PLANNING AND IMPLEMENTING

Health Education in Schools

MARIO

PLANNING AND IMPLEMENTING Health Education in Schools

MARION POLLOCK
with Chapter 6 by Evalyn Gendel
with Chapters 9 and 10 by Peter Cortese

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Dedicated to the memory of Delbert Oberteuffer... whatever the role... teacher, writer, editor, mentor, charismatic speaker and actor... he was the best. His philosophy and vision continue as lodestars for school health educators today.

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Foreword

This is the kind of book that health educators have been seeking and not finding—a *complete* and *even* treatment of planning and conducting health education in the school setting. There is solid theoretical and practical material on the complete range of topics for the study of school-based health education programs: the rationale, the factors and forces that influence the nature and scope, considerations in developing or selecting curriculum and teaching methods, and specifics on how to go about evaluating the outcomes.

The text will be most appreciated by experienced faculty members who find in it substance that is often lacking elsewhere. There are exceptionally complete and lucid presentations of philosophy, law, curriculum development, community controversy and evaluation—topic areas that are often slighted or omitted.

It is tailor-made for the professional preparation of health educators at the undergraduate level but sophisticated enough for graduate or in-service courses. The questions, exercises, and references at the end of each chapter make the teacher's job easier. And the availability of appendices with current statements about comprehensive school health programs, health services, and responsibilities of the generic health educator save much searching for important supplementary material.

The book is also an appropriate resource for use by school-community committees and coalitions.

Marion Pollock and her collaborators, Evalyn Gendel and Peter Cortese, all eminent health educators and teachers as well, have produced a highly professional book. In the hands of an expert teacher who can add examples, stimulate discussion, and inspire confidence, it can go far in improving the quality of that basic of basics: health education in schools.

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New York University
July 18, 1986

Preface

This textbook has been written primarily for students enrolled in colleges and universities offering at least an undergraduate major in school or community health education. The theory and practical examples of its application provided throughout will also be useful to graduate students of health education, those teaching health as a secondary assignment, principals and others responsible for school administration, and health care professionals employed by schools. For example, school administrators, members of boards of education, school physicians, school nurses and nurse practitioners, and public health personnel whose responsibilities include the provision or supervision of certain health services or care in schools.

Although the book focuses on the practice of school health education in secondary schools, this is because health instruction as a separate class is seldom if ever scheduled in elementary schools. Any health teaching done below the sixth grade is provided by elementary teachers along with all of the other basic studies. However, the skills and procedures employed in the development of a curriculum for health education, whatever the level of schooling, are exactly the same. Usually such curriculum plans, as developed by a school district or state office of education, build upon sets of long range goals whose achievement is expected as the result of the subsumed objectives proposed for each grade, K through 12. In that sense, secondary school health curricula are an extension of that planned for elementary grades and dependent in many ways upon the quality and comprehensiveness of the health education provided in those earlier years.

Planning and implementing are in some ways discrete and in other ways inseparable sets of activities. Planning health education curricula must be based upon assessment of individual and community needs. Its principal procedures involve date gathering, synthesizing, and decision making. Implementing is concerned with designing, managing, and evaluating the success of the activities or interventions provided as appropriate and valid means

of achieving the purposes of such plans. There is, therefore, inescapably a circularity between them. However carefully plans are made, it is the implementation stage of a program that tests their worth and feasibility. Evaluation of the results of a curriculum or program means some amount of replanning and that in turn means redesigned objectives and activities, more evaluation and so on.

School health educators have long been required to learn how to plan lessons and develop curriculum materials at least for their own use. Similar coursework has seldom been required of community health educators. Very few have been persuaded that there was value in taking such a course because "community health educators are not going to be teachers." It is the thesis of this book that the skills particular to curriculum development and pedagogy are not, however, the exclusive responsibility of school health educators. Health education means education for health. A health educator needs to know how to plan and carry out educational programs capable of promoting health. As Mabel Rugen has remarked sagely, "I found out early in my career that school health people and community health people do much the same things. They just use different words when they talk about it."

Every health educator needs to know how to plan and implement health education because differences in settings or in the subject matter of interest don't change the processes involved. There are other reasons. First, children don't spend all of their time in schools. They do encounter health education in the other settings. That education ought to be based upon knowledge of what is being provided or not provided in the schools, and it needs to be planned with care so that it complements, reinforces or if necessary supplements school programs. Second, health educators of all kinds often serve as resource persons for schools: as consultants, demonstrators of health related techniques such as cardiopulmonary resuscitation (CPR), guest speakers on specific topics, or providers of field-trip experiences designed to acquaint students with community health facilities. Third, community-based health educators are more and more participating in local- and state-level curriculum decision making and in developing curriculum guides for classroom teacher use. That means that they have to know how to prepare meaningful and measurable instructional objectives appropriate to the needs and abilities of specified students. They also have to know how to design learning and evaluation activities that match those objectives. Just as importantly, they have to be aware of the constraints under which health teachers work if they are to avoid causing controversy or criticism of their teaching or the school.

