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THE CURRENT STATUS OF COMPREHENSIVE SCHOOL HEALTH EDUCATION AND PROGRAM CRITERIA IN MICHIGAN PUBLIC SCHOOLS, 1981-83

By

Stella Ann Hansen

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

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ABSTRACT

THE CURRENT STATUS OF COMPREHENSIVE
SCHOOL HEALTH EDUCATION AND PROGRAM CRITERIA
IN MICHIGAN PUBLIC SCHOOLS, 1981-83

By

Stella Ann Hansen

This dissertation uses both a survey research method, and a participant observation research method to assess the 1981-83 status of comprehensive school health education in Michigan public schools. The survey consists of a statewide assessment of all public school principals on various health education program criteria. The participant observation study includes observation of health education programs in three different size school districts in Michigan.

Results of the survey indicated that Michigan public schools lack a sound organizational structure necessary to implement and maintain a health education program. The organizational structure surrounding a comprehensive school health education program is quite complex, and should include a health education program coordinator, advisory board, community participation and sponsorship, parent and student participation, integration with community professionals and a mechanism for continuous evaluation. Instructors of health have not received adequate college preparation in general health education, nor do they receive health education on a yearly schedule. The content of most health education courses is fragmented and inconsistent with different curricula being

used by teachers within same grade levels in same districts.

The results of the participant observation indicated that for health education to be effective, it should be presented in terms of students' personal responsibility and decision-making, as well as be relevant to the students' own experience. Hands-on educational experiences and positive student-teacher relationships were observed to be important components for effective health instruction.

The major barriers to implementation were observed to be time constraints, incomplete teacher compliance, and lack of a health content. The major innovations observed were parent involvement, participation by community professionals, and the use of a closed circuit television for broadcasting health instruction and health education inservice.

DEDICATION

To my loving husband Peter,

and to our beautiful daughter

Adrienne

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CHAPTER I

THE PROBLEM

STATEMENT OF THE PROBLEM

Health education in Michigan public schools has been an overlooked and under-supported aspect of general education throughout Michigan educational history. In the majority of public schools, comprehensive school health education is virtually non-existent, or totally inadequate to meet the rapidly expanding complex needs of today's children and youth. (Sliepcevich, 1965).

One of the more important problems in health education has been to reach a concensus on terminology. In 1972, the Journal of School Health published a report on Health Education Terminology. The following terms are defined in this dissertation using the Journal of School Health's terminology.

Health education. "A process with intellectual, psychological, and social dimensions relating to activities that increase the abilities of people to make informed decisions affecting their personal family, and community well-being. This process facilitates learning and behavioral change in both health personnel, and consumers, including children and youth."[1]

---

[1] "Report of the 1972 Joint Committee on Health Education Terminology", Journal of School Health, (January 1974), 33-37.

Comprehensive school health education program. "All the health opportunities affecting learning and behavior of children and youth in the total school health curriculum. The health content for comprehensive school health education includes such concepts as: quality of life, the human organism (growth and development), nutrition, safety, disease control; including venereal disease, drug use and abuse; including alcohol and tobacco, family health or family life education (human sexuality), mental health, consumer health, personal health practices, health careers, and community health including environmental health factors and ecology."[2]

The Michigan Board of Education has also been involved in the clarification of terminology. In 1980, the Board published a position paper on comprehensive school health education which defined a school health program as:

School health program. "The composite of learning activities and experiences within the school setting that are directed toward developing an environment that promotes and protects the health of the students and the school personnel."[3]

Health education is often regarded by the public school curriculum committees as a fringe subject on a similar

---

[2]"Report of the 1972 Joint Committee on Health Education Terminology", Journal of School Health, (January 1974), 33-37.

[3]Michigan State Board of Education. "Position Paper on Michigan Comprehensive School Health Education", (Lansing, Mi: Michigan Department of Education, 1980) 5.

status as music or art, and does not consider health an important priority. The Michigan Department of Education has tried to improve this lack of emphasis on health education by making health education one of the Michigan Essential Skills for grades K-9, and in the Life Role Competencies for grades 10-12 (MDE, 1980). Despite this emphasis, health education continues to be fragmented and inconsistent.

There are several important issues in health education involving content, methods of instruction, qualifications of instructors, appropriate age of students receiving certain information, budget cutbacks, limited enrollments, etc., which this thesis will address. The following is a summary of some of the more important issues.

1. Health is defined by the World Health Organization as "a state of physical, psychological and social well-being."[4] However, the concept of health also needs to be understood in terms of behavioral choices that an individual makes which affect her/his health condition. The health oriented (positive) behaviors and the anti-health (negative) behaviors must be examined in view of their physical, emotional and social results.

2. The teaching of health education <u>may</u> or <u>may not</u> influence or affect the decision-making and ultimate behavior choice of the students. The presentation of health education information to students does not guarantee that the students will choose health-oriented or positive health behaviors.

---

[4]World Health Organization, 1967, Geneva, Switzerland.

3. Health education tends to teach information about anti-health options; ie., smoking and drug abuse, and perhaps may be addressing only the symptoms and not the causes of the problems. The motivation for engaging in anti-health behaviors may be based more on an individual's social role models, need for attention, peer pressure, etc. Young women especially, get messages from childhood through adulthood that they need to appear and/or behave in certain ways if they are to be considered attractive and accepted. (Daly, 1978).

4. The content of most K-6 health education programs contains typical health issues such as nutrition, safety, etc. However, the non-typical social issues which affect students' lives also need to be included. Some of these issues are:

- moving and mobility--pulling up roots
- drugs, crime, and violence
- loss and grief--death, disappointment
- contradictory health messages in the media, stores, etc.
- teaching of respect for others who are different, handicapped, etc.
- new brothers and sisters, new roles, competition, etc.
- parents' unemployment
- domestic assault, child abuse

5. Health education is being taught mostly by instructors who do not have any professional preparation in health education. (Sophiea, 1981). In grades K-6, four semester hours of health education are recommended by the Michigan Department of education before instructors are qualified to teach health. Although the Michigan

Department of Education has made this recommendation, most of the Michigan colleges and universities do not require health education as a prerequisite for teacher certification. As a result, very few instructors have met this professional standard.

Parallel to this issue is the additional dilemma of providing financial assistance to the public schools. The Michigan Department of Education sets the standards for comprehensive school health education, but has not provided any financial support to the local schools for its implementation or training. If these curricular changes are to be implemented statewide, there needs to be some sort of financial assistance available to the local schools to meet the costs of health education materials, teacher training, and program implementation and maintenance. Without some sort of financial compensation, local school districts are unlikely to invest the time, money, and effort for development and maintenance of a comprehensive school health education program.

6. Health education has a different type of content from that of other public school subjects, in that community professionals, agencies, and organizations are involved in health promotion. Health education instruction needs to have community integration with outside resources such as nurses, physicians, public health personnel, plus health agencies such as March of Dimes, etc.

7. The diagnostic tests used for identifying

students with developmental lags or in need of special attention may actually be an unreliable and invalid instrument, that is culturally biased. The labelling of these students as slow, or remedial, often affects their self-esteem and self-concepts in negative ways. These students begin to learn that they will receive more attention if they are not achieving the same level as their classmates. Health education needs to be more sensitive to these cultural misinterpretations.

8. The Michigan Department of Education uses test items based upon the objectives found in the Essential Performance Objectives for Health Education in Michigan to determine whether the students in 4th, 7th, and 10th grades are receiving and learning health education concepts. These objectives may or may not be accurately reflecting what is being learned by the students in their health education classes. Alternative ways of describing the content being taught in health education courses is necessary. Perhaps a more descriptive narrative of the actual content of the classes could help to neutralize some of the fears and inappropriate accusations which are directed at certain content areas of health education (such as sex education).

9. Teaching of reproductive health education is felt by some individuals to be immoral and to be an inappropriate content for public school education. Others argue however, that not teaching reproductive health

encourages ignorance and experimentation, and also increases the likelihood of unwanted pregnancy. The omission of reproductive health education in the health education curriculum is one example of a general educational phenomenon that occurs in several academic subjects where fundamental value-laden topics are omitted from the curriculum. The omission of controversial issues may serve to protect the schools from political conflict, but it comes at the cost of student awareness and ability to comprehend critical issues affecting their lives.

10. Program criteria for comprehensive school health education have not been approved by the Michigan Department of Education. The Department is now in the process of developing these criteria. Research is needed to contribute to the development of these program criteria so that the criteria are defined in ways that can be applied to actual school settings.

11. The methods in which health education is taught can be as important as the content itself. A description of the different methods used to teach health education can contribute to the literature and development of comprehensive school health education programs.

Resolution of these important issues will be possible only if there is valid information and descriptions provided on the practice of comprehensive school health education in Michigan public schools. This information needs to go beyond the simple survey of health education

program criteria, especially when the results are being used to evaluate educational policies. A more detailed analysis of the implementation of this criteria is needed to give a realistic understanding of the actual status of comprehensive school health education.

Accordingly, this dissertation uses two different methods to provide understanding about health education. One method includes a statewide health education survey of all public school principals in Michigan. The results of this survey give a broad overview of health education ongoing in Michigan. The second method involves participant observation of three health education programs that have implemented the health education program criteria in varying degrees. These three participant observation studies serve the purpose of illustrating how three different programs have implemented the health education program criteria.

The broad overview provided by the statewide health education survey, and the more focused analysis provided by the participant observation of the three health programs serve to complement each other and provide a more thorough examination of comprehensive school health education in Michigan public schools.

In view of the severe budget cutbacks and decreasing enrollments now faced by public schools in Michigan, descriptive research that sheds light on the current status of comprehensive school health education is essential for

development and allocation of public resources. Changes within educational priorities are rapidly taking place. These changes must be identified and documented so that the needs of the students, the school personnel, and the community at large can be addressed.

In May, 1981, Ms. Muriel VanPatten, Acting Director of School Program Services, Mighigan Department of Education, addressed the Michigan School Health Association at their annual meeting in Southfield, Michigan. In her speech she said:

> I believe the State Board of Education should take on the responsibility of defining statewide program standards. We can influence quality of programs across the state by:
>
> 1. Establishing the program standards.
> 2. Providing a needs assessment mechanism.
> 3. Preparing educators and seeing to it that trained people are available to assist the local school staff.
>
> The standards should be based both on research and good judgment and experienced (professional) wisdom. The standards must be reasonable and reachable, they must provide a level of quality possible for all schools to achieve, and a level that Michigan citizens and educators believe should be achieved.[5]

The program criteria for comprehensive school health education are necessary to provide a level of quality and a standard by which comprehensive school health education programs can be measured. A standard document developed and now used by the Michigan Department of Education tests student performance in health education based on Essential Performance Objectives for Health Education in Michigan. This document was made available to local school districts

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[5]Michigan State Board of Education, 1980.

by the Michigan Department of Education in 1974 (it was then termed Minimal Performance Objectives). In 1979, a statewide sample of 4th, 7th, and 10th grade students were tested on their achievement of the Essential Performance Objectives. It was found that the overall attainment for 4th grade students was the highest of all three grade levels with a 70% achievement. The average attainment for 7th graders was 47%, and a further decline was achieved by the 10th graders, who achieved only 45% on the Essential Performance Objectives.

These Essential Objectives are used by the Michigan Department of Education and various other organizations involved in school health as a standard for comprehensive school health education. However, these objectives may or may not reflect what the students are actually learning in their health education courses.

The reliability and validity of the objective testing of the Essential Objectives is beyond the scope of this study. However, one aspect of this dissertation will be to investigate the major reasons for such poor achievement of these objectives, and whether the health education being provided in the schools reflects the Essential Objectives for Health Education in Michigan.

PURPOSE OF THE STUDY

The purpose of this study is to provide valid information regarding the current status of health education

being taught in Michigan public schools and to investigate the program criteria on which identified comprehensive school health education programs are based. These program criteria will focus on the K-6 aspects of the comprehensive school health education programs.

PROCEDURES USED IN THE STUDY

Two main procedures were used to describe the current status of comprehensive school health education in Michigan and to investigate the program criteria on which identified school health education is based.

The first procedure was a statewide survey that was sent out to all public school principals in Michigan (approximately 3,766). The findings of this survey provide a global understanding of what the current status of comprehensive school health education is in Michigan public schools. Also derived from the survey was a list of high quality health education programs, three of which were selected for an indepth study using participant observation of the health program criteria.

The second procedure was a participant observation study of three target schools (identified by the statewide survey) that assessed the program criteria being used in the actual teaching of the comprehensive school health education program. These three health education programs were then compared to each other on a number of criteria that comprised their health education programs.

