SEVENTH EDITION

TURNER'S School health and health education

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School health and health education

Clair E. Turner

1890-1974

Professor Turner's career spanned more than 60 active years. This book and *Personal and Community Health* are his best-known written works. Through the previous six editions of this text and the fourteen editions of the other, thousands of students have obtained health information and attitudes relevant to their personal lives, and many were motivated to enter careers in school or community health education.

Dr. Turner was a distinguished teacher, researcher, and doer as well as a writer. At MIT he taught the first course in health education ever offered in a school of public health and originated the first program leading to the Master of Public Health degree in health education. His studies and demonstrations in the Malden, Massachusetts schools during the 1920's laid the foundation for much of what is done in the field of school health and health education today. During and after World War II much of his effort was directed to the improvement of international health, primarily through his work with the World Health Organization and UNESCO. He was the first president and chief advisor of the International Union for Health Education, as well as the honorary president of that organization from 1968 to 1974, and was active in and honored by a host of other health-related organizations.

It was therefore with some sense of awe that we undertook the task of rewriting and revising *School Health and Health Education*. Our trepidation was not lessened by the social context in which we write, a time of rapid social change, much of which is of a discouraging nature. We were deprived of the benefit of Professor Turner's wisdom and criticism by his death. Any deficiencies are to be charged to us, not to him.

Preface

In this edition we have provided new and updated information. In addition, we have tried to relate the principles and practices of school health and health education to conditions prevailing in American schools and society. Pursuit of this goal has resulted in content less didactic and more issue oriented than that presented in other and earlier school health program texts. The new emphasis on the individuality of children and youth led us to depart from the style of writing characterized by the phrase "the child is." We have also tried to avoid sex role stereotyping. We hope instructors and students who use this text will be more comfortable in doing so as a result.

Rejection of the notion that school professionals should accept without question the dictates of restrictive school and health laws, the orders handed down from on high by authoritative administrators, and the demands of vocal but unrepresentative citizen groups led to the inclusion of two chapters dealing with law, public relations, and administration. Recognition of the importance of school social climate to mental health resulted in a separate chapter devoted to the subject. Affective education has been given greater prominence in this edition, since it is now increasingly practiced in schools.

At the cost of some repetitions, we have attempted to write the book in such a way that instructors may omit selected chapters or sections or may assign chapters in varying sequence at little risk of failing to cover essential principles.

We wish to thank the thinkers and researchers whose work has contributed to the book, our families, and typists Frances Greene and Allan Older.

Frank H. Jenne
Walter H. Greene

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PART ONE

Nature and development of school health and health education

CHAPTER 1 ❦ Place of health in today's schools

School health and health education is at once rewarding and frustrating work. It is rewarding to watch a child or young person improve in health, appearance, and behavior as a result of your efforts as a teacher, nurse, dental hygienist, or other school professional. It is frustrating to view the collapse of your work and plans as a result of your own failure or the apathy, prejudice, or ignorance of some parents, community leaders, or school administrators. The broad purpose of this book is to increase your likelihood of professional success in improving both the health of children and youth and your own job satisfaction.

WHY SCHOOL HEALTH AND HEALTH EDUCATION?

Schools exist for several reasons. First among them is to transmit the culture to the young through organized learning experiences. But schools also serve as agents of cultural change by changing the content of instruction in line with changing knowledge, social needs, and values. Another purpose of schools today is to serve as surrogate homes, with teachers as parents. This function keeps young people out of the job market and permits both legal parents to work or to perform other social roles. School health and health education are intimately involved with and essential to both of these purposes.

Health, schools, and learning. Health is an important part of our culture. Unlike the Christians of ancient Rome who despised the body, we care for it through an elaborate system of health products, information, and services. We recognize and have names for many different kinds of illnesses, just as the Eskimos are said to recognize and have names for many different kinds of snow. By the World Health Organization's definition we have gone beyond the idea of health as the mere absence of disease or infirmity and have embraced the notion of health as a state of positive and total well-being.

School health and health education serve to perpetuate both the system and the ideal. One of their objectives is to assist children and young people in entering the health care system for care related to health promotion as well as for the diagnosis and treatment of health problems. Another is to teach the value of positive health and the known means of promoting it as well as to develop skills in the choice and use of health products and services.