Further justification is explicit in the description of a proposed undergraduate health education curriculum that would develop a "generic health educator." The generic health educator is hypothesized as the individual

whose professional preparation has not been biased in favor of any of the settings and who theoretically could perform acceptably in any of them, albeit in a subordinate role without further study and experience. Four of the seven areas of responsibility specified as essential in the professional preparation of the generic health educator include the following:

1. Assessing individual and community needs for health education
2. Planning effective health education programs
3. Implementing health education programs
4. Evaluating the effectiveness of health education programs

These happen also to be the focus of much of this text, not because the text has been written to conform to the logic of the framework, but because the framework adheres to the state of the art.

School health education is not synonymous with the school health program. A comprehensive school health program involves far more than provision of health instruction. It involves every teacher and all of the school personnel. It also encompasses many health services and environmental arrangements designed to promote and protect the health of both students and staff while on campus or en route between home and school. It should be noted that, as indicated by the title, this text is concerned almost entirely with curriculum and instruction. Each of its chapters has been written so as to lead logically from the first, which presents a rationale for the provision of health instruction in schools, through the last two chapters, which discuss the role of administrators and the community in determining the quality and nature of the curriculum.

The intention has not been to tell you *what* students should be taught about health and health behavior. Rather it has been to explain how to plan and carry out meaningful and effective health instruction, whatever the setting in which it is provided. Secondarily, it has been our intention to provide health instructors intending to work in other settings an understanding of the special goals, constraints, and techniques with which school health educators must be concerned. Surely communication among health educators will be facilitated and the quality of their collaborations enhanced when all of them, not just school health educators, have had an opportunity to work with curriculum planning.

The book has not been written for some safely ambiguous reader or student, but for you. You will often be asked to pause and think about what has been said or explained and to make a decision about it before you go ahead. The intention of the book is to instruct, and the questions and the exercises at the end of each chapter are there for you to test your comprehension of what you have read. Most of them can be done, but need

not be done by yourself. Some of the exercises may be more interesting if you collaborate with a few classmates. If you understand what you have read, all of the questions and exercises should be easy for you. Don't look for the answers in so many words in the text. What is wanted is evidence of your ability to apply what you have just learned in a new situation so that your answer is not an echo but an application of your own. Any items that give you trouble are indicators that related sections of the chapter may need to be reviewed. Having done that, if you still have difficulty we would appreciate your telling us about it.

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Many people have helped, either directly or indirectly, to move this book along the road between proposal and completion. I am deeply grateful to every one. First and foremost among them, in terms of primacy and impact, was the late Delbert Oberteuffer. In a very real sense, it is his book, too. Obie participated actively during the first stages of its development, reacting to the preliminary outline and suggesting specific sections of his prior works that he very much wanted to see updated and included. What he wanted to do at this point in his career was to edit and to advise. And that is what he did, as long as he could. His support and encouragement as the project was begun were as prized as they have been sorely missed.

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Finally, I am grateful to all of the health educators and educational theorists whose writings have together shaped the organization and content of this book. I wish that it were possible to acknowledge every one of them, as well as of the faculty and students who together have taught me all that I know about health education. But if that is not feasible, let me admit with all humility and sincerity that, in a way, this is their book, as well.

Marion B. Pollock

Contents

1
A rationale for health education in schools

Health education is health education whatever the setting in which it is practiced. Today those settings are usually categorized as school, community, clinical, and business or industrial. Undergraduate programs designed to meet the need for professional health educators tend to focus either on school health or community health. Those who major in community health can serve as health educators in any of the last three settings. Those who major in school health are unique in that they are qualified to hold positions in any one of them. Although both programs prepare students to be health educators, only the school health major requires certain courses and field experiences focused specifically on teaching skills.

Preparation for health teaching in schools is much like that in community, clinical, and work site settings in most ways, yet different in some ways. For example, school health education is more concerned than the others with learning theory, pedagogy, and immediate evaluation of results. School health educators are more accountable to the community for the nature and acceptability of their activities. Health education is more closely scrutinized for its content and methods than any other subject commonly taught in schools. Unlike the

target groups in other health education settings, students constitute a captive audience. Parents and taxpayers have the right to question how and what children are being taught. The concern is that teaching activities do not intrude on family privacy or provide information not appropriate for any particular age group.

