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Trends and Issues in Health Education Curriculum

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Health Education Teacher Resource Handbook

A Practical Guide for K-12 Health Education

**Edited by
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Current Trends

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We would do well to remember that infants do not smoke, do not take drugs, and do not deliberately risk their health for pleasure or convenience. These behaviors are learned and occur much later in life. Our task is to prevent these behaviors from developing.

—G. M. Hochbaum, "Behavior Modification"

Introduction

In 1979, the Public Health Service published *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. In 1980, based on assessment, surveillance data, and hopes for the future, *Promoting Health/Preventing Disease: Objectives for the Nation* was released (U.S. Public Health Service 1980). In this document, health goals for the ten-year period 1980–1990 were specified. Within the document's more than two hundred specified goals, nearly one hundred could be attained through school health programs.

In 1990, a revision of the 1980 health goals for the nation, entitled *Healthy People: 2000*, was released. This document built on the prior successes and failures of Americans to achieve health goals for the nation. Several important concepts were added to *Healthy People: 2000* that had not been included in its predecessor. The document's three guiding principles included:

Increase the span of healthy life for Americans.

Reduce health disparities among Americans.

Achieve access to preventive services for all Americans.

Within these foci were more than three hundred goals specifically directed at health promotion, health protection, and preventive services. As with its predecessor, more than two hundred of the goals in *Healthy People: 2000* could be effected in some way through comprehensive school health programs.

Goal 8.4 has particular relevance for those involved in school health:

Increase to at least 75% the proportion of the Nation's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade quality school health education. (*Healthy People: 2000* 1990, 255)

It is this goal that has driven, in part, the development of this *Health Education Teacher Resource Handbook*. It is our hope that the information

contained herein will aid you—the teacher, administrator, school health service professional, food service worker, or parent—in realizing the importance of comprehensive school health, particularly quality comprehensive school health education. The *Handbook* was prepared for you, to act as a guide, a resource book, and a catalyst, as one way to attain and surpass the lofty goal set forth for school health education for the year 2000.

A Recent History of Health Education

A landmark for school health occurred in 1942 with the publication of *Health in Schools*, by the American Association of Secondary School Administrators. This was followed in 1950 by a publication from the Department of Elementary School Principals of the National Education Association, entitled *Health in the Elementary School*. Five years later, at the White House Conference on Education, representatives of both education and medicine specified fourteen goals, each of which included health as a major component. In 1959, the Education Policies Commission of the States released a statement endorsing health, safety, and physical education as integral parts of both elementary and secondary school curricula.

In 1959, the Education Policies Commission endorsed health, safety, and physical education as integral parts of curriculum.

The elementary curriculum, among other things, teaches the essentials of safety and personal health and promotes physical coordination and skill. The programs of all secondary-school students should include English, social studies, science, mathematics, and fine arts, as well as physical and health education. (National Education Association and American Association of Secondary School Administrators, Educational Policies Commission 1959)

Health educators have historically advocated both health education and healthy environments for students. In the early 1960s, the School Health Education Evaluation Study, sponsored by the Samuel Bronfman Foundation, was designed to “explore the status of students’ health knowledge and behavior in grades 6, 9, and 12” (Sliepecevic 1963). More than 17,000 students from thirty-eight states participated. The primary conclusion was that school health education was “appalling.” Major problems identified were the following:

1. Failure of the home to encourage practice of health habits learned in school.
2. Ineffectiveness of instruction methods.
3. Parental and community resistance to certain health topics.
4. Lack of coordination of the health education program throughout the school grades.
5. Insufficient time in the school day for health instruction.
6. Inadequate professional preparation of staff.
7. Disinterest on the part of some teachers assigned to health teaching.
8. Failure of parents to follow up on needed and recommended health services for children.
9. Indifference toward and hence lack of support for health education on the part of some teachers, parents, administrators, health officers, and other members of the community.