A classic statement of the objectives of general education is to be found in *A Design for General Education,* which says with reference to health that general education should lead a student "to improve and maintain his own health and take his share of responsibility for protecting the health of others." In further elaboration of this primary health objective, the report states:

> In order to accomplish this purpose the student should acquire the following:
> A. Knowledge and understanding
> 1. Of normal body functions in relation to sound health practice
> 2. Of the major health hazards, their prevention, and control
> 3. Of the interrelation of mental and physical processes in health
> 4. Of reliable sources of information on health
> 5. Of scientific methods in evaluating health concepts
> 6. Of the effect of socio-economic conditions on health
> 7. Of community health problems, such as problems related to sanitation, industrial hygiene and school hygiene
> 8. Of community organization and services for health maintenance and improvement

B. Skills and abilities
   1. The ability to organize time to include planning for food, work, recreation, rest and sleep
   2. The ability to improve and maintain good nutrition
   3. The ability to attain and maintain good emotional adjustment
   4. The ability to select and engage in recreational activities and healthful exercises suitable to individual needs
   5. The ability to avoid unnecessary exposure to disease and infection
   6. The ability to utilize medical and dental services intelligently
   7. The ability to participate in measures for the protection and improvement of community health
   8. The ability to evaluate health beliefs critically

C. Attitudes and appreciations
   1. Desire to maintain optimum health
   2. Personal satisfaction in carrying out sound health practices
   3. Acceptance of responsibility for his own health and for the health of others
   4. Willingness to make personal sacrifices for the health of others
   5. Willingness to comply with health regulations and to work for their improvement*

The source of these statements indicates that school health and health education serve the general education purpose of the schools. Thoughtful consideration shows that the objectives are as valid today as they were three decades ago when they were written. Their interpretation, however, varies in the 1970's from their interpretation in the 1940's. At that time newly discovered antibiotics, pesticides, and other medical and environmental control materials and techniques were ready to be applied to combat disease and premature death. Today we are confronted by problems of overpopulation, food and other resource shortages, and overproduction of economic goods and their resulting pollutants, as well as by personal psychosocial problems related to drug use and sexual behavior. These problems threaten both the quality and continued existence of human life on this planet within the foreseeable future.†

Other and older aspects of health affect learning, and practices of both individuals and schools affect health. Acute hearing, for example, facilitates learning. An undetected, untreated ear infection can damage hearing, and the school health education program can facilitate early detection and treatment of ear infections. Location of a school within a mile of a busy jet airport can also damage hearing, but such a location is preventable by knowledge of the hazard and intelligent school-community planning.

The reports of the Project on Instruction of the National Education Association* published during the 1960's suggest that the school should be directing its educational efforts toward using rational processes, developing social responsibility, making more intelligent consumer choices, building international competence, increasing understanding of complicated issues confronting voters and taxpayers today, learning through discovery, developing self-direction and self-responsibility, and analyzing mass communication and propaganda.

One important implication of this list is that more attention should be paid to learning to learn and to value. Such learning may be more important than learning today's facts, which may turn out to be tomorrow's fallacies. Irrational laws relating to drug use and sexual behavior can be overcome only by rational thinking, social and individual responsibility, and increased voter understanding of issues. Overreliance on what self-appointed authorities tell us has resulted in dangerous self-medication and needless anxiety about our physical and emotional normality. We have accepted monstrous school buildings and intense pressures to learn more faster in the name of quality education, because we have not learned to analyze propaganda and practice self-direction.

Thus, school health and health education

**A design for general education,* Washington, D.C., 1944, American Council on Education.

†Meadows, D. H., and others: *The limits to growth: a report for the Club of Rome's project on the predicament of mankind,* Washington, D.C., 1972, Potomac Associates.

*National Education Association, Project on the Instructional Program of the Public Schools: *Schools for the sixties, a report,* New York, 1963, McGraw-Hill, Inc., p. 9.

(as they should be practiced) not only contribute to the transmission and modification of the culture but are in themselves aspects of general education. In addition, by helping to promote, protect, and maintain the health of children and young people, they facilitate development as well as learning. In a classic investigation Turner* showed by a controlled experiment that the introduction of health education without any other changes in school procedure can improve health practices and physical growth rates.

A schoolhouse is a home. Not so long ago the stereotypical American mother aroused herself and her family each morning. She saw to it that her husband and children were fed, supplied with clean clothes, and left the house on time for work or school. After serving as family chauffeur and shopper, she returned home to wash, clean, and cook. If a telephone call came from school about a sick, injured, or misbehaving child, she immediately reassumed responsibility. After school she welcomed her brood home, entertained them, provided moral education, fed them, and saw to it that they bathed and got to bed. Her spare time was spent in PTA, church, and other social and community activities. Home was one thing, school another, and mother was the coordinator.

Such mothers and the homes they make are increasingly rare. The 1970 U.S. census showed that jobs outside the home are held by half of all mothers with children in school. In addition, the increasing number of divorces leaves many children in homes with a single parent who must serve as both provider and homemaker. American mobility leaves the nuclear family unextended by the presence of aunts or grandmothers who might serve as surrogates. Few families can afford household help. And even the availability of work-saving appliances, no-iron clothes, and the prepackaged meals are not sufficient aids to permit mothers to perform all their other traditional functions and to hold down jobs as well.

