which topics are covered tells us nothing about how those topics are taught and in what context. Similarly, asking principals or their designees to report on the contents of vending machines at their schools can provide general information on what is available (eg, snack items), but these respondents might not know the specific foods and beverages contained in these machines (eg, baked potato chips).

## Strategies

To overcome the challenge of using survey data, it is important to use additional methods of collecting information whenever possible. To improve understanding of what is being taught in the classroom, detailed analyses of curricula and classroom observations provide a more complete picture than teachers can provide in a survey. For example, methods for conducting standardized classroom observations such as SOFIT (System for Observing Fitness Instruction Time)<sup>3</sup> can be developed and refined. In the case of vending machines, having data collectors observe the machines could yield more specific and accurate information than asking school principals or their designees to report on the contents. This technique is being implemented as part of the current (2014) cycle of SHPPS. Data collectors who conduct in-person interviews with school staff are taking digital photographs of the contents of sampled vending machines. These photographs can later be coded with as much specificity as desired, providing more detailed information than what could be provided through a survey. Of course, the downside of using these techniques is that they are more resource intensive. It is important, therefore, to complement survey data with other types of data that might be less expensive to collect. For example, process measures, such as those documenting how many people attended a professional development workshop, are another way to monitor what is happening in school districts. Similarly, whereas success

stories do not quantify data, personal anecdotes can demonstrate progress ([http://www.cdc.gov/healthyyouth/stories/success\\_stories.htm](http://www.cdc.gov/healthyyouth/stories/success_stories.htm) shows examples).

### **CHALLENGE #3: TO OBTAIN SOME OF THE DESIRED INFORMATION, COMPLEX QUESTIONNAIRES ARE REQUIRED**

When assessing school health policies and practices, certain questions are appropriate for only a subset of respondents; other questions need to be repeated for multiple items on a list. Some questions require the use of prefilled variables, such as course names. In addition, respondents sometimes require clarification of complicated concepts.

#### **Strategies**

While Profiles is limited by the use of computer-scannable questionnaire booklets, the computer-assisted technology used in SHPPS allows for complex questions. For example, both the web-based questionnaires used at the state and district levels and the computer-assisted personal interviews used at the school and classroom levels allow the use of intricate skip patterns, prefilled variables, and “loops” in which a series of questions are repeated for multiple items on a list. Furthermore, both types of technology allow for question-by-question clarifications when needed. Weeks<sup>4</sup> provides a review of these methods and their implications for survey operations. Although these methods offer significant advantages over paper-and-pencil methods, their cost obviously can be a drawback.

### **CHALLENGE #4: STATE, DISTRICT, AND SCHOOL STAFF MIGHT PROVIDE SOCIALLY DESIRABLE RESPONSES WHEN COMPLETING QUESTIONNAIRES AND INTERVIEWS**

Often, respondents know which policies and practices are supposed to be in place and might be hesitant to report that they are not implementing them. For example, the Child Nutrition and WIC Reauthorization Act of 2004 required school districts participating in any federal school meal program to establish a local school wellness policy by the first day of the 2006–2007 school year. District staff knowledgeable about this requirement might not be likely to report that their district did not have such a policy in place.

#### **Strategies**

It is important to emphasize to participants that their responses are confidential and not linked with the name of their district or school. It might also be useful to remind them that truthful responses may help improve school health policies and programs in their jurisdiction or nationwide. To the extent possible, questions requiring a “yes/no” response in which the desired answer is obvious should be avoided. For example, a Profiles question designed to assess whether a single individual is responsible for enforcing the school’s tobacco-use prevention policy asks “At your school, who is responsible for enforcing your tobacco-use prevention policy? (A) No single individual is responsible; (B) Principal; (C) Assistant principal; (D) Other school administrator; (E) Other school faculty or staff

member.” A question worded: “At your school, is a single individual responsible for enforcing the school’s tobacco-use prevention policy? (A) Yes (B) No” would be less useful. Another technique to avoid socially desirable responses is to ask specific questions rather than more general questions. For example, instead of asking “Does your school district have a local wellness policy? (A) Yes (B) No”, asking about components of such a policy (eg, “Does your school have specified time requirements for physical education?”) is likely to yield more valid results because the socially desirable response is not immediately obvious to respondents.