Children may not attend school unless their health has been certified by a physician. Effective health education designed for a healthy young audience in schools must be more comprehensive in scope and involve the learner more directly in the learning experiences than in the other settings. The target group includes the total population of youngsters of school age, not just groups defined by a common health problem or need. As of this writing, only school health education specialists are expected in most states to be credentialed if they wish to be full-time teachers.

This book focuses on health education as it is taught in schools and has been written for school health education majors. Yet there are many good reasons why every health educator should be equally as familiar with its content. First, almost all the concepts and skills required of school health educators are also needed by health educators in any setting. Second, schools are part of the community, and school health programs can be depended upon to complement and promote adult health education programs in community settings. The reverse is also true. Only if community and other health educators understand the purposes and methods engaged in by their colleagues in the schools will the kind of collaboration and cooperation needed to promote the health of the nation be possible. Adolescents will soon be the adults whose decisions and actions can significantly enhance or compromise the health of their families, neighbors—even the health of their entire community. Third, health educators in all settings are increasingly serving as consultants to schools and boards of education when curriculum guides are being developed or revised. Knowledge of community health problems is not sufficient background for curriculum development. Construction of teaching-learning guides requires a grasp of curriculum theory and special skills in curriculum development. Fourth, teaching materials specific to certain health problems (e.g., cardiovascular disease, drug and alcohol abuse, sexually transmitted diseases, and tobacco dependence) created and provided by health educators and agencies outside the school need to be educationally sound and appropriate for use with the specified age group.

In sum, sooner or later every health educator finds it necessary to participate in planning for health instruction. There is much more to curriculum writing than outlining the subject matter that describes a health problem. Health instruction is not merely providing health-or disease-related information. Beyond the subject matter, there must be meaningful and feasible objectives, worthwhile learning opportunities, effective organization and administration, and evaluation

of results. Without good planning, there cannot be successful implementation of any program of health education, whatever its setting.

THE ORIGINS OF HEALTH EDUCATION

Health education had its beginnings in schools in Massachusetts under the leadership of Dr. William A. Alcott, an influential writer and educator, Horace Mann, the first secretary of the first state board of education in the United States, and other prominent educators early in the nineteenth century. Alcott, called the "father of school health education" in the United States, wrote a prize-winning book on the healthful construction of schoolhouses in 1829, was the first to suggest that schools should have an attending physician, and was the first to write a health book suitable for children. Horace Mann, probably the most influential educator of his day, strongly recommended that physiology and hygiene be included in the curriculum of the common (elementary) schools in all six of his annual reports between 1837 and 1843. He said: "The study of Human Physiology, however—by which I mean both the Laws of life, and Hygiene or the rules and observances by which health can be preserved and promoted—has claims so superior to every other, and, at the same time, so little regarded or understood by the community, that I shall ask the indulgence of the Board, while I attempt to vindicate its title to the first rank in our schools, after the elementary branches." He gave direct responsibility for this to the schools, adding, "I see no way in which this knowledge can ever be universally, or even very extensively diffused over the land, except it be through the medium of our Common Schools" (Means, 1962, p. 34).

Subsequently, in 1850, Massachusetts became the first state to require physiology and hygiene by law as a compulsory subject in all the public schools of the commonwealth. That same year Lemuel Shattuck's famous Report of the Sanitary Commission of Massachusetts gave school health education further strong support. Although the Shattuck report dealt with public health concerns, he had been a teacher and served as a member of the school committee charged with reorganizing the public schools in Concord, Massachusetts. It was not surprising that he saw the implications for school health in the recommendations made by the Sanitary Commission. He said:

> Every child should be taught early in life, that, to preserve his own life and the lives and health of others, is one of the most important and constantly abiding *duties*. By obeying certain laws, or performing

> certain acts, his life and health may be preserved; by disobedience, or performing certain other acts, they will both be destroyed. By knowing and avoiding the causes of disease, disease itself will be avoided, and he may enjoy health and live; by ignorance of these causes and exposure to them, he may contract disease, ruin his health and die. Every thing connected with wealth, happiness and long life depend upon *health;* and even the great duties of morals and religion are performed more acceptably in a healthy than in a sickly condition. (Means, 1962, p. 44)

Between 1880 and 1890, the Women's Christian Temperance Union led by Mary Hanchett Hunt was successful in motivating thirty-eight states and territories to pass laws mandating certain aspects of health teaching described as "the evil effects of alcohol, tobacco, and narcotics."

By 1921, Charles Chapin, superintendent of health in Providence, Rhode Island, freely admitted that schools and departments of education were more systematic in their approach and accomplished more with their health teaching than did the public health departments of the day. At that time, public health education was limited to propaganda, pamphlets, and publicity. (The present-day Public Health Education section of the American Public Health Association was titled the Section on Health Education and Publicity when founded in 1921.) Eventually, public health workers began to move away from propagandizing to adopt the schools' more successful organized teaching in their work with adults. So it was that education for health began in the schools and has been expanded first to community and by now to clinical and industrial settings.