These procedures were chosen to answer a number of problems that are characteristic of single method studies of educational programs. The health education survey allows a quantitative analysis of identified health education program criteria that are reported to be provided by the public school principals. This information allows a statewide frequency count on several health education program criteria. In addition, the survey also asks the principals to answer what they believe are the major improvements needed for their health education program. Although the survey is effective in providing an overview of the Michigan health education program status, it does not allow an indepth or qualitative analysis of what is actually happening within a comprehensive health education program. A qualitative participant observation investigation of three different health programs was conducted to give perspective on the inside functions of a health program.

This qualitative research method gives insight into the roles and obligations of the various "actors" who provide and contribute to the health education program, as well as describing the program components that they must administer.

An indepth qualitative study often has the limitations of not being characteristic of a typical health education program. By selecting three different health education programs each with a different program emphasis, I have tried to include some of the possible variations

that occur within comprehensive school health education programs. By conducting both a quantitative health education survey and a qualitative indepth participant observation study of three different health programs, I have tried to overcome several of the limitations experienced by the use of only one method.

LIMITATIONS OF THE STUDY

One limitation of this study is the impossibility of verifying the health education survey results. Surveys tend to inflate the frequency of desired responses (Hays 1973; Borg and Gall, 1963), as the principals at schools that did not have a health education program tend either not to respond, or to give inaccurate responses on the survey. A phone survey of non-respondents was conducted to estimate the validity of the respondent population. However, these measures do not correct inaccurate survey responses.

A second limitation in the participant observations of health education classrooms involves the nature of the volunteer teacher who has been willing to allow observation in the classroom. The teacher who volunteers to participate in collaborative research such as participant observation may not be representative of the general health education teacher population. The observed health education programs were selected because of their unusually high quality based on the survey results. Perhaps the teachers who volunteered to allow observations in their classrooms are also of an

unusually high quality. This factor could not be assessed in the present study.

A third limitation is the ability of this study to provide the total picture of comprehensive school health education ongoing in Michigan. Participant observation study of three K-6 health education programs and a statewide survey of school principals can provide only a limited perspective of the total picture of comprehensive school health education in Michigan. The total picture of comprehensive school health education in Michigan is beyond the scope of this study. However, this study does provide valuable information and a framework on which future research in health education can be based.

DESCRIPTION OF THE CONTENTS OF THE DISSERTATION

The dissertation that follows consists of six chapters. There is a chapter on the review of the current literature, followed by a chapter on the methods used to conduct the research. The findings of the dissertation are divided into three chapters. One chapter gives the results of the Statewide Health Education Survey. A second findings chapter contains the ethnographies and commentaries of each of the three sites studied using the participant observation method. The third findings chapter gives a comparison of these three sites based on a number of health education program criteria as well as an assessment of the major strengths and barriers found in each program.

The final chapter provides the reader with the conclusions and recommendations for continued research and program development in comprehensive school health education.

CHAPTER II

REVIEW OF THE LITERATURE

DEFINING THE REALMS OF COMPREHENSIVE SCHOOL HEALTH EDUCATION: LAWS AND POLICIES PERTAINING TO COMPREHENSIVE SCHOOL HEALTH EDUCATION

Comprehensive school health education has been in the process of becoming an institutionalized goal of Michigan general education for several years.

Michigan Comprehensive Health Education had its first formal definition in 1969 with the passage of Public Act 226. This Act gave the Michigan Department of Education (hereafter referred to as MDE) the authority to promote, support, and conduct critical health problems and educational programs. The Act states that such programs "shall include, but not be limited to, the following topics as the basis for comprehensive health education in Michigan public schools: drugs, narcotics, alcohol, tobacco, mental health, dental health, vision care, nutrition, disease prevention and control, accident prevention and related safety topics".[1]

Additional laws that have affected Comprehensive School Health Education is the School Code of 1976 of Michigan Compiled Laws (MCL). This law has several sections that affect Comprehensive School Health Education. Section 1169 (MCL 380.1169) mandates that the principal modes by

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[1]Public Act 226 of the Public Acts of 1969, Michigan Compiled Laws, Lansing, Mi.

which dangerous communicable diseases are spread and best methods for the restriction and prevention of these diseases shall be taught in every public school in this state.[2] Communicable diseases include syphilis, gonorrhea, and chancroid.[3]

Section 1170, (MCL 380.1170) mandates instruction be given in physiology and hygiene with special reference to substance abuse, including the abusive use of tobacco, alcohol, and drugs, and their effect on the human system.[4] To date, this section is the only mandate of a specific content area in health education. Section 1170 mandates that Comprehensive School Health Education programs shall be developed as prescribed in Public Acts 226. An important clause of Section 1170 mandates that a child, upon the written statement of parent or guardian, shall be excused from attending classes where instruction is being given that is in conflict with her or his sincerely held religious beliefs. This clause allows for students to be excused from any health education class (among other subjects) if the parents feel that it conflicts with their religious beliefs.

The definition of sex education is also defined in Section 1501 of the School Code of 1976. It defines sex

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[2]Section 1169 of the School Code of 1976, (MCL 380.1169), Lansing, Mi.

[3]Section 151 of the "Venereal Diseases Act", (MCL 329.151), Lansing, Mi.

[4]Section 1170 of the School Code of 1976, (MCL 380.1170), Lansing, Mi.

education as "the preparation for personal relationships between the sexes by providing appropriate educational opportunities designed to help a person develop understanding, acceptance, respect, and trust for herself/himself, or others. Sex education includes the knowledge of physical, emotional, and social growth and maturation and understanding of the individual needs. It involves an examination of mens' and womens' roles in society, how they relate and react to supplement each other, the responsibilities of each toward the other throughout life, and the development of responsible use of human sexuality as a positive and creative force."[5]

This definition of sex education is extremely broad. It includes the topics of sex roles, family relationships, emotional and mental health, growth and development, and human sexuality. Under this definition of sex education, it is quite probable that sex education is taught in a variety of educational subjects, and is not limited to health education.

Other aspects of the School Health Code of 1976 pertaining to Comprehensive Health are:

Section 1502 states that health education and physical education shall be established and provided in all Michigan public schools.[6]

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[5]Section 1501 of the School Code of 1976 (MCL 380.1501), Lansing, Mi.

[6]Section 1502 of the School Code of 1976 (MCL 380.1502), Lansing, Mi.

Section 1502 mandates that school districts offering a course in health education or physical education shall engage qualified instructors for that instruction.[7]

Section 1506 specifies that a program of instruction in reproductive health shall be supervised by a registered physician, nurse, or other person certified by the State Board as qualified. Section 1506 also states that upon the written request of a pupil or the pupil's parent or guardian, a pupil shall be excused without penalty or loss of academic credit, from attending classes in which the subject of reproductive health is under discussion.[8]

Section 1507 states that a board of a school district may engage qualified instructors and provide facilities and equipment for instruction in sex education, including family planning, human sexuality, and the emotional, physical, psychological, hygienic, economic, and social aspects of family life. Instruction may also include the subjects of reproductive health and the recognition, prevention, and treatment of venereal disease.

There are six main stipulations on Section 1507.

1. The class shall be elective and not required for graduation.

2. The pupil shall not be enrolled in a class in

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[7]Section 1503 of the School Code of 1976 (MCL 380.1503), Lansing, Mi.

[8]Section 1506 of the School Code of 1976 (MCL 380.1506), Lansing, Mi.

which the subjects of family planning or reproductive health are discussed unless the pupil's parent or guardian is notified in advance of the course content and is given prior opportunity to review the materials to be used in the course, and is notified in advance of her/his right to have the pupil excused from the class. The State Board shall determine the form and content of the notice required.

3. Upon the written request of a pupil or pupil's parent or guardian, a pupil shall be excused without academic penalty.

4. A school district that provides a class thus described shall offer the instruction by teachers qualified to teach health education. A school district shall not offer this instruction unless an advisory board is established by the district board to periodically review the materials and methods of instruction used, and to make recommendations to the district regarding changes in the materials or methods. The advisory board shall consist of parents having children attending the district's schools, pupils in the district's schools, educators, local clergy, and community health professionals.

5. As used in 1507 and 1508, "Family Planning" means the use of a range of methods of fertility regulation to help individuals or couples avoid unwanted pregnancies, bring about wanted births, regulate the intervals between pregnancies, and to plan the time at which births occur in relation to the age of the parents. It may include a study

of fetology, and marital and genetic information. Clinical abortion shall not be taught as a method of family planning, nor shall abortion be taught as a method of reproductive health.

6. A person shall not dispense or otherwise distribute in a public school a family planning drug or device.[9]

Section 1508 of the School Code of 1976 states that the State Board shall:

1. Aid in the establishment of educational programs designed to provide pupils in elementary and secondary schools, institutions of higher education, and adult education programs, with wholesome and comprehensive education and instruction in sex education.

2. Establish a library of motion pictures, tapes, literature, and other educational materials concerning sex education, available to school districts authorized to receive the materials under rules of the State Board.

3. Aid in the establishment of educational programs within colleges and universities of the state, and inservice programs for instruction of teachers and related personnel to enable them to conduct effective classes in sex education.

4. Recommend and provide leadership for sex education instruction established by school districts, including guidelines for family planning information.

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[9]Section 1507 of School Code of 1976 (MCL 380.1507), Lansing, Mi.

5. Establish guidelines and may review and recommend materials to be used in teaching family planning, reproductive health, and the recognition, prevention, and treatment of venereal disease. The guidelines shall be formulated in cooperation with the Departments of Public Health, Mental Health, and State Department of Social Services. A school district that provides instruction as permitted in Section 1507 may adopt the guidelines established by the State Board, or shall establish its own guidelines in cooperation with its Intermediate School District, and its County or District Department of Public Health.[10]

Section 1531 of the School Code of 1976 states that the State Board shall determine the requirements for and issue all licenses and certificates for teachers, and the requirements for and endorsement of teachers as qualified counselors in the public schools of the state.[11] The State Board shall certify as qualified the supervisors required in Section 1506. The State Board shall certify the teachers as qualified to teach the class described in Section 1507, based on the recommendations of a teacher's educational qualifications and experience, and upon any additional requirements the State Board considers necessary.

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[10]Section 1508 of School Code of 1976 (MCL 380.1508), Lansing, Mi.

[11]Section 1531 of School Health Code of 1976 (MCL 380.1531), Lansing, Mi.

The laws that have been enacted by the Michigan Legislature have encouraged the development of materials and policies that further define Comprehensive School Health Education. The most important document was the adoption, in 1974, by the State Board of Education, of the Minimal Performance Objectives for Health Education in Michigan. This document was a part of an accountability model that developed performance objectives for eight basic educational disciplines. The objectives address ten different topical areas in health that include the topical areas listed in Public Acts 226 of 1969. These ten topic areas are listed below with a descriptive summary of the possible contents in curriculum.[12]

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[12]Taken in part from the Health Education Curricular Progression Chart prepared for the Primary School Health Curriculum Project, the School Health Curriculum Project, the Minimal Performance Objectives for Health Education in Michigan, and the Recommendations for Comprehensive School Health Education.

Topical Area	Summary
Disease Prevention and Control	Study of factors contributing to the development of chronic, degenerative and communicable diseases and disorders, methods for the detection, prevention, and/or control of cardiovascular disease, digestive and respiratory disorders, sexually transmitted diseases, cancer, and other health problems.
Personal Health Practices	Development of positive health care habits, including grooming, physical fitness and other personal health habits that maintain the body and promote overall wellness.
Nutrition	Sources of the principal nutrients, function of food in meeting body needs, essential components of a balanced diet, significance of eating a wide range of foods, potential influence of food fads and fallacies on nutrition.
Growth and Development	Structure and function of the systems of the body, their interdependence and contribution to the health functioning of the body as a whole, reciprocal relationships between growth and development.
Family Health	Exploration of the roles and interaction of individuals within the family life cycle, responsibility and privileges experienced by each family member, physical, mental and social changes anticipated for each person from birth to death, the family's responsibility for the health maturation and socialization of children.
Emotional and Mental Health	Ability to handle stress appropriately, to apply problem solving skills to the resolution of individual and family concerns, achievement of a positive self-concept that respects the rights of others to be different, and acceptance of responsibility for her/his own health as well as for that of others.

Topical Area	Summary
Substance Use and Abuse	Knowledge of the effects which drugs and other substances have on the body, the ability to distinguish between substance use facts and fallacies, knowledge of possible contributing causes to drug dependency, drug prevention strategies, such as decision-making and coping with peer pressure.
Consumer Health	Study of forces influencing individuals in the selection of health information, products, and services, evaluation of commercial appeals motivating the sale and purchase of health related products and services.
Safety	Methods of the identification and elimination of hazardous conditions or situations, rules for safe living in home, school, and community, patterns of behavior promoting accident prevention, techniques for first aid and emergency care.
Community Health	Study of ways the individual can effectively contribute to the solution of community-wide health problems, functions of voluntary, official, professional and other health organizations.