10. Neglect of the health education course when combined with physical education.
11. Inadequate facilities and instructional materials.
12. Student indifference to health education.
13. Lack of specialized supervisory and consultative services. (Sliepcevich 1963, 11-12)

Clearly, the School Health Education Study results indicated that not only curriculum issues were important, but also the integrated approach to family and community at large might be a key to improved status of school health.

In the early 1960s, the School Health Education Study concluded that school health education was "appalling."

In the mid-1970s, what has been called perhaps the single most significant enterprise in school health education since 1960, the School Health Education Evaluation Study (1967), was released. This major curriculum project incorporated ten focal concepts into a framework for school districts to organize a comprehensive school health education program that would be sensitive to the needs and interests of both students and the larger community. The ten concepts included in the School Health Education Evaluation Study have formed the basis for most school health education curricula currently available within the United States.

In 1981, The School Health Education Evaluation Study was conducted to evaluate the effectiveness of four specific curricula. More than 30,000 children in grades 4 through 7 in 1,071 classrooms in twenty states supplied information about overall knowledge, attitudes, practices, and program-specific knowledge. As a result of this study, it became clear that factors influencing the earlier criteria were a well-planned, sequential program, taught in coordination with other disciplines, with planned and continuous in-service programs, readily available resources, and an effective administrative system (Bedworth and Bedworth 1992).

Comprehensive School Health Programs

To promote a healthier population, large numbers of that population must be reached with specific information about the benefits of positive health habits and environments, as well as the opportunities to make a difference in their own lives and the lives of others. The accessibility of segments of any population will determine who is effectively reached.

Likewise, to make a difference for tomorrow's generations, today's generation is a primary target. Future adults are now attending schools. Schools are therefore a primary site for health educators to provide affective, cognitive, and behavioral opportunities to learn. The comprehensive school health concept is based on the premise that "schools could do more perhaps than any other single agency in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more productive lives" (Allensworth and Kolbe 1987, 409).

The anticipated short-term outcomes of established comprehensive school health programs are an improvement in student health-related behaviors and cognitive performance, and long-term outcomes include higher educational achievement and improved health status for Americans.

The Basics

Social learning theory espouses that much of our learning and behavior are directly related to various forms of modeling. As such, it makes sense that children in school will respond better to an environment wherein they see what they are being taught as part of an overall health system. In other words, students give more credence to information about the harmful effects of cigarette smoking when there is no faculty smoking lounge in the building; they better understand the value of good nutritional practices if the meals served at school are nutritionally sound.

In 1987, The American School Health Association presented the results of a special project funded through a grant from the Metropolitan Life Foundation at its annual conference. Those who worked on the project intensively studied eight components of comprehensive school health. The eight components presented included:

1. comprehensive school health education program (sequential, prekindergarten through twelfth grade)
2. school health service programs
3. school health environment
4. physical education
5. school counseling
6. integrated school and community health promotion efforts
7. school food service
8. worksite health promotion at the school for all school employees

The comprehensive school health education program "is designed to motivate and enable students to maintain and improve their health and not merely to prevent disease" (Allensworth and Kolbe 1987, 411). It is highly integrated with all of the other seven components. The curriculum should be sequential, including topics of cardiovascular risk factors and fitness activities, family planning, maternal and fetal health, sexually transmitted diseases, injury prevention, environmental health factors, oral hygiene, alcohol, tobacco, and other drugs, dietary risk factors, and mental health issues.

School health service programs, which typically employ health-care professionals from many domains, such as nurses, physicians, social workers, and speech pathologists, are ideal for screening such measures as high blood pressure, stress factors, dental health, physical fitness, and communicable diseases such as tuberculosis. Primary prevention programming and management strategies for hypertension, obesity, and teen pregnancy and parenting could also be included.

The school health environment includes all physical and psychological elements of the school, from safety features to emotional supports. Some

examples of school environment include, but are not limited to, policies regarding immunization prior to admission to school; no vending machines, or only those that provide healthful foods; fluoridated water source; tuberculosis testing; smoke-free schools; adequate lighting; absence of lead-based paints and asbestos; seating to provide proper body position in computer labs; and safe school buses.