One clear result of these trends, whether one approves of them or not, is that schools are becoming second homes, and teachers and other school workers must either do more parenting or let children go inadequately parented. The development of prekindergarten programs and child care centers, some of which are school related, is a clear indication that the trend is toward assumption of greater parental responsibility by schools, at least for young children.

Good teachers have always been concerned with the health and welfare of their students. They view health promotion, including parenting, as a privilege as well as a responsibility. It enriches teacher-pupil relationships. It is part of good professional practice. It is an activity for which professional teacher preparation provides essential skills and understandings, and it is clearly becoming a social necessity.

The assumption that children and young people come to school with adequate breakfasts in their stomachs—if it was ever true—is no longer valid; no one works, learns, or relates to others well whose blood glucose level is too low. Thus, the inhabitants of the school-as-home need food, often including breakfast and snacks as well as the now traditional lunch. The school must also be prepared to provide extended temporary care for ill or injured students and perhaps even obtain definitive medical care on behalf of those parents whose work makes them unavailable. However, primary responsibility for obtaining health care still rests with the home, and what schools do in this regard must be done with the advice and consent of the parent. These new responsibilities are modifications of old ones, which can be met by adjustment of existing school feeding and emergency care programs.

In requiring school attendance, the state assumes an obligation to protect the health of students during school activities as well as on their way to and from school. Provision of a safe and healthful school environment, safe passage, and an adequate program of

*Turner, C. E.: Malden studies in health education and growth, Am. J. Public Health **18**:1217-1230, 1928.

communicable disease control are clear-cut responsibilities of the school in collaboration with community health authorities and the police.

Both good schools and good parents maintain surveillance over the health of children and young people. Where health defects or departures from normal health are found, both the school and the parent must be interested in definitive diagnosis and, if indicated, treatment and/or rehabilitation.

WHAT SCHOOL HEALTH AND HEALTH EDUCATION CAN AND CANNOT ACCOMPLISH

Health care, the environment, and the school. As an educational agency, the school has neither the responsibility nor the legal right (at this time) to provide medical treatment to school children. The rights and responsibilities of schools include appraisal of pupil health status, provision of emergency care, guidance in obtaining medical attention, and the control of communicable disease.* Schools also play an important role in rehabilitation, which is in large part an educative activity, through special education and vocational training programs.

That many Americans, adults as well as children, are denied access to medical care by economic, geographic, and racial barriers has been well documented in a recent study. Programs such as Medicaid, designed to overcome these barriers, have been less effective than they might be, partly because of bureaucratic red tape and callous insensitivity.† Legalization of full-scale medical care by the school would be wasteful of manpower and money because the needed facilities and personnel would be idle much of the time and would only duplicate those needed by the total community. The proper role of the school is largely educational; it can effectively call attention to the problem and explore solutions in health education classes as well as in community forums.

Although schools can provide a safe and healthful physical and social school environment, their ability to do so is limited by the quality of the environment of the entire community. A well-planned and equipped outdoor activity area is useless when the ambient air is seriously polluted. The hazards of walking to school are multiplied for students who must cross the boundaries of a gang to which they do not belong or for any students living in an area with a high crime rate.

Christopher Jencks and associates* argue that achievement of social and economic equality depends much more on changes in our social and economic systems than on educational reform. But equality may not be all that desirable as a goal. A more realistic and attainable aim for schools may be to help individuals achieve whatever potential they come to school with, sensitize them to human problems, and provide them with problem-solving skills.

Behavior modification. Most authorities in health education hold that the central purpose of the subject is to improve both individual and group human health behavior. The present state of the art is such that our success in doing so is best described as mixed. There is much evidence that health education can induce people to utilize available health services. A voluntary topical application fluoride program, for example, was offered to pupils in the Dearborn, Michigan schools at no charge for many years. A continuous dental health education program among both pupils and parents kept participation at about 80%. When a fee representing full cost was instituted by the school board for the service, participation declined only to 75%. With continued education, participation increased to its former higher level in less than 2 years.

With the assistance of other social forces,

*Miller, D. F.: *School health programs: their basis in law,* Cranbury, N.J., 1972, A. S. Branes & Co., Inc., pp. 51-52, 65.

†Citizens Board of Inquiry into Health Services for Americans: *Heal yourself,* Washington, D.C., 1972, The American Public Health Association.

*Jencks, C., and others: *Inequality: a reassessment of the effect of family and schooling in America,* New York, 1972, Basic Books, Inc., Publishers.