These Minimal Performance Objectives (now referred to as Essential Objectives) are currently being used as one of the content standards for Comprehensive School Health Education throughout Michigan.

Other documents developed and/or adopted by the State Board of Education consist of the Guidelines for a Comprehensive School Health Education Program, (1979); Michigan Essential Skills, (1979); Michigan Program Criteria for Essential Skills Education, (still in draft); Michigan Life Role Competencies, (1980); State Board of Education Position

Statement Regarding Comprehensive School Health Program, (1980); Support Materials for Health Education, (1980). All of these documents support and/or apply the definitions of comprehensive school health education contained in the Essential Performance Objectives for Health Education in Michigan.

Other organizations in Michigan have also developed policies and/or programs that define comprehensive school health education. The main organization addressing Comprehensive School Health in Michigan is the Michigan School Health Association (MSHA). In 1981, the MSHA adopted recognition standards for the identification of Comprehensive School Health Education models. These standards require that (1) the Comprehensive School Health Education model meets the established Minimal Performance Objectives for Health Education in Michigan (Essential Objectives), (2) and/or be based on the Health Related Michigan Life Role Competencies, (3) have potential to become part of a Comprehensive School Health Education program, (4) follow the state guidelines for Comprehensive School Health Education. The recognition standards address the goals and objectives of the models, methods/material resources, evaluation, content and management.

The Michigan School Health Association has also published a document entitled 1979-80 Michigan Educational Assessment Program Health Education Interpretive Report. This publication analyzes the results of a statewide testing

of Health Education Objectives under the Michigan Education Assessment Program (MEAP). The results of this assessment showed that 4th, 7th, and 10th graders in Michigan public schools have poor attainment of the health education objectives tested. The following table indicates the percentage of 4th, 7th, and 10th grade objective attainment for the ten topic areas of health education.

Table 1. 4th, 7th, and 10th Grade Health Education (MEAP) Test Results

	4th	7th	10th
Disease Prevention and Control	69.8%	56.2%	52.3%
Personal Health Practices	62.0	52.6	56.1
Nutrition	54.0	24.0	21.5
Growth and Development	66.0	35.6	33.7
Family Health	77.3	64.6	53.6
Emotional and Mental Health	81.2	64.2	49.1
Substance Use and Abuse	74.5	63.1	36.5
Consumer Health	75.7	49.7	48.4
Safety	77.1	40.1	57.5
Community Health	65.6	24.3	37.1

One of the most interesting findings that can be seen in the table is that as the grade level increases, the attainment of objectives in the same topic area generally decreases.

There are many reasons why the results of the Michigan Educational Assessment Program tests for Health Education have been so poor. One reason may be that the students simply are not learning comprehensive health education in Michigan public schools. Another reason may be that the Michigan Educational Assessment Program Health Education tests being given to the students are not measuring what the students are learning. The students may be learning health education concepts, but are not able to apply these concepts to the health education objective tests used in the Michigan Educational Assessment Program (MEAP).

One of the purposes of this research is to investigate why these test results may be so poor, and to answer the question "What are the students actually learning in their health education classes?"

Other organizations that have addressed Comprehensive School Health Education are the Statewide Health Coordinating Council with staff assistance from the Office of Health and Medical Affairs, which have combined efforts to prepare the State Health Plan, 1980-84. The State Health Plan addresses various health topics, such as heart disease, cancer, health promotion, and the identification of a specific role for school health education.

PREVIOUS STUDIES OF COMPREHENSIVE SCHOOL HEALTH EDUCATION

Perhaps the most significant national study conducted to document the status of comprehensive school health

education was the School Health Education Study (SHES). This study was first supported by the Samuel Bronfman Foundation of New York, and then later supported by the Minnesota Mining and Manufacturing Company (known as 3M Company).

The School Health Education Study achieved two main objectives. First, the Study described the status of school health instruction in the United States public schools. Second, the Study described the health knowledge, health attitudes, and health practices of a wide sample of elementary and secondary students. Several publications resulted from this study. Some of these publications are: Synthesis of Research in Selected Areas of Health Instruction, School Health Education Study: A Summary Report, and School Health Education: A Call to Action.

The study consisted of a survey of 135 school districts across the United States selected by the use of a multistage, stratified cluster sampling procedure. A total of 1,101 elementary schools containing 529,656 students from 38 states were represented in the study. Elementary schools had a 94.4% return rate of the surveys. The findings of this study showed that most health instruction in elementary schools is integrated into the curriculums of other subjects. There were eight health education topics that were neglected or not emphasized by the elementary schools. These topics were: consumer education, boy-girl relationships, health careers, international health activities, non-communicable

diseases, sex education, venereal diseases, and foot care. The only health education topics that were emphasized by the schools were accident prevention, cleanliness, dental health, nutrition, and exercise. (Sliepcevich, 1964).

The School Health Education Study Director, Elena M. Sliepcevich, stated that in a majority of public schools, health instruction is either virtually non-existent or totally inadequate to serve the needs of a rapidly expanding, increasingly complex society.[13]

Some of the recommendations from the School Health Education Study are that local school systems or states should do an evaluation study of their school health education programs that includes a critical appraisal of professional preparation of instructors, teaching effectiveness, inservice allotment, omission of content areas, policies regarding controversial health topics, instructional methods and teaching approaches, grade level appropriateness, community organization, and parent education.

Other recommendations suggest that communities participate in the health education program. The health program should be linked with school health services and a building health coordinator should be appointed. Graduate schools need to address health education preparation of instructors.

Another national study on Comprehensive School Health Education was conducted in 1981 by the Education Commission

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[13]Elena M. Sliepcevich, Study Director: School Health Education Study: A Call to Action, (New York: Samuel Bronfman Foundation, 1965) p. 8.

of the States. The purpose of this study was to document the state level support for activities in school health.

This study found that thirty-seven states' and District of Columbia Boards of Education have addressed school health education in a variety of ways including policy or position statements, resolutions, guidelines, administrative regulations or bylaws. Twenty-four states require a definite amount of health instruction to graduate, and forty-one states offer health certification for health teachers at secondary level. Forty-seven states have a health education coordinator, and thirty-four states and the District of Columbia have published health education curriculum and planning guides. (Education Commission of the States, 1982).

There have been several studies related to Comprehensive School Health Education in Michigan.

A study by Frank H. Myers, in 1969, (Myers, 1969) assessed the features and patterns of school health education in Michigan junior and senior high schools. One of the recommendations Myers made was that a health education study on the current status of health education should be conducted at the K-6 level of education in Michigan. Myers also recommended that schools should appraise and evaluate their own health education programs in light of current goals and objectives of health education.

An unpublished dissertation conducted by John A. Romas in 1976 (Romas, 1976) surveyed all the public school

superintendents in Michigan school districts. Romas found that Comprehensive School Health Education continues to be fragmented and inconsistent, offering little or few learning experiences for children and youth to examine crucial health issues affecting their lives. Romas found that health education topics are usually integrated with other subjects and that there are no curriculum guidelines regulating what, when, or how health education should be taught. In most cases, when a separate health education course is offered, it is taught by an individual who lacks professional preparation in health education.

This finding was later confirmed in a more recent study, conducted in 1981 by Kathleen Sophiea (Sophiea, 1981). Sophiea surveyed all teacher preparation institutions in Michigan with regard to their health education requirements for teacher certification. Sophiea found that 71% of the colleges required zero hours of professional preparation in health education for graduation, 8% required three hours or less, and 4% required four to six hours. It may be noted that the Michigan Department of Education recommends that all elementary health instructors have at least four semester hours of professional preparation in general health education, Michigan Department of Education Teacher Competency Guidelines (draft document).

These studies all point to the conclusion that comprehensive health education lacks competent instructors, and a sense of educational priority in Michigan public schools.

These studies also have several limitations. The most important limitation in both the School Health Education Study and the Romas Study is that they were completed in 1969 and 1974 respectively--more than fifteen and nine years ago. Educational programs and values can change dramatically in a short time, and a more recent assessment of the current status of Comprehensive School Health Education is needed. Also, with the recent decline in economic prosperity in the State of Michigan and the resultant budget cutbacks, educational programs have had to curtail their expenditures. Health education, along with other curriculum subjects, has been affected by these economic factors.

Although the Romas Study had a high return rate, a survey of the superintendents may not reveal as specific health program information as is possible from a school principal or a health education instructor.

NEED FOR CURRENT RESEARCH

A need for a study that describes the current status of Comprehensive School Health Education has been called for by a number of agencies and organizations concerned with school health. The Michigan School Health Association, Michigan Department of Public Health, Michigan Health Council, and the Michigan Department of Education have all worked together to propose the statewide health education survey that was conducted as a part of this dissertation. This statewide health education survey uses the public school

principal as the key respondent. It was felt that the public school principals would be sufficiently close to the health education to give specifics about the health education program content.

The health education survey also offers the principals an opportunity to voice their concerns and opinions regarding the improvement of Comprehensive School Health Education in their district.

The Health Education Survey does have several limitations. Some of these limitations are inherent in the processes of survey research. Problems such as second-guessing the researcher, and the distortion of reality by subjects are often unintended consequences of survey research (Argyris, n.d.).

A quantitative study such as the health education survey provides a reliable method of data collection. However, the health education survey cannot give any reliable information on the roles of individuals within a health education program. Quantitative research continues to pay insufficient attention to individuals who comprise social settings, and instead, puts undue emphasis on the effects of the system and its capacity to shape behavior. It is abundantly clear that the acts of individuals have a great role in shaping the system (Swartz and Jacobs, 1979).

To understand the processes that comprise a health education program, the researcher must get close to the people whom (s)he studies, and (s)he can best understand

their actions when observed from within the natural ongoing environment (Schatzman and Strauss, 1973).

In the school health education literature, there is a shortage of detailed research about the processes and relationships that allow a health education program to function. To answer this void in qualitative health education research, this study has combined the methods of quantitative survey research with qualitative participant observation research. The purpose of these combined methods is to maximize discovery of the structure and functions of a health education program.

PROGRAM PLANNING IN HEALTH EDUCATION

One of the most significant frameworks for health education program planning is the PRECEDE[14] framework suggested by Green, Kreuter, Deeds, and Partridge in their book Health Education Planning: A Diagnostic Approach. The authors describe a process by which to conduct five diagnostic assessments: (1) a social diagnosis or assessment of life concerns, (2) an epidemiological diagnosis to assess etiologies, (3) a behavioral diagnosis to assess relevant health behaviors, (4) an educational diagnosis to assess the causes of health behaviors, and (5) an administrative diagnosis that assesses organizational capacities. Each of these factors are assessed as to their importance and

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[14]PRECEDE is an acronym for predisposing, reinforcing and enabling causes in educational diagnosis and evaluation.

changeability, followed by a selection of targets that can most readily be changed.

The PRECEDE framework has been applied to anticipate the outcomes of school health education programs in order to plan program activities more effectively. (Green, Kreuter, Deeds, and Partridge, 1980).

Program planning in health education is a very complex process. Depending on the goals and directions of the local school district, health education programs may vary considerably in their overall organizational structure. One of the first steps in establishing a health education program is to have the school board develop an overall policy of school health (Anderson and Creswell, 1976). Other steps that need to be taken are to organize a health education steering committee and/or advisory board to assess the local status of the school district's comprehensive school health education, to generate program objectives and ideas, and to implement the program and evaluate program progress and outcomes (National Parent Teacher Association, (NPTA) n.d.).

In Michigan, there is no reason to "reinvent the wheel" or to recreate a new health education curriculum. Model health education programs that have been validated by the Michigan Department of Education and recognized as being comprehensive by the Michigan School Health Association are available for any school district to adopt or adapt for their own school health program. Information regarding these model health programs may be obtained through contacting the

Michigan Department of Education.

In a school district that has a high quality comprehensive school health program, it is often one individual, perhaps a teacher, or administrator who has played a key role in development and maintenance of the health education program (Bensley, 1970). The process of establishing and maintaining a comprehensive school health program is often beset with problems and barriers. In most school districts, an influential administrator needs to be an advocate of Comprehensive School Health Education, if a program is to survive. An administrator who wants to improve school health in his district needs to orientate himself, the faculty, and school employees in the descriptions of what a Comprehensive School Health Education program is, and why such a program is warranted. The administrator should have a "master plan" on how to implement school health, and should not permit objecting minority groups to distort and impede program progress (Byrd, 1964). This is not always an easy task. There are many issues and concepts taught as a part of Comprehensive School Health Education that certain groups find objectionable.