Physical education, particularly noncompetitive varieties, not only helps students to obtain immediate exercise benefits, but also helps them develop exercise patterns for lifetime fitness. Other measures for this component include use of safety equipment in all sports, periodic physical fitness testing, and emphasis on cardiorespiratory fitness activities for lifetime enjoyment.

School counseling can help students to cope with specific problems they might encounter, such as changes in their family structure or a geographic move. It can also give them, individually or collectively, the opportunity to practice skills that will assist them in interpersonal relationships. Psychologists and counselors, available through the school, can be a focal resource for students. High-risk activities, such as smoking, alcohol and other drug use, eating disorders, and suicidal inclinations can all be addressed through the counseling component.

Although schools and the communities they serve are sometimes viewed as separate entities, they are virtually inseparable. Overall support from the community at large for comprehensive school health can yield materials, equipment, and personnel to facilitate any of the other seven components. Interagency networks to coordinate programming strategies, school access to community programs and services that target school-aged children, and community advocacy for youth are all methods to enhance school/community coalitions in the effort to improve the health of students (Allensworth and Wolford 1988).

A comprehensive approach to school meals means that healthful foods will be available through school programs and that students will also have the opportunity to learn how to wisely select their foods. Foods available through schools should be low in sodium, cholesterol, and calories; high in fiber, vitamins, and minerals. Menus should follow USDA/DHHS guidelines. Educating food-service workers so they can respond to student questions during meals is also a contribution to this component.

Faculty and staff often are role models for students, so it is important that they also be afforded the opportunity to maintain and improve their own health status. A school's commitment to comprehensive school health implies a commitment to keep its employees healthy by providing them with opportunities for improved health. Faculty screening programs for blood pressure, tuberculosis, and cholesterol are examples of worksite opportunities to assess health status in specific areas. In addition, faculty programs for activities such as smoking cessation, weight control, stress management, alcohol or other drug use, and physical fitness are all methods to provide a healthy environment for all employees.

Students will give more credence to anti-smoking information when there is no faculty smoking lounge.

Current National Studies and Surveillance

In an effort to monitor the health of school-aged children throughout the nation, a coalition of the American School Health Association, the Association for the Advancement of Health Education, and the Society for Public Health Education, Inc., funded by the Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (DASH), conducted the National Adolescent School Health Survey (NASHS). The NASHS explored health-related knowledge, beliefs, and behaviors regarding eight crucial areas. The areas were injury prevention; suicide prevention; AIDS; sexually transmitted diseases; violence; tobacco, drug, and alcohol use; nutrition; and consumer skills. This survey was administered to more than 11,000 eighth- and tenth-grade students between October and December 1987. When the results were published in 1989, there was further indication that comprehensive school health education and comprehensive school health programs were needed.

Currently, the CDC's DASH maintains an ongoing project known as the Youth Risk Behavior Surveillance System (YRBSS). One component of this system was the 1990 Youth Risk Behavior Survey (YRBS). This survey focused on indicators of high-risk behaviors of adolescents, as derived from mortality and morbidity rates. Six major categories resulted:

1. behaviors that result in unintentional and intentional injuries
2. drug and alcohol use
3. sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended pregnancy
4. tobacco use
5. dietary behaviors
6. physical activity (Kolbe 1990)

The 1990 survey was administered to more than 11,000 students in grades 9 to 12. In all six areas, the study showed great room for improvement. One critical means toward that improvement is to implement comprehensive school health programs. For further information on specific areas, refer to the *Youth Risk Behavior Survey* (Centers for Disease Control and Prevention 1990).

DASH's plan is to

perform the following functions: (1) to focus efforts of relevant agencies on specific behaviors established during youth that cause the most mortality, morbidity, and social problems; (2) to assess whether these behaviors increase, decrease, or remain the same over time; (3) to provide comparable data across six categories of behavior; (4) to provide comparable national, state, and local data; and (5) to provide means to monitor relevant National Health Objectives for the Year 2000 (Kolbe 1990, 48).

To that end, the YRBSS should be a continuing source of up-to-date information regarding the areas most critical to be targeted for health education and promotion in schools.