Professional preparation of health education specialists began during the 1920s. The first undergraduate degree in school health education was granted by the Georgia State College for Women in 1923. In that same year, the first specialist preparation program in a U.S. school of public health was given by the Harvard-Technology School of Public Health (a short-lived alliance between Harvard and the Massachusetts Institute of Technology). The degree was a CPH (Certificate of Public Health), later changed by Harvard to the now familiar MPH, entitling the recipient to work either in school health or public health education fields (Means, 1975, p. 178).

Separation of health education into two fields of concentration—school health education and adult health education—is first mentioned as having been established at the University of Michigan in 1935. The latter field was soon renamed public health education (Rugen, 1972, p. 9). By 1950, a national survey revealed that students could major in health education in a total of thirty-eight institutions of higher education. Today more than three hundred colleges and universities offer professional preparation programs

in school or public health education at undergraduate or graduate levels or at both.

WHAT DO WE MEAN BY "HEALTH"?

Does that seem like a foolish question? Surely everybody knows what health is, or at least what it *isn't*. Nevertheless, nobody yet has been able to devise a definition that is clear-cut and comprehensive enough to gain universal acceptance. Statements describing health range from the comfortably direct "Health is what enables a person to be what he wants to be and to do what he wants to do" (Hochbaum, 1978, p. 33) to more elaborate statements such as "Health is a dynamic, ecological resultant involving the interaction of many complex predisposing, precipitating, and perpetuating factors and conditions" (Hoyman, 1965, p. 114).

Health has also been referred to as "high-level wellness," "biological well workingness," "a comprehensive, generalized concept, not a fact," a "positive direction or position on a theoretical continuum between wellness and death," and perhaps most often as "not being sick." Analysis of those definitions most frequently cited in the literature reveals a number of common elements. Let's look at a few that might be considered representative of current beliefs.

First, if there *is* a universally accepted definition, it has to be that of the World Health Organization (WHO), which has been approved by every one of its member nations as they joined over the years since its founding in 1947: "Health is a state of complete physical, mental, and social well being and not merely the absence of disease and infirmity." When that was written, it was far from earlier notions of health as a state of being, determined by the lack of discernible disease or infirmity. Moreover, it was the first to specify dimensions of health other than the purely physical. The definition has often been criticized as describing health in terms that are impossible to achieve. Nevertheless, it was a landmark statement and remains the official statement for most of the world. Other definitions, devised more recently, include:

"Health is the condition of the organism which measures the degree to which its aggregate powers are able to function" (Oberteuffer, 1960, p. 47).

"Health can be regarded as an expression of fitness to the environment, as a state of adaptation" (Dubos, 1965, p. 350).

"Health is a quality of life involving dynamic interaction and interdependence among the individual's physical well being, his mental and emotional reactions and the social complex in which he exists" (School Health Education Study, 1967, p. 10).

"Health is a state of well-being sufficient to perform at adequate levels of physical, mental, and social activity, taking age into account" (Lalonde, 1974, p. 6).

"Health is the quality of physical, psychological, and sociological functioning that enables the individual to deal adequately with self and others in a variety of situations . . . a dynamic and relative state of functions (Bedworth and Bedworth, 1978, p. 347).

"Health is a relational concept . . . not an entity that can be directly promoted but a relationship between capacities and demands" (Baranowski, 1981, p. 254).

"Health is the capacity to cope with or adapt to disruptions among the organic, social, and personal components of the individual's health system." (Bates and Winder, 1984, p. 36).

Some of the terms that recur in these statements seem to view health as a *quality* (e.g., dynamic, multidimensional, interdependent, relational). Others perceive health as an indicator of successful coping abilities (e.g., adaptation, interaction, functioning, performance). In essence, these definitions are more alike than they are different. All of them reflect a notion of health as an active rather than a passive concept, as optimal functioning, as wellness, and as indicating a strongly positive position on a continuum of well-being.

Inasmuch as "health" as described is the goal of health education, the selection of subject matter for health teaching logically focuses on health promotion rather than on information about the disease of the month or year and its prevention. Study of anatomy and physiology or the etiology of certain diseases is not the stuff of health education unless that information is demonstrably essential to the promotion of health, never as an end in itself.

WHAT IS HEALTH BEHAVIOR?

Probably every purposeful human reaction or goal-directed action is to some extent health related or health directed. If that is true, then everything we do is health behavior. McAlister (1981) defines health behavior more specifically as "any action that influences the probability of immediate and