SELECTED HEALTH EDUCATION ISSUES

There is probably no other factor in the school's curriculum that influences a pupil's identity, values, attitudes, or habits as directly as health education (Kolacki, 1981). Some groups and/or parents find this

influence quite threatening to their personal and/or professional status. In an experimental study on child initiated care that teaches children health education concepts, decision-making, and self-care, the parents became very concerned and threatened if their children became "un-child" like and began to look after themselves. When students became active participants in their own health and well-being, many adults became extremely discomforted (Lewis and Lewis, 1982). Perhaps this is because the parental role is usurped when the children begin to take responsibility for their own health care. Another reason is that much of the health education concepts taught to the students may contradict the behaviors, attitudes, habits, and values that are practiced in the home setting. For example, if a student learns that cigarette smoking can lead to lung cancer, and that the children of parents who smoke have an increased level of respiratory ailments, and (s)he has parents or adults in the house who smoke, the student is faced with a value discrepancy that may cause him to be at odds with the smoker, particularly if that student confronts the smoker and urges her/him to quit. Although this is a minor example, it points out how discomforting health education can be. However, this struggle may be necessary for social change to take place. Another point expressed by Lewis and Lewis is that children have very little power in the adult world. They are passive participants in activities for which they will be expected to assume responsibility without formal

training at some magical age. Children are undervalued by adults and are perceived to be far less competent than they truly are (Lewis and Lewis, 1982).

This issue of children's competence is at the root of another vital and difficult issue facing comprehensive school health education. This is the issue of teaching reproductive health education. Some individuals, (particularly certain religious groups) feel that teaching reproductive health is immoral and inappropriate for public school education. One perspective on reproductive health education suggests that if students learn reproductive health education, they will try sexual experimentation. This experimentation is suggested to increase unwanted pregnancies and venereal diseases. This sentiment is echoed by James Pawsey, who states "Despite the growing emphasis on the teaching of sex (reproductive health), the rate of abortions continues to increase, and small wonder, for if we teach our children German, can we be surprised when they practice it?"[15]

An article by Donald Reid, Assistant Director of the Health Education Council in London, reviews the literature on reproductive health education and the causes of teenage pregnancies. Reid cites several authors who have studied the effects of reproductive health education on students.

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[15]Pawsey, James M. P. The Sex Education That Isn't Working, (London Daily Mail, August, 1980).

Reid classifies these effects into three categories: Effects on knowledge, effects on attitudes, and effects on behavior. The effects of reproductive health on knowledge show that there are short term knowledge gains (Rogers, 1974), (Kapp, et al, 1980), (Hoch, 1971); however, long term gains are minimal (McGuffin, 1980), (Zelnik and Kanter, 1977).

The effects of reproductive health education on attitudes is reported to have a general liberalizing effect on attitudes to sexuality, but without any accompanying effect on personal behavior (Scales, 1978; Kirby, 1980). Reproductive health serves to reduce embarrassment (Watson and Rogers, 1980), and does not influence students' personal permissiveness toward sexual activity (Hoch, 1971; Parcel and Luttman, 1981). The student's peers, family, and the media seem to dilute any attitudinal effect (Reid, 1982).

The effects of behavior are more difficult to assess. Kirby conducted a study on college age students that showed reproductive health education showed no evidence of behavior change. "If college classes which are more explicit do not increase sexual behavior, then high school classes which are more limited probably do not affect behavior either."[16]

One question regarding the teaching of reproductive health education and its consequences is, "Who is it that gets pregnant, and why didn't they use contraception?"

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[16]Kirby, D. The Effects of School Sex Education Programs: A Review, (Journal of School Health, December 1980), 559-563.

Answers to this question come from the female teenagers who have become pregnant. Apparently these teenage women have an increase in sexual activity and also have lingering puritanical values. It seems that teenagers are sufficiently liberated from these attitudes to give in to their emotions, but too guilty to admit this even to themselves (Reid, 1982).

A study by the Francomes points out that couples with high "moral" principles may be at particular risk--they are especially unlikely to take precautions for sexual activity (Francomes, 1979). This is confirmed by (Kanter and Zelnik, 1973), who found that white United States church attenders were less likely to use contraception when sexually active, while black church attenders were more likely to use contraception (Kanter and Zelnik, 1973).

Another study by Kanter and Zelnik in 1979 points out that teenage sexual activity often begins with a risky phase of episodic and unanticipated activity. It is estimated that 20% of United States teenage pregnancies occur in the first month of sexual activity (JBF Associates, 1980).

Reid concludes his article that there is no evidence to support the view that school sex (reproductive health) education encourages experimentation. Reid suggests that to encourage younger teenagers to defer sexual activity to an age of greater maturity and deeper, more loving relationships, parents must have greater involvement, and reproductive health must teach specific techniques to resist social pressures (Reid, 1982).

Warren McNab reiterates Reid's conclusion that parents and the school need to work in a collective effort to emphasize the positive and rewarding aspects of sexuality. McNab recognizes that the question is not whether children will get reproductive health education, but how and what kind they will receive. "Parents are the main sex educators, whether they do it well or badly. Silence and evasiveness are just as powerful teachers."[17]

Continuous parent involvement and community participation in development, implementation, and evaluation of comprehensive school health education can serve to prevent many of the objections frequently experienced toward reproductive health education.

ORGANIZATIONAL COMPONENTS OF A COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM

A comprehensive school health education program can prevent many problems from occurring, and can overcome many of the problems that do arise by having a very strong organizational structure. There are several components of a strong organizational structure. One important component is a school health education advisory board made up of parents, students, health professionals, teachers, administrators, clergy, and community business representatives. The advisory board can serve as a liaison between the community and the district school board, review curriculum

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[17]McNab, Warren. "Advocating Elementary Sex Education", Health Education, September-October, 1981, p.22.

materials, and make recommendations to the school board regarding program improvements.

The importance of community participation through a health education advisory board is strongly recommended by Zimmerli in his article on "Organizational School Health Education Programs at the Local Level". Zimmerli identifies community control of a Comprehensive School Health Education Program a key feature in program survival. Communities need to accept ownership of health education curriculum, development implementation, and evaluation if they are to successfully fight opposition to the program (Zimmerli, 1981).

Another important organizational component is the integration of school health services into the overall health education program. Health personnel (ie., school nurses) already present in the school district may greatly contribute to the improvement of a comprehensive school health education program (Sliepcevich, 1965; Newman, 1982).

In a Florida Department of Education model for managing Comprehensive School Health Education, the collaboration of community resources is also seen as a high priority in the overall model. The Florida Department of Education recommends that a Comprehensive School Health Education that provides community coordination will have a cost-effective, reasonable, and rewarding investment. "Because so many people and organizations are concerned about school health education, there is a constant, almost overwhelming flow of new programs, instructional materials, teaching techniques

and research.... There must be a system for becoming aware of these resources, reviewing their appropriateness and effectiveness, and distributing them to the classroom."[18]

The local Comprehensive School Health Education Advisory Board can serve such a role. However, this Board also needs another very important organizational structural component: the Health Education Coordinator.

A strong health education coordinator, who is responsible for the implementation, coordination, and maintenance of the program is seen as the most important factor in the survival of the program. Several studies have indicated that a strong local leader and administrative support are the most vital elements in successfully establishing an educational program. (Emrick et al., 1977; Carlson, 1964; Pincus, 1974; Berman and McLaughlin, 1975).

The Education Commission of the States identified that the most important factor at the state level for supporting school health education is the professional preparation, leadership, and commitment of the education specialists. Thus, a Health Education Coordinator must have adequate professional preparation, be a strong leader, and be willing to endure considerable opposition and conflicts that arise. Perhaps one of the most important reinforcements for health education coordinators is to have an adequate

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[18]Tremor, M. A Model for Managing Comprehensive Health Education Programs in Schools (draft), (Tallahassee, Florida: Florida Department of Education, 1979).

peer support system. The opportunity to share experiences and concerns with other health education coordinators can be an excellent source of new ideas and strategies for health education program improvement. Establishing oneself within the professional network of health educators can help to strengthen health education statewide as well as in the local school district.

The Health Education Coordinator has a multitude of responsibilities. One of the most important functions of the health education coordinator is to provide health education inservice to the teachers responsible for health instruction. For teachers who have not had any professional preparation in health instruction, inservice education may be the only way for them to gain adequate preparation. In-service education can be provided using a number of different teaching methods. A study by Elaine Anderson used a pretest/post-test design on 192 school teachers learning reproductive and environmental health. Anderson recommended the use of a criterion-referenced test procedure for inservice health instruction.

Another inservice study by Eugene Kolacki recommended that when planning a health education inservice program, it is important to identify specific learning objectives for the teachers. Examples of objectives for health education in-service are increased knowledge, increased skills, increased understanding, and the stress and problems elementary students face. (Kolacki, 1981).

Another method of teaching health education in-service is the use of a team teaching approach, where a team of teachers take a leadership role and teach the health instruction to other teachers. This method, advocated by Alyson Taub and Vivian Clark, generated several inservice recommendations. The first recommendation is that more team training of elementary personnel is needed.

Second, a follow-up of health education inservice is necessary to avoid diminished effectiveness.

Third, intensive, long inservice sessions are seen as more effective than numerous short courses. The fourth recommendation is that there needs to be a system of continuous feedback by the participants during the training period. This provides insights for trainers about program effectiveness, and facilitates evaluation of the inservice program.

Fifth, the authors also felt that a requirement of a financial investment from the participants served to assure commitment from the participants as well as help to fund the inservice program. Requiring a financial investment also served as a means for screening out participants who were not genuinely interested in learning.

Finally, Taub and Clark recommended that it is important to communicate regularly with the school administrators about the health education inservice program. This communication serves to ensure continued support for the training efforts. (Taub and Clark, 1977).

HEALTH EDUCATION AS A MEANS OF EDUCATIONAL CHANGE

Introducing a comprehensive health education program in a school district that has not been previously provided, may be met with considerable opposition. Because of severe budget cutbacks and limited hours in the teaching day, many teachers are opposed to trying to fit health education into their overcrowded curriculums. The introduction of comprehensive health education, or any educational change, is a delicate process.

The literature on social and educational change offers many suggestions that can apply toward health education. When introducing an educational change, it is better to persuade and motivate teachers rather than to give them orders. Educational innovations are more successful when teachers want to implement the educational change. To do this, teachers need to be allowed and encouraged to participate in the discussion and decision-making process of the educational innovation. (Argyle, 1967).

Sharing decision-making authority is more likely to reduce many of the problems that accompany an educational change. The teachers are the ones who ultimately must implement the changes, and without their input, or enthusiasm, the educational innovation may not have the desired consequences. A study by Lewis and Lewis regarding implementation of a new health education program showed that only teachers who were enthusiastic in their implementation of the

educational innovation had a significant impact on their students. Teachers who were opposed to the educational change, or neutral, did not induce a significant impact on their students. (Lewis and Lewis, 1982).

There are many barriers to educational change that may affect the implementation and stability of a comprehensive health education program. Some of these barriers are: overload of tasks expected from the teachers, failure to provide adequate assistance or materials, weak support from administration, school board, or community, conflicts and misunderstandings between central administration and health education program director, absence of monitoring or feedback, and absence of leadership. (Gross, 1979).

There are several steps that can be taken to overcome or prevent these problems from occurring. Perhaps the most important prevention strategy is to conduct a detailed needs assessment of the present status of health eudcation being taught in the school district. (Herriott and Gross, 1979).

This needs assessment should include specific information on the health problems and concerns of the local community, as well as a list of persons who are supportive of the proposed health education program. (Havelock, 1974). Other suggestions to overcome some of the barriers to educational innovation include: continuous evaluation and critique of program by program participants, sharing of power and decision-making between administration and faculty, working from within the existing mechanisms for educational

change if at all possible, building a permanent mechanism for obtaining resource information from both the inside and outside of the school district, and maintaining a realistic future orientation. (Argyle, 1967; Herriott and Gross, 1979; Leavitt, 1965; Havelock, 1970).

Even if the health education program has a sound organizational structure, and the teachers have had adequate health education professional preparation, and the content of the health education program is comprehensive, the students still may not be able to apply health education concepts to their personal lives. The sources of health behaviors are very complex. The mere teaching of health concepts does not constitute an effective health education program. The curriculum must also influence normative beliefs about matters other than long or short term physiological effects. (McAlister, 1981).