American Cancer Society Workshop

In 1991, as a response to national educational reform, President George Bush released *America 2000*, as a guideline (U.S. Department of Education 1991). Within this document were six major educational goals for the nation dealing with readiness to learn, school completion, demonstrated competencies, renewed math and science achievement, universal literacy, and safe, disciplined, drug-free schools. As a result of this and other national attention to education reform, the American Cancer Society sponsored a landmark event related to school health in Phoenix, Arizona, in June 1992.

Although schools and the communities they serve are sometimes viewed as separate entities, they are virtually inseparable.

Professionals representing nearly forty national organizations from the disciplines of education, health, and social services, including governmental, voluntary, and professional organizations and associations, met to draft a national action plan. The overall goal was to promote comprehensive school health education as a critical component of a national effort to meet the growing education and health-care needs of America's youth. This meeting was historic for dual reasons. First, it was the first time that all the diverse national-level organizations, agencies, and associations had ever met. Second, it was the first time that a national-level workshop dealing with comprehensive school health education had been conducted for the specific purpose of drafting an action plan to move comprehensive school health education from a theoretical concept to a national reality.

The purpose of the meeting was threefold:

1. Develop a practical, collaborative plan to institutionalize Comprehensive School Health Education for all school-age children nationwide.
2. Establish a means by which Comprehensive School Health Education can reach and involve the entire spectrum of people from the national level to the nation's classrooms, to directly affect school children and youth.
3. Develop a practical set of collaborative steps for endorsement, implementation, evaluation, and followup of Comprehensive School Health Education in areas including public policy, advocacy, training, and effective instruction. (Seffrin 1993, 9)

From the Phoenix workshop, a national action plan evolved that is available to school districts through their local chapter of the American Cancer Society. This plan contains specific measures that can be taken by school and community personnel to help ensure that comprehensive school health education can become a reality. (For a more complete discussion of the 1992 American Cancer Society Phoenix Workshop, see Seffrin 1993.)

Keeping Up to Date

A Joint Committee of the American School Health Association and the Association for the Advancement of Health Education (1992) has suggested that all preservice elementary teachers should be exposed to the concepts and methods of teaching school health. In general, elementary teachers should be able to communicate the concepts and purposes of health education; assess

health instruction needs and the interests of elementary school students; and plan, implement, and evaluate school health instruction. If these skills are not developed in the preservice professional preparation of the elementary teacher, then in-service education programs should be conducted so that elementary teachers are able to perform these roles.

For secondary teachers, particularly when health instruction is a separate course, the consensus is that the health course should be taught by a qualified (preferably certified) professional health education specialist. This would mean that the individual has a major in health education or health and physical education, or has a minimum of a minor in health education during his or her preservice professional preparation. Regardless, the areas that should be included in the preservice professional preparation of health educators would be:

- direct health content
- related health content
- educational skills
- orientation to the profession
- demonstration of skill and knowledge

In-service education, although the responsibility of the school administration, may be initiated through requests from the teachers as well. The estimated "life span" of a health fact is only five years. If this is the case, it is critical that teachers keep abreast of these rapid changes. A good program of in-service education for teachers can help boost morale, help teachers keep abreast of new developments, and help keep the comprehensive school health education program dynamic.

There are many ways teachers can keep up to date in health education. Obviously, in-depth in-service education provided at the school site is an excellent means of keeping current. Teachers might also suggest that the school subscribe to selected professional journals. Another is to attend conferences and workshops that are held in the region. Several national organizations have state-level affiliates that conduct annual meetings. In addition, the teacher may wish to join a professional association that has health as a focal point.

Regardless of the method the teacher uses to stay current, it is important to remember that the goal of keeping up to date is to improve the health instruction delivered to children. By participating in in-service programs, reading professional journals, attending health-related conferences, and conducting a self-evaluation of the methods that he or she uses in the classroom, the teacher can remain current and keep the health education class dynamic for our nation's most precious resource, its children.

Commitment to comprehensive school health implies a commitment to keeping school employees healthy.