## **CHALLENGE #5: USING SURVEYS TO MONITOR POLICIES CAN BE DIFFICULT**

The first aspect of this challenge is that a policy might be “on the books,” but the extent to which specific aspects of that policy are being followed is open to interpretation. For example, a tobacco-use prevention policy might state that “all tobacco use is prohibited on school property.” Even a respondent familiar with this policy might not be certain how to respond when asked whether smokeless tobacco use is prohibited on school buses, because the policy does not explicitly state this. Second, although there is interest in obtaining information on school policies, policies are rarely set at the school level. Although a school would be expected to follow a policy set at the district or state level, it is not clear whether that means the school “has” such a policy. Similarly, a district that follows a state law requiring protection of human immunodeficiency virus (HIV)-infected students and staff from discrimination but does not have its own policy on the issue might respond “no” to a survey question asking whether it has a policy on this topic, but that does not mean that the district is not complying with the law. Such results can be misleading. A third piece of this challenge is that policies tend to be updated regularly, so policy data gathered through surveys might be outdated by the time it is analyzed and published.

### **Strategies**

CDC has established 2 strategies to address the difficulties encountered in monitoring policies. First, when using surveys to assess policies, CDC has included language to acknowledge that policies are not always set at the district or school level. SHPPS questions ask whether a district has “adopted a policy” related to a particular topic and provide the following instructions to respondents: “For the purposes of this questionnaire, ‘adopted a policy’ means either that the district has its own policy or that the district follows a policy established at the state level, including any law, rule, regulation, administrative order, or similar kind of mandate.” Second, CDC has moved to using data sources other than surveys to assess policies. When SHPPS was first developed in the early 1990s, asking state education agency staff about school health policies was the best way to obtain this information. Now, state policies are readily available on the Internet, and even have been compiled into searchable databases (eg, [http://nasbe.org/healthy\\_schools/hs/index.php](http://nasbe.org/healthy_schools/hs/index.php) and <http://class.cancer.gov>). To the extent that these sources are updated regularly, the problem of having outdated information is alleviated. As a result, SHPPS no longer includes questions about state-level policies, and CDC and others rely on other sources for this

information. It is critical, therefore, for those managing these systems to keep those sources updated and continue to broaden the scope of the information available.

Recent publications have highlighted the need for surveillance of school health policies and practices. For example, in explaining the importance of systematic public health policy surveillance, Chriqui et al<sup>5</sup> note that “what gets measured gets changed.” Similarly, Birch<sup>6</sup> calls for the development of a formal research agenda for school health education as a way of “improving professional practice, increasing the perceived value of (school health education) among decision makers and stakeholders, and assuring access to quality instruction for all students.” Such an agenda would necessarily include assessments of policies and practices related to school health education.

SHPPS and Profiles, surveillance systems funded by CDC, provide valuable information on school health policies and practices at the national, state, and local levels. The strategies CDC has developed to overcome the challenges of collecting this information have resulted in high-quality data that are well respected by the field of school health and used by decision makers at many levels. Of course, there is often a trade-off between quality and cost. CDC and others developing ways to assess school health policies and practices are encouraged to strive for obtaining the highest quality data by identifying additional challenges to collecting such data and implementing strategies to overcome such challenges, particularly strategies that do not require large amounts of additional resources.

## References

1. Foti K, Balaji A, Shanklin S. Uses of Youth Risk Behavior Survey and School Health Profiles data: applications for improving adolescent and school health. *J Sch Health*. 2011; 81:345–354. [PubMed: 21592130]
2. US Department of Health and Human Services. Healthy People. 2020. Available at: [www.healthypeople.gov/2020/default.aspx](http://www.healthypeople.gov/2020/default.aspx). Accessed December 12, 2012
3. McKenzie TL, Sallis JF, Nader PR. SOFIT: system for observing fitness instruction time. *J Teach Phys Educ*. 1991; 11(2):195–205.
4. Weeks MF. Computer-assisted survey information collection: a review of CASIC methods and their implications for survey operations. *J Off Stat*. 1992; 8(4):445–465.
5. Chriqui JF, O’Connor JC, Chaloupka FJ. What gets measured, gets changed: evaluating law and policy for maximum impact. *J Law Med Ethics*. 2011; 39:21–26. [PubMed: 21309890]
6. Birch DA. Considerations for a unified research agenda for school health education. *J Sch Health*. 2012; 82(11):493–495. [PubMed: 23061551]