This influence on normative beliefs has frequently been challenged by opponents of health education. The argument against health education is summarized in the Surgeon General's Report on Health Promotion and Disease Prevention: "One of the fears associated with health education is that it interferes with individual lifestyles. Actually, the goal of health education is just the opposite--to guarantee the individual's freedom of choice regarding his own health by giving him the reliable information he needs to make decisions about how he wants

to live."[19]

To make these kinds of life decisions, the individual must be responsible for her/his own life choices. This element of personal responsibility for one's own decisions and behaviors is seen as an essential characteristic of comprehensive health education. (Sliepcevich, 1965). Health education must allow for complete autonomy of the individual to choose her/his own behavior.

Assumption of responsibility for health behaviors, and increased awareness of disease prevention and control has changed the overall complexion of the health care industry. A knowledgeable public can participate more effectively in decisions that tend to be made by lawyers, physicians, and politicians concerning the health care system, and environmental factors that influence health. (Green, 1974).

A more active role by the public in health-related matters has caused considerable disarray in the power structure of medical and health care industries. The public has become more concerned with its own health and wellbeing, as is evidenced by the unprecedented rise in self-health care initiatives. (The Boston Woman's Health Collective, 1976).

The wisdom and knowledge which was previously held only by health and medical professionals now has to be

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[19]U. S. Department of Health, Education, and Welfare, Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention (background papers), Washington, D. C. USGPO, 436, 1979.

shared more freely. (Ehrenreich and English, 1978). Some of this knowledge dissemination has resulted through the efforts of general health education. This struggle over health and medical knowledge has been ongoing for several hundred years. The advent of the consumer movement has made considerable progress in achieving a more active role by the public toward health-related concerns.

However, this progress has only just begun to address itself to the multitude of health and medical problems facing today's society. One of the purposes of this dissertation is to describe how the elements of personal choice and responsibility for personal and social health are being used as a primary focus for an effective comprehensive school health education program.

This discussion of the current literature suggests that comprehensive school health education is fragmented and inconsistent, or non-existent in Michigan public schools. When health education is taught, it is taught by instructors who lack adequate professional preparation in health education. School health education programs often lack a sound organizational structure for program implementation and operation. Several components for this organizational structure have been suggested such as a competent health education coordinator, a community advisory board, parent involvement, inservice education for health instructors, integration of school health services, continuous program evaluation, school board endorsement, and a health education

content that emphasizes decision-making and personal responsibility.

This review of the literature also suggests that there is a need for an updated study of the current status of comprehensive school health education in Michigan public schools. This study needs to include both quantitative and qualitative research methods in order to give both a broad overview of comprehensive school health education being provided throughout Michigan, as well as a more focused analysis of the processes and functions of a health education program.

CHAPTER III

METHODS USED IN THE DISSERTATION

The methods used to conduct this dissertation combine a participant observation of three health education programs with a statewide health education survey. The statewide survey gives a general overview of the status of comprehensive school health education ongoing in Michigan public schools.

The survey results give a statewide frequency count of several health education program components.

The survey results were also used to identify three health education programs that were used as sites for a participant observation study.

The participant observation portion focuses in on three health education programs identified by the survey. Each site contains a description of the organizational structure, program content, methods of instruction, and how various health education issues are incorporated into the health education program.

INTRODUCTION TO THE RESEARCHER

To help the reader better understand the methods that were used to conduct this research, I have included a brief description of myself, my goals, and some of my personal philosophies.

My relationship to health education and the field of medicine has been developing since my birth. Since my father is a physician, and my mother a nurse, the practices of medicine and the emphasis toward health has been a continuous focus during my life.

I have learned through my own experience that my health and lifestyle were greatly determined by the behavioral and psychological choices I made on a daily basis. I further believe that one's ability to lead a meaningful life is in part, determined by being able to assume full ownership and responsibility for one's behavioral and psychological choices, and to be able to use whatever adversity and misfortune that happens as a means for growth and improved understanding.

Coupled with the process of learning individual responsibility is also the process of learning global responsibility. The term "global responsibility" refers to the responsibility all persons have toward maintaining and improving the quality of all forms of life on our planet. Our recognition of our inter-connectedness with all other forms of life and matter carries with it our need to be responsible for life's past, present, and future existence.

Individual and global responsibility cannot be separated. All individuals are a part of the whole, and any individual's action or choice necessarily affects the actions and choices of others. Thus, the health and lifestyle of any one individual affects the health and lifestyle of others.

The process of assuming both an individual and global responsibility for one's life choices presents a paradox. The choices I make to give purpose and meaning to my life may not always be beneficial to the global totality. Similarly, choices made by others for their personal life's course may be detrimental to the opportunities and needs of the global society. In addition, what may be meaningful for me in my life may not necessarily be meaningful to others. I cannot help anyone else find meaning or purpose in their life, nor can anyone make my life meaningful to me. This is something all persons must find for themselves.

One question at this point may be, "If I cannot help another person to find meaning in his life, what then is the purpose of education?" To me, education, in particular health education, is a process that provides the student with information, ideas, and directions that help the student to understand his body, his changes, and the effects they have on others and on the environment.

Health education can serve as an impetus for personal, social, and global change. However, it is up to each individual student to learn and apply this education toward his own life choices. The student must be ready to receive and make these changes; no instruction or teacher can do this for the student. There are many factors that affect the educational process, ie., social, environmental, cultural, physical, etc. There are also certain educational conditions that may facilitate this process. One of the

purposes of this dissertation is to articulate some of the ways in which health education can be, and have been, optimally enhanced.

CONDUCTING A REVIEW OF THE LITERATURE

My review of the literature has been an ongoing process since I began my dissertation research in 1980. I conducted preliminary searches in order to prepare my dissertation proposal, and to prepare my report on the Statewide Health Education Survey for the Michigan School Health Association.

There are three main health education journals that I have used extensively: The Journal of School Health, Health Education, and the Health Education Quarterly.

I also conducted both a manual and a computerized ERIC Search. For the ERIC Search, I matched the descriptor Health Education with the following five categories of descriptors:

1. Educational planning, school administration, educational policy, administration program development, program implementation, comprehensive programs, educational administration.

2. Decision-making skills, decision-making, conflict resolution, student responsibility, educational responsibility.

3. School-community relationship, school-community coordination, educational sociology, cooperative programs, school involvement.

4. Educational methods, educational strategies, methods, educational technology, classroom techniques, psycho-educational methods, educational practices.

5. Sex education, family health, sex, contraception, ethical instruction, venereal disease.

Out of these five categories, I got forty-eight printed abstracts of the articles or documents. Out of these forty-eight documents, eighteen were found to be the most useful for the review of the literature chapter.

Additional sources for the review of the literature chapter were found through the personal file of the Health Education Specialist at the Michigan Department of Education, The Social Science Citations Index, Dissertation Abstracts, Reader's Guide to Periodicals, and my previous review of the literature conducted in preparation for my Comprehensive Examinations.

HEALTH EDUCATION SURVEY

HEALTH EDUCATION GRANT PROPOSAL

In response to the lack of current information regarding the status of health education in Michigan public schools, the Michigan School Health Association and the Michigan Health Council combined their expertise in grant writing and school health education and submitted a grant to the W. K. Kellogg Foundation. Among other components in the grant, it was proposed that the Michigan School Health Association and Michigan Health Council would together conduct a statewide survey of comprehensive school health education.

The W. K. Kellogg Foundation awarded a grant to the Michigan Health Council and Michigan School Health Association. The grant project was entitled the School Health Education Resources Coordination Program, or "SHERC". Mrs. Mardi DuShaw was named Project Director, and I was hired as Research Consultant.

WHY PUBLIC SCHOOL PRINCIPALS?

An obvious question at this point is why were public school principals selected as the individuals from whom school health education information could be gained? A past survey in 1976 conducted by John A. Romas surveyed all public school superintendents. Although the return rate for this study was quite high, (90%), it was felt that the

superintendents weren't close enough to the actual teaching of health education to know the specifics of program instruction.

Health education instructors were also considered as candidates for the survey respondents, however, it was noted that health education instruction wasn't always existent. The problem of who would fill out the survey, if there weren't any health education instructors still remained.

It was decided that the public school principals were the most likely candidates to be both existent and close enough to health education instruction to be knowledgeable of the specifics of the program. It was also felt that even if the principals were not knowledgeable about health education instruction, the survey could serve as an impetus for further learning and investigation. This proved to be the case for several principals, who responded that they didn't know about the Minimal Performance Objectives for Health Education (now termed "Essential Performance Objectives"), and desired a copy.

After the principals were selected to be the target respondents, the question still remained--how many principals, if it should be a random sample, or simply survey all public school principals in the state. It was decided that the findings would be more reliable and valid if the entire public school principal population were surveyed.

In order to better understand the results of the

survey, let's now take an indepth view of the survey as an instrument to obtain information on the status of Comprehensive School Health Education.

INSTRUMENTATION OR SURVEY CONSTRUCTION

The school health education survey originally consisted of only one major part (referred to as Part I). Part I contains twenty-five YES/NO/NA questions, two questions asking for a percentage, one question asking the principals to fill in the number of minutes per week, and weeks per year of health instruction taught in grades 1-9, and one question asking for a checklist of health education content.

Part I of the survey was constructed prior to my involvement in the SHERC project.

When I was hired by the SHERC project, I was invited to respond to the survey, and make suggestions for its improvement. I recommended to the SHERC project that surveys tend to make subjects feel depersonalized, submissive and dependent upon the researcher, (Argyris, nd.), and suggested giving the principals an opportunity to voice their opinions through some open-ended questions. I developed Part II, containing three open-ended questions in consultation with a Michigan State University learning and evaluation professor, Dr. Walker Hill, and the health education specialist for the Michigan Department of Education, Dr. Wanda Jubb.

Part I of the survey assessed several different components of health instruction. The largest category of questions concerns the organizational structure of the health instruction. Questions such as: Is there a school health advisory board, is health education integrated into other subjects, have curriculum guides for grades K-9, that include the Minimal Performance Objectives (Essential Objectives), been developed by the teachers? Are school health services integrated into the total comprehensive health program? All attempt to assess how extensively the comprehensive health education program has been structured into the schools.

A second category of questions inquired about the content of health instruction being taught. Questions such as: Do all teachers within a grade level follow the same curriculum? Does your school district have a plan/policy for first aid, and a specific checklist of the ten topic areas for Comprehensive School Health Education for each grade level. All request information about the content of health instruction being provided in the schools.

Professional preparation of instructors and the building health coordinator make up another category of questions on Part I of the survey. Questions regarding health education inservice, and whether health instructors have had four semester hours of professional preparation in health education assess whether the health instructors have had adequate health education preparation.

Other categories of questions in Part I of the survey include questions on health instruction methodology, time allotment of health education, and a self-assessment of personal leadership in health program development.

For a breakdown of Part I survey questions by category, see Table 2.

Table 2. Part I of Survey Questions by Category

Category of Questions	Survey Questions (Part I)
Organizational Structure	1, 2, 7, 9, 13, 14, 15, 18, 19, 22, 23, 25, 26, 28, 29
Content	17, 20, 21, 24, 27, 28, 29
Professional Preparation	3, 4, 5, 6, 8, 12
Methods	11
Time Allotment	16
Leadership	10

Part II of the health education survey attempts to give the principals an opportunity to give their opinions on certain aspects of health education in their school district.

Question One asks whether they consider the Minimal Performance Objectives for Health Education applicable to their school district. If not, why not? This question is to assess whether the principals are aware of the Minimal Performance Objectives, and if they are, whether they can apply them to their school district.

Question Two asks the principals what improvements

they felt could be made within their school district to enhance the development of a comprehensive health education program. Instead of just leaving the question wide open, we suggested five possible areas: needs assessment, inservice training, curriculum development, integration with community professionals, and a healthful school environment. These options were suggested in order to help the principals identify what a particular stage of development their school district's health education program may be in. If they did not have any idea of their health education program status, a needs assessment would be a likely choice. If their program was more developed, integration with community professionals may be more appropriate. As we had hoped, principals also stated their own improvements, independent of the suggested areas provided in the question.

Question Three asks the principals whether they believed their school district would like assistance from the Michigan Department of Education on developing or expanding a comprehensive health education program. If so, in what areas? The purpose of this question is to provide a basis for identifying schools that desire assistance to improve or develop their health education programs, and allowed a follow-up effort to be structured for this attention.

In addition, all principals were offered a copy of the Final Survey Report by checking a box on the survey.

DATA COLLECTION

On March 10, 1981, the first draft of the questionnaire was completed and sent out to six school principals. These six principals were selected by the Michigan Department of Education Health Education Specialist because of their known commitment toward improving comprehensive school health education. Enclosed with the survey was a cover letter asking the principals to evaluate the questionnaire and make suggestions for improvements. These suggestions were then incorporated into a revised final version of the questionnaire.