The Challenge: Controversial Subjects

It is clear from the abundance of information and increase in national awareness that we are making some movement toward initiation of comprehensive

school health and comprehensive school health education. Our nation's leaders, on many fronts, are acknowledging the importance of these measures. How does that translate for those who work "in the trenches"? Basically, it means that the battle is probably just beginning. Advocacy at every level is critical. The relationship between national initiatives and "sex, drugs, and rock 'n' roll" on the local level can be obscure, and frustrating for those who feel they are receiving little or no support for their health education or comprehensive school health efforts in their own back yard.

Teaching health is intrinsically different from teaching math. The math teacher will probably not have to defend a decision to teach a specific progression of information, whereas health educators must continually be aware of the demand for sensitivity and accountability, not only to their students, but also to parents, teachers, and the community at large. Philosophically, there are many avenues to health education, ranging on a continuum from the philosophy that no controversial subjects should be taught in school, that they should all be learned at home from loving, well-informed parents, to the belief that students need to be armed, through comprehensive school health education, with the facts, all the facts, about hazardous health behaviors in order to make the best possible decisions about their own lives.

In the final analysis, health educators as individuals must come to their own levels of comfort with their own situations. We are not all crusaders, but we all do have a basic responsibility to our students. The fact that we may have to leave our personal "comfort zones" to tackle the controversial areas is a clear and omnipresent charge. Convincing others in our communities that a healthful school environment is critical may be an overwhelming task for some.

It is not a secret that we all have our own biases about health issues and health knowledge. Developing our own personal philosophies of teaching health is the basis on which to build larger and longer-reaching programs. Recognizing our own biases and putting them aside in order to provide the best coverage of information is the key. We need to be aware not only of what we teach but also of how we teach it. Comprehensive school health education is the critical framework from which to develop our teaching strategies.

In this sense, the process we experience can serve as a model for our students. Teaching students the information they need to make informed decisions about their health behaviors within a planned, sequential program, is one component. Giving them the opportunity to explore how they feel about those behaviors, as well as allowing them to practice refusal and decision-making skills and to initiate healthy behaviors within that same framework, provides them with the best opportunity for healthy lives.

Regardless of a personal stance on controversial topics, it stands to reason that a young person who understands the facts will have a better chance at making reasonable decisions than one who is uninformed. The issue for us in acting as advocates for comprehensive school health education is that we cannot afford not to promote a mechanism that allows for a healthy, well-informed population.

How can you accomplish these seemingly overwhelming tasks? There are resources available to you. You can refer to the research that has been done,

The estimated life span of a health fact is 5 years; teachers must keep abreast of rapid changes.

demonstrating the benefits of comprehensive school health and health education. You can work as a part of your community to introduce new concepts, techniques, strategies, curricula, and even philosophies to community leaders who can provide you with the political support you will need. Such people might include those in leadership of community organizations, professional societies and private medical and dental practice, official and voluntary health agencies, service clubs, private industry, youth groups, and parent-teacher associations.

When you are planning to teach controversial material, whether it is a part of a commercially available health education curriculum or whether you are teaching a particular topic such as sexuality or alcohol and other drug use, you need to carefully review what is out there. Invest a bit of your time in discovering what is available. Share it with others in your district. You may want or need to bring it before a committee of community members and parents. You may want to offer the opportunity for a public meeting about the curriculum.

Upon close examination, comprehensive school health education, like other areas of the school curriculum, requires planning in order to develop a logical sequence throughout the school years. It requires trained teachers, current curricular materials, adequate time, futuristic thinking, and sufficient resources if it is to be effective.

The short- and long-term dangers of unintended adolescent pregnancy, sexually transmitted diseases, alcohol and other drug use and abuse, and suicide—to name a few—are real. The potential short- and long-term benefits of health awareness, information-based decisions, and healthy choices are also real. Those of us in a position to help our children differentiate between the positive and the negative, and to act accordingly, have an obligation to do so. It is our hope that this book will provide you with the resources to accomplish your goals.

We cannot afford *not* to promote a mechanism that allows for a healthy, well-informed population.

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