The SHERC project director and the Michigan Department of Education Health Education Specialist both decided that the superintendents of all school districts should be contacted prior to the principals, to inform them about the purpose of the survey, and ask for their cooperation. On March 27, 1981, approximately 780 letters were sent to 100% of the public school superintendents throughout Michigan. See Appendix for a copy of the superintendents' letter.

On April 2, 1981, health education surveys totaling 3,766 were sent out to 100% of all public school principals in Michigan. Accompanying the survey was a cover letter that explained the purpose of the survey and a request that they complete the questionnaire and return it to the Michigan School Health Association by April 24th. The cover letter also assured principals that with the exception of principals who indicate they would like assistance from the Michigan

Department of Education, all answers to the survey will be held in strictest confidence by the Michigan School Health Association. The principals were informed that statewide statistics resulting from the survey would be shared with the Michigan Department of Education, Michigan Department of Public Health, and any other interested school health groups. The letter also indicated that they could receive a copy of the final report by checking the box in page four of the survey.

By the April 24th deadline, 790, or 20.8% of the surveys had been returned. To improve the return rate, follow-up letters with a duplicate copy of the survey were sent out to all non-respondent principals. The cover letters indicated that we had not received their survey, and to have accurate and meaningful statewide results, their survey response is needed. The final cut-off date was established as May 27, 1981. Although some surveys did continue to straggle in throughout the summer and fall, this deadline was needed in order to meet the July 1st deadline for the completion of a Final Report.

By the May 27th final deadline, a total of 1,536, or 40.7% of the total public school principal population had returned the health education surveys.

All mailings of the superintendent letters and the two sets of principal letters and surveys were conducted by myself. I also drafted the cover letters that were later approved by the SHERC Project Director. All address labels

of the superintendents and principals were obtained through the Michigan Department of Education.

During the weeks of June 1--June 12, a phone survey was conducted to non-respondent principals to determine their answers to six survey questions identified as being the most important and informative questions on the survey. This non-respondent phone survey was conducted to improve the external validity of the survey results, by comparing the answers of the non-respondent principals to the respondent principals on the six questions. There were approximately 100 non-respondent school principals randomly selected to participate in the phone survey. Because the timing of the non-respondent phone survey was so close to the end of the school year, time allowed for only fifty schools to be contacted, and thirty-one principals agreed to participate in the survey. A minimal sample size of thirty is needed to approximate a normal distribution (Hays, 1973). Not all questions received thirty responses, however, questions that did not have thirty responses are indicated. A table describing the questionnaire activity and date conducted follows.

Table 3. Schedule of Survey Procedures

Activity	Date
Health Education Survey Development	Prior to March 10
"Pilot" survey sent to six principals	March 10, 1981
Final draft of questionnaire completed	March 25, 1981
780 letters sent to all Michigan public school superintendents	March 27, 1981
3,766 letters and surveys sent to all Michigan public school principals	April 2, 1981
First cut-off date for survey return	April 24, 1981
Follow-up letters with duplicate survey sent to non-respondent principals	April 30, 1981
Final cut-off date for survey return	May 27, 1981
Non-respondent phone survey	June 1--June 12, 1981
Final report completed	July 1, 1981

DATA ANALYSIS

The data from Part I of the survey was analyzed by computer. The statistical package for the Social Sciences (SPSS) was used as the computer program for questions 1-29 (Part I). Each of the three possible answers to each question (YES, NO, N/A) was cross tabulated with the grade levels contained in that particular principal's school. The grade levels' categories were as follows:

K-6 or K-5	Elementary
6-8 or 7-9	Junior high/middle school
9-12 or 10-12	High school
7-12	7-12
K-12	K-12
Other*	

The "other" category comprised schools that did not contain the standard grade levels. The "other" category contained special education schools, and schools with odd grade levels such as 1-3, 3-5, 5-7. So for any one question, there was a cross-tabulation of grade level by the answer to each question.

In addition, there were eight different questions that had special statistical manipulation. Four of these questions were to correct for principal errors in their responses. Both questions number four and number six are to be answered only if the preceding question's answer was no. However, many principals answered questions four and six regardless of their previous question's response. To

correct for this error, a cross-tabulation was done that showed the answers for questions four and six only if answers to questions three and five were no.

Another cross-tabulation was done to match the professional preparation of instructors with whether or not they received health education inservice on a yearly schedule. This statistic enabled me to assess the numbers and percent of principals who responded that the teachers in their school building did or did not have health education inservice training, and whether or not the teachers had professional preparation in health education. This cross-tabulation was done for both elementary and junior high school principals.

A cross-tabulation was also conducted to combine the question of "Is health education integrated into other subjects" and the question whether health education is taught as an identified separate subject. This statistic allowed me to assess how many principals answered yes or no or n/a (not available) to both questions.

The open-ended questions in Part II of the health education survey were entirely analyzed by hand. I tabulated the number and percent of each question, as well as accounted for any comments that were stated, and how often they occurred. There was no analysis by grade level for Part II of the survey.

The non-respondent phone survey was also tabulated by hand. The different responses were analyzed as to the

actual number and percent of each question's possible responses.

The time frame in which the data analysis of the health education survey was ongoing as soon as surveys began to be returned.

Key-punching of Part I of the survey responses was begun immediately, but did not have a computer analysis until after the final deadline of May 27. Part II tabulation of data was ongoing throughout the months of May and June. All data analysis on the health education survey was completed by July 10, 1981.

SELECTION OF A THESIS TOPIC

Because of my personal interest in health education, I was able to obtain several jobs that involved working in a health education context. Some of these jobs included Michigan State University Research Assistantships in the Departments of Surgery, College of Human Medicine; University Center for International Rehabilitation; and the Non-formal Education Information Center in the Institute for International Studies. In addition, I worked as a health education research consultant for the Michigan Health Council, (MHC), and the Michigan School Health Association (MSHA).

During the academic year 1980-81, I participated in the ethnographic research methods course sequence offered at Michigan State University by Profs. Buschman, Florio, and Erickson. During the fall term, Prof. Erickson asked for three students to volunteer to be on a research team to investigate a health education program at Urbandale Public Schools. The research would involve using participant observation as a means to investigate the health program. I volunteered to serve on this team with Victor Cole and Marilyn Parkhurst. Prof. Erickson supervised our research, and each one of us focused on a different aspect of the health program. I studied the kindergarten health program, Victor looked at upper elementary, and Marilyn investigated the high school component.

My participation in the research team on the health project, and my nine-month affiliation with the qualitative research methods class encouraged me to begin looking at educational research and health education with a totally different perspective. My previous research experience had been predominantly of a quantitative nature. I had taken numerous statistics and program evaluation courses, almost all of which emphasized quantitative methods for educational research. Almost all of the research in the health education field was quantitative, comparing treatment groups to control groups on several numerical manipulations. Even the health program at Urbandale which we were investigating had been evaluated (somewhat unjustly) using means and deviations on educational objectives that had nothing to do with health education.

I began to desire to investigate health education using more than a quantitative method. I also wanted to look qualitatively at other health education programs, and compare their differences and similarities and discover what makes a health program succeed or fail.

In the spring of 1981, I was hired by the Michigan School Health Association (MSHA) to conduct a statewide health education survey of all public school principals in Michigan. My involvement in the research of the Urbandale Health Education Program and the opportunity to conduct the survey led me to the decision to focus on health education as my dissertation topic. I decided to use the survey

results to identify two additional health education programs that met a high standard of program criteria. These two programs would be used for possible sites to conduct two other participant observation investigations.

The criteria set for selection of a health education program to be used in a participant observation study were that the principal of the school must have answered "yes" to the following survey questions:

1. Is health education taught as an identified separate subject?
2. Is health education integrated into other subjects?
3. In grades 1-6, do the teachers have at least four semester hours of professional preparation in general health education, ie., personal health/community health, and school health problems? (This question is only for K-6).
4. In grades 7-9, are the health education teachers certified teachers holding majors or minors in health education? (This question is only for 7-9 schools, and was later deleted as only K-6 schools were used).
5. Has a person been appointed as the building health coordinator to help develop, coordinate, implement and evaluate the comprehensive school health education program?
6. Do teachers receive health education inservice training on a yearly schedule?

Additional criteria were that the school personnel were willing to participate in the study, that the three schools needed to differ in size, geographic location, and ethnic composition of the students, and finally, that the schools were accessible to the researcher without excessive mileage.

My dissertation proposal to investigate health

education using the statewide survey and participant observation of three health education programs was approved by my doctoral committee in June, 1981.

I also contacted the University Committee for Research on Human Subjects and gained their approval for my proposed research. I then began the long process of negotiation for entry into the two additional health education programs.

NEGOTIATION OF ENTRY INTO THE FIELD

The three sites selected for the participant observation portion of this study were Hobart, Urbandale, and Botham City. Hobart is a small rural town with approximately 7,000 residents, and is located on one of the Great Lakes of Michigan. The Hobart School District has approximately 902 elementary students and three elementary schools involved in the health education program.

The Urbandale School District is located in a larger city with approximately 131,400 residents. The Urbandale School District has three different health education program components for the kindergarten, elementary, and high school grade levels. My observations of the Urbandale health program focused on the kindergarten health education component. In the Urbandale school district, there were approximately 330 kindergarten students and six elementary schools (eleven classes) involved in the health program.

The Botham City School District is located in a large urban area with approximately 197,650 residents. The Botham City School District has 13,974 elementary students and 45 elementary schools.

A more detailed description of these three sites is provided in Chapter V on page 117.

URBANDALE

Negotiation of entry into the Urbandale Health program was the easiest of all three sites. Because I was participating on a research team that had been invited to conduct research by the health program coordinator, the entry process went through without any major difficulties. I had approximately seven entry meetings with different combinations of the health program staff, the evaluation staff, and the research team to discuss our proposed research. The Urbandale School District requires a research study request form be approved by the Office of Evaluation Services before any educational research can be conducted in the Urbandale School District. I submitted this form on December 29, 1980, and received approval to conduct my research on January 16, 1981.

HOBART

The negotiation of entry to the Hobart School District was the most difficult and lengthy entry of any of the three sites. I first contacted the Director of the Hobart Health Program in April, 1981. At that time, I described my research to her and asked for her recommendations on how best to proceed in the entry process. The Director said I would need to put my request in writing and contact both her and the superintendent of the Hobart School District. At that time, I was still unsure of my final site selection, so I told her as soon as I knew for sure,

I would make formal contact.

During July, 1981, I met with the Hobart Health Program Director to discuss my proposed research, and to reaffirm my research plans. I provided a copy of my dissertation proposal and discussed what I would need to include in my formal written request for entry into the Hobart School District.

In August, 1981, I submitted a formal request to both the health program director and the school superintendent to conduct a participant observation investigation of the K-6 Hobart Health Education Program.

On August 31st, I received a letter from the superintendent of Hobart Public Schools to inform me that he was "inclined to permit..." me to conduct research in the elementary schools, however, before a final decision was made, I was asked to meet with the elementary principals to explain in detail my research procedures. The letter stated that they were concerned that my research might interfere with student learning and/or teacher instruction.

I had approximately fourteen different meetings to negotiate entry into the Hobart Public Schools.

At first, I was informed that I could probably begin observations in early October, but that was retracted at a later date. I felt a pressing need to gain entry into the Hobart schools as soon as possible, because I was six months pregnant in October, and needed at least six weeks of observations to conduct my research. I wanted to complete my

observations of Hobart before the birth of my first child, due in January.

By early November, I still had not been permitted to observe in any of the health education classes. I began to get quite impatient and discouraged. I had grossly underestimated the amount of time it would take to gain entry into the Hobart Schools.

After I received official permission to conduct my research from the superintendent, the entry process and establishing rapport in the field still demanded considerable time and effort.

Ultimately, I feel it was outside influence from health education professionals that eventually helped me gain rapport from the health education program director. Once I was able to gain the trust and approval of the program director, the process of gaining rapport from the teachers proceeded smoothly.

Teachers from the 3rd, 6th, 2nd, and 1st grades volunteered to allow me to observe their health education classes. Because I had to synchronize my observations with the teaching of a particular health unit, my observations were ongoing into the spring of 1982.

On November 17, I began observation of the 3rd grade Growing Up unit, and completed my observations of the Hobart health program on March 29, 1982.

BOTHAM CITY

I began my entry into the Botham City School District with a letter to the Botham City school superintendent on March 9, 1982, to request permission to conduct participant observation of the health education program being taught at Schultz Elementary School.

On March 11, a letter from the Health Education Specialist for the Michigan Department of Education was also sent to the school superintendent on my behalf, asking for his cooperation and support of my research.

On March 30, I met with the principal of Schultz School to discuss my research. By this time, the Botham City school superintendent had already contacted the principal with regard to my research.

The principal was very open and interested in facilitating my research study. The principal offered to contact the teachers on my behalf, and obtain a list of volunteers who would allow me to observe in their classrooms.

Upon my second meeting with the principal on April 15, a schedule of observations for different health education classes was already established. I conducted my research observations with these volunteers between April 16 and May 2, 1982.

METHODS OF COLLECTING DATA AND RANGE OF DATA COLLECTED

The predominant form of data collected in the participant observations of the three health education programs was the use of a field note technique recommended by Anselm Strauss and Leonard Schatzman in their text, Field Research Strategies for a Natural Sociology. All observations were first recorded on paper and then recopied and expanded within a short period of time (usually within 24 hours). The expanded version of field notes included articulation of Observational Notes, Theoretical Notes, and Methodological Notes (Schatzman and Strauss, 1973). The observational notes are statements regarding events experienced through actual watching and listening to the setting. Observational notes are not interpretive, but instead try to describe the event as objectively as possible. Whenever possible verbatim accounts of the participants using either tape recordings or actual quotations, as well as description of behaviors and activities were used for evidence to enhance the internal reliability of the study.

Theoretical notes describe my attempt to make sense of the observed activity. The theoretical notes were used as a means to hypothesize relationships, and to infer categories and classes from the data within the theoretical notes. I also used the "disciplined subjectivity" technique for monitoring my own tension and/or personal biases

regarding the observations. If a particular scene brought forth a particular emotion or response from me, I noted it as such, and used it to signal my own objectivity.

The methodological notes were instructions within the context of my observations that directed me to seek additional tactical maneuvers to gain more observational and theoretical evidence. Methodological notes identified gaps in my data collection, as well as providing follow-up leads for further investigation.

This transcription and expansion of the field notes was a very time consuming process. For one hour of classroom observation, the transcription process required between three and four hours to type and analyze the observations.

The tape recorder to record classroom observations and activities was only used in the observations at Urbandale. The difficult and tentative entry at Hobart made me decide not to further antagonize my informant relationships by asking to tape record their classroom activities. Instead, I used several methods for insuring internal reliability. Some of these methods included using verbatim accounts, interview data, using multiple field informants, and asking for participant reaction and participation in the observation and analysis of findings (LeCompte, 1982).

I also developed my own methodology for obtaining participant reaction and participation in the research

process. In several key observations, I asked the teacher of the classroom to read over my expanded transcription of the field notes. I asked the teacher to "relive" the happenings of the situation with me as we together read the field notes, line by line. I asked the teacher to stop anywhere along the line and add what (s)he was thinking and/or feeling at the time, or to add any reaction (s)he had to my observations. This methodology of using participant reaction provided a rich source of analysis and perspective that had not previously been obtained. For example, as Mr. O'Brian read over a section describing a student's question about how food gets down to the stomach, he stopped and said, "my example of using the long, skinny balloon (see page 168) just came to me....that's how this health education gets transmitted....no one told me to use that example, nobody could....that's where the quality of the teacher really makes the difference in a health education course...." This method of using participant reaction was adapted from my previous work with Dr. Norm Kagan, using the Interpersonal Process Recall (IPR) technique for counselor training. (Kagan, 1975).

Another type of data collected was that of several documents obtained from the various health programs I observed. I also kept an introspective journal of my personal reactions and feelings during the research process.

One source of data used to "piece together" the various health education programs was supplied through my

informal connections to the health education professional network. Several individuals outside of the observation sites helped me to better understand the processes involved in developing and maintaining a comprehensive health education program. These individuals are professionals in the health education field and are very knowledgeable about various health education programs ongoing in Michigan. This form of peer review and examination also helped to improve the internal validity of the findings (LeCompte, 1982).

For a summary of the sources and amounts of data collected for each of the three sites, see Table 4.

Table 4. Sources of Data Collected

Source of Data Collection	Urbandale	Hobart	Botham City
Observations	17	17	6
Interviews	5	7	9
Letters	--	1	1
Dairy Council Information	--	--	1
Textbooks	--	--	All texts, K-6
Health Project Documents	7	3	5
Bulletin Boards	--	3	2
Staff Meetings	11	2	--
Luncheon Discussion	1	--	--
Specific Entry Meetings	7	14	1
Curricular Notebooks	--	3	--

DATA ANALYSIS

The analysis of the data began while I was still in the field. In the beginning of my research at the Urbandale health program, I met with the other members of the research team, and with the class members to discuss perceptions, and develop working hypotheses. Through the formulation of research questions, and subsequent alterations during the field research process, the analysis of the data became more focused.

The Hobart health program was studied in greatest depth of any of the three sites. Early in the research process, I developed five main categories of data within my observations. These five categories were: organizational structure, program content, methods of instruction, behavioral choice and decision-making, and health education issues. The establishment of these categories and classes of data was reflected in the research questions and in the overall analysis of data.

The Botham City health program was studied in the least depth of the three sites. I used three of the same categories I used for the Hobart data analysis for the analysis of the Botham City health program. These categories were: organizational structure, methods of instruction, and program content.

Immediately following my observations of each site,

I wrote out a chronology of all meetings, observations, interviews and activities that took place during my observations. From this compilation and in the transcribed field notes, I color-coded the different categories of data and wrote up separate analysis for each category. This process illuminated how interdependent the five classes were in each of the three health education programs. It became apparent that the establishment of one category permitted the presence of other categories, and that some categories were dysfunctional without the other categories. For example, the overall organizational structure of the health program allowed for the categories of program content, instructional methods, and behavioral choice and decision-making to exist. The methods of instruction were dependent upon the content of the health education. Some methods of instruction were more appropriate for teaching a certain health education content than others. Health education issues seemed to be found in all of the other categories.

After mapping out the interdependency of the data categories, I was able to make sense of the whole picture by using a theme of a nesting effect of the five major categories. By nesting effect, I mean that some categories of the data were nested in other categories, and all were interdependent and interrelated with each other.

The data analysis seemed to take on the shape of a spiral, with a more focused and specific constructs at the center, and a more broad and global constructs on the

fringes. The spiral nesting effect of the five categories allowed me to articulate a conceptual scale of health education program quality. The more a health education program reflected each of the five categories, the better the program quality seemed to be.

Between the observations of all three health programs, I was able to theoretically combine parts of each program to propose an optimal health education program that contained components of each.

Thus, the observations of the three health programs enabled me to create a synthesis of their program strengths, and to suggest recommendations for health education program improvement.

CHAPTER IV

RESULTS OF THE HEALTH EDUCATION SURVEY

The statewide health education survey was sent out to all public school principals (approximately 3,766) in Michigan. After the final deadline date, 1,536, or 40.7% of the surveys, had been returned. The reader is reminded that 40.7% is a moderate return rate, and the interpretation of the results must be held in perspective of this moderate respondent population. The following table gives a description of the respondent population who returned the survey.

Table 5. Survey Respondents

Grade Level	Number of Principals	% of Respondents	% of total Population
K - 6	760	53.3	33.7
7 - 9 or 6 - 8	287	20.1	52.6
9 - 12 or 10 - 12	285	20.0	61.1
7 - 12	51	3.6	32.4
K - 12	8	.6	33.3
Other	30	2.3	
	1,421	99.9	

As can be seen from the table, 760 or 53.3% of the respondents were elementary principals, which was 33.7% of the total elementary principal population. Two hundred

eighty-seven or 20.1% of the respondents were middle school or junior high principals, which was 52.6% of the total middle school/junior high principal population. Two hundred eighty-five or 20% of the respondents were high school principals, which was 61.1% of the total high school population. Fifty-one, or 3.6% were 7-12 principals, which was 32.4% of the total 7-12 principal population. Eight, or .6% of the respondents were K-12 principals, which was 33.3% of the total K-12 principal population. Thirty, or 2.1% were classified as other principals. The other category comprised schools that did not contain the standard grade levels, such as 1-3, 3-5, 5-7, or special education schools.[1]

Even though this effort was made, some high school principals did not respond to those specific questions. This made the high school principals' responses a smaller sample size, which may result in a higher discrepancy between the high school respondent answers and the high school non-respondent answers. Most of the results of the survey have been reported by the total respondent population. Individual grade categories are reported only when a significant finding is shown.

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[1]Possible error in the survey findings might be due to the fact that certain questions asked the principals from K-9 to respond, and did not apply specifically to high schools. In an attempt to make the survey more applicable to high schools, all high school principals received an insert in their questionnaire which read as follows:
"Your school building has been identified as containing grades 9-12. Please answer questions 5, 16, 27, 28, and 29 of Part I, and question 1 of Part II as they apply to your school building. Thank you."

The description of the results of the survey have been separated into five main categories: organizational structure, program content, professional preparation, methods of instruction, and principal opinions regarding program improvement. The following section discusses the survey results of these five categories.

ORGANIZATIONAL STRUCTURE

Perhaps the most important results of the health education survey indicate that Michigan Public Schools lack a developed organizational structure to implement a comprehensive school health education program. Several questions from the survey point to this conclusion. The following table summarizes the main organizational structure survey responses.

Table 6. Organizational Structure Survey Results

Question	Total Principal Response		
	Yes	No	N/A (Not available)
Is health education taught as an identified (separate) subject?	54.2	45.5	.3
Has a person been appointed as the building health coordinator to help develop, coordinate, implement, and evaluate the comprehensive school health education program?	31.0	66.3	2.6
Have curriculum guides for grades K-9 that include the ten areas, as defined by the Minimal Performance Objectives for Health Education in Michigan, been developed by the teachers?	32.1	57.4	10.5
Does your school district have a health curriculum planning committee to provide leadership in the development and implementation of the comprehensive health education program?	44.2	52.1	3.6
Has the local school board approved curriculum guides and policies for implementing a comprehensive health education program?	47.5	47.2	5.3

Table 6. (continued)

Question	Total Principal Response		
	Yes	No	N/A (Not available)
Has the school board appointed a school health advisory board made up of parents having children attending the district's schools, educators, (eg., administrators, teachers, professional staff), local clergy, community health professionals, and other interested citizens?	31.2	62.7	6.1
Is school health services component integrated into the total comprehensive health program?	49.8	35.1	15.1

First, 54.2% of the total principal population, and 43.3% of the elementary principal population indicated that health education is taught as an identified (separate) subject.

Second, 66.3% of the total principal population, and 70.2% of the elementary principal population answered that their school did not have a building health coordinator appointed to help develop, coordinate, implement, and evaluate the program. The percentages of "yes" answers were the highest for the high school principals (36.3%), followed by the junior high principals (33.0%), and lastly, the elementary principals with 27.3% "yes".

Third, 57.4% of the responses from principals in all grade levels, and 62.6% of the elementary principals indicated that curriculum guides for grades K-9 that include the Minimal Performance Objectives have not been developed by the teachers.

Fourth, 52.1% of the principals from all grade levels responded that their school district did not have a health curriculum planning committee to provide leadership in the development and implementation of a comprehensive health education program.

Fifth, 47.5% of all principals from all grade levels except the 7-12 grade level, indicated that the local school board had approved curriculum guides and policies for implementing a comprehensive health education program. Thirty-four percent of the 7-12 principals (which comprised 3.6% of

the total population), indicated that their local school board had approved curriculum guides and policies.

Sixth, the majority of school principals (62.7%) in all grade levels answered that the school board had not appointed a school health advisory board, made up of parents having children attending the district's schools, educators, local clergy, community health professionals, and other interested citizens. There is a trend, however, that shows that as the grade level increases, the likelihood that the school board has appointed a school health advisory board also increases.

Finally, when asked if the school health services component is integrated into the total comprehensive health program, 49.8% of all principals answered "yes", 35.1% answered "no", and 15.1% answered "N/A" (not available).

CONTENT OF HEALTH INSTRUCTION

The second category of questions pertains to the content of the health education program.

The most informative question regarding program content asks the principals to check the appropriate boxes on a grid showing the ten topical areas contained in the Essential Objectives, and grade levels 1-9. There were a number of principals who did not respond to this question at all.

The elementary principal responses ranged from an average of 568 or 39.4%, to 169 or 11.7% of the total responses received. The junior high principal responses

ranged from an average of 256 or 17.8%, to 179 or 12.4% of the total responses received. The high school principal responses ranged from an average of 80 or 5.5%, to 63 or 4.4% of the total responses received.

A distribution of the most frequently checked topic areas for grades 1-6, 7-9, and 10-12, to the least checked topic area is provided in Table 7.

As shown in Table 7, the three different grade levels vary considerably as to what content areas are most frequently taught at each grade level. Certain topics such as Safety and Personal Health which are of particular importance to the lower grade level students, are taught more frequently at elementary level than junior high and high school levels. The reverse is also true for areas such as Emotional and Mental Health, and Disease Prevention and Control; such topics seem to be more relevant to the older student and are more frequently taught at the high school level.

The elementary principals' responses for grades 1-6 reveal certain trends. One trend shows that for grade levels 1-4 the order of health education topical areas checked was the same for all grade levels for the first four areas. Safety was the most frequently checked area, followed by Personal Health, Nutrition, and Disease Prevention and Control. A second trend showed that Substance Use and Abuse was taught more frequently in the 4th, 5th, and 6th grade levels. Other trends showed Growth and Development

Table 7. Frequency Distribution of Health Education Content Areas

Grade Levels		1 - 6	7 - 9	10 - 12
Most Frequently Checked	1	Safety	Personal Health	Disease Prevention and Control
	2	Personal Health	Nutrition	Emotional and Mental Health
	3	Nutrition	Substance Use and Abuse	Substance Use and Abuse
	4	Disease Prevention and Control	Safety	Nutrition
	5	Growth and Development	Growth and Development	Personal Health
	6	Substance Use and Abuse	Disease Prevention and Control	Growth and Development
	7	Family Health	Emotional and Mental Health	Family Health
	8	Emotional and Mental Health	Family Health	Consumer Health
Least Frequently Checked	9	Community Health	Consumer Health	Safety
	10	Consumer Health	Community Health	Community Health

was taught more in 5th and 6th grades. Community Health and Family Health were taught less frequently in the 4th, 5th, and 6th grades than in 1st, 2nd, and 3rd grades. Disease Prevention and Control was taught less frequently in the 5th and 6th grades than in the earlier grades.

For the junior high principal responses, Personal Health was the most frequently taught subject for 7th and 9th grades, and second for the 8th grade. Substance Use and Abuse was taught more frequently in the 9th grade than in 7th or 8th grades. Disease Prevention and Control was more often taught in the 9th grade level than in 7th and 8th grades. The last four topic areas that are the least frequently taught for grades 7th, 8th, and 9th were (in descending order): Emotional and Mental Health, Family Health, Consumer Health, and Community Health.

For the high school level, Disease Prevention and Control, and Emotional and Mental Health seemed to be the most frequently taught subjects. The 10th grade level had equal numbers of the first four areas checked. These areas were: Personal Health, Nutrition, Substance Use and Abuse, and Disease Prevention and Control. In all three grade levels of high school, Community Health was the least taught subject area.

Throughout all grade levels, there did not seem to be any one topic area that was taught most frequently. There was, however, a trend that showed Community Health and Consumer Health to be the least taught subject areas in all

grade levels. There was a small number of responses to this question from the high school grade levels, which makes it difficult to make any assumptions about what topic areas are most and least frequently taught in the high school population at large. There is also no way to guard against possible error in which principals marked topic areas being taught in grade levels other than those contained in their school building. There are enough responses, however, to indicate the general frequency of health education topic areas being taught in grades 1-9. For grades 1-9, the two most frequently checked topic areas were Personal Health and Nutrition.

Additional survey questions that pertain to the content of the health education program are summarized in Table 8.

Table 8. Content Responses of Health Education Survey

Question	Yes	No	N/A
Do all teachers within a grade level follow the same curriculum?	64.4	27.7	7.4
Are the health education knowledge tests suited to the grade level where they are administered?	49.5	5.1	45.4
Are current health education periodicals and health reference materials available for classroom use?	76.7	21.1	2.3
Does the Minimal Performance Objectives for Health Education in Michigan serve as a guide for your school district's health curriculum?	58.5	31.3	10.3

As can be seen from the table, 64.4% of all principals in all grade levels responded that all teachers within a grade level followed the same curriculum. 27.7% of the principals responded no and 7.9% answered N/A. A closer look at the different grade levels shows that only 59.4% of the elementary principals answered yes, as compared to 74.9% and 71.2% of the junior high and high school principals, respectively. This statistic indicates that elementary teachers are more likely to teach different health education curriculums within the same grade level.

When asked whether health education knowledge tests were suited to the grade level where they are administered, 49.5% of all principals answered yes, 5.1% answered no, and a sizeable percentage, 45.4%, answered N/A.

A high majority of principals from all grade levels (76.7%) responded yes, that current health education periodicals and health reference materials are available for classroom use.

The last content question refers to whether the Minimal Performance Objectives for Health Education in Michigan serve as a guide for the school district's health curriculum. A majority (58.5%) of principals from all grade levels responded yes, 31.3% responded no, and 10.3% responded N/A.

The questions regarding content of health instruction indicate that health curriculums being taught in the same grade level are not consistent and often do not provide a comprehensive health curriculum.

PROFESSIONAL PREPARATION OF INSTRUCTORS

There were three main questions in the survey that inquired about the professional preparation of instructors. When the elementary principals were asked if the teachers have at least four semester hours of professional preparation in general health education (preservice education), only 19.5% answered yes, 59.2% answered no, and 21.3% answered N/A. Those who answered no were asked what percent of the teachers did have at least four semester hours of professional preparation in general health education. Controlling for inappropriate responses from junior high and high school principals, the following table indicates the various percentages.

Table 9. Percent of Elementary Teachers with at Least Four Semester Hours of General Health Education

	0%	1-10%	11-24%	25-49%	50-74%	75+%
Percent of Principal Responses	10.6	37.0	10.2	18.5	20.8	3.0

Perhaps the most important question regarding professional preparation of instructors asks whether teachers receive health education inservice training on a yearly schedule. A high majority (81.1%) of principals in all grade levels answered that health education inservice is not being received by the teachers on a yearly schedule. Examining just the elementary principals, 12.2% responded yes, 84.8% responded no, and 3.0% responded N/A.

The following table summarizes the elementary principal responses to the survey questions regarding professional preparation.

Table 10. Professional Preparation of Elementary Teachers

Question	Yes	No	N/A
In grades 1-6, do the teachers have at least four semester hours of professional preparation in general health education, ie., personal health/community health, and school health problems?	19.5%	41.6%	21.3%
Do teachers receive health education inservice training on a yearly schedule?	12.2%	84.8%	8.0%

Statistics regarding professional preparation of the teachers show that very few principals responded that their teachers had preservice education (college training) or inservice education in health education.

A cross-tabulation of the question regarding preservice education, and the question on inservice education was made. This statistic showed that the largest percentage of elementary principals, 52.2%, indicated that the teachers did not have four semester hours of general health education, nor did they receive health education inservice on a yearly basis. The second largest category showed 16.1% of the elementary principals answered that the teachers did not have at least four semester hours of professional preparation, and responded N/A with regard to whether the teachers had health education inservice training on a yearly schedule.

The statistics regarding professional preparation of the instructors indicates that very few instructors in Michigan public schools receive inservice or preservice health education.

METHODS OF INSTRUCTION

Only one question on the health education survey referred to the Methods of Instruction. This question asked if the teachers offer study options, extra credit, and/or choice for students in projects. Of the elementary principals, 55.1% answered yes, 32.3% answered no, and 12.6% answered N/A.

PRINCIPAL OPINIONS REGARDING PROGRAM IMPROVEMENT

Part II of the questionnaire consists of three open-ended questions asking principals' opinions on development of a comprehensive school health education program. There was no analysis by grade level for any of the three questions in Part II. Question #1 asks if they consider the Minimal Performance Objectives for Health Education in Michigan (MPO's) applicable to their school district, and if not, why not?

There was a total of 1,524 principal responses to this question. Out of these, 859 or 56.3% answered yes, 116 or 7.6% answered no, 494 or 32.4% answered N/A, and 56 or 3.6% answered that they did not know about the Minimal Performance Objectives.

There were ten principals who requested a copy of the Minimal Performance Objectives. These were sent to them soon after the requests were received. Out of the responses that said no, the Minimal Performance Objectives were not applicable, the following reasons were given:

"lack of funding or priorities"
"we set our own objectives"
"not used at present time"
"we should develop our own"
"not required"
"not enough time"*
"Berkley model is used"*
"have never seen them"
"lack of materials to teach from"
"we don't have staff training district-wide, or money to train them"

*This reason was cited by several principals.

The second question in Part II asks the principals what they believe are the major improvements which could be made within their school district to enhance the development of a comprehensive health education program.

There was a total of 1,524 responses to this question. Most of the principals answered that there was more than one area that could be improved in their school district. The following table describes the principals' responses.

Table 11. Improvements Suggested by all Public School Principals

	% of Total Survey Responses*
No answer	36.1
Inservice	27.4
Curriculum Development	20.3
Needs Assessment	9.3
Integration with Community Professionals	8.7
More money	6.8
All of the above	4.7
No improvements needed	3.4
Health Educator	3.0
Healthful environment	2.4

*Percentages are based on number of principals responding, not on the total number of categories checked. Most respondents checked more than one category.

Question #3 of Part II asks if the principals believed that their school district would like assistance from the State of Michigan Department of Education in expanding or developing a comprehensive school health education program. If so, in what areas?

There was a total of 1,483 responses to this question. Of these, 294 or 19.3% answered yes, 484 or 31.8% answered no, 600 or 39.4% did not answer the question or answered N/A, and 105 or 6.9% answered that they didn't know. With regard to the areas of assistance in which the principals

who answered yes, the following table summarizes their responses.

Table 12. Areas of Desired Assistance from Michigan Department of Education

Areas	% of Total Survey Responses*
Inservice	25.0
Curriculum Development	22.2
All areas	16.0
Needs Assessment	10.0
More money	8.0
Materials	3.8
Integration with Community Professionals	3.5
Substance Abuse	4.8

*Percentages are based on the number of principals responding, not on the total number of categories checked. Most respondents checked more than one category.

The survey questions of Part II indicate that the majority of principals feel that their school districts could use some improvement in expanding and developing a comprehensive health education program. Inservice Education and Curriculum Development were the two most frequently cited areas that needed improvement and assistance.

SUMMARY OF THE FINDINGS OF THE NON-RESPONDENT PHONE SURVEY

The non-respondent phone survey consisted of six questions (four of which are relevant to the K-6 principal population). The following table indicates the respondent

and non-respondent answers to these questions.

The findings of the non-respondent phone survey indicate that percentages for yes responses are generally higher on most questions for the respondent population than the percentages for the non-respondent population on all questions asked. These statistics suggest that the principals who did not return the survey have a less-developed comprehensive health education program than the principals who returned the surveys.

CONCLUSION

The results of the School Health Education Resources Coordination Project survey have suggested several implications that warrant particular attention. The areas of professional preparation, inservice training, and application and utilization of the Minimal Performance Objectives for Health Education in Michigan, the content of health education, and the lack of a well-developed organizational structure for health education have been articulated as deficit areas in the current status of comprehensive school health education. Focused attention and enrichment of these deficit areas will be necessary for a continued improvement of comprehensive school health education in Michigan public schools.

A statewide survey of public school principals on health education can provide only a small part of the total picture of comprehensive school health education ongoing in

Michigan. The total picture of comprehensive school health education in Michigan is beyond the scope of this study. However, this study does provide valuable information and a framework on which future research in health education can be based.

Table 13. Non-respondent Phone Survey

Question		Survey Non-Respondent N	Survey Non-Respondent %	Survey Respondent N	Survey Respondent %
Is health taught as an identified (separate) subject?	YES	9	29.0	780	54.2
	NO	20	64.5	655	45.2
	N/A	2	6.4	4	.3
Is health integrated into other subjects?	YES	25	86.2	1,291	90.2
	NO	2	6.8	124	8.7
	N/A	2	6.8	15	1.0
Has a person been appointed as the building health coordinator to help develop, coordinate, implement and evaluate the comprehensive school health program?*	YES	9	31.0	446	31.6
	NO	18	62.0	953	66.3
	N/A	2	6.8	38	2.6
Do teachers receive health education inservice training on a yearly schedule?	YES	3	10.0	222	15.5
	NO	25	83.3	1,162	81.1
	N/A	2	6.6	49	3.4

*Indicates that the non-respondent population is less than 30.

CHAPTER V

ETHNOGRAPHIES OF THE THREE HEALTH PROGRAMS

MAIN ISSUES IN THE THREE SITES

The analysis of the observations of the three health education programs identified five main factors necessary for a high quality health education program. These five factors are:

1. Organizational structure.
2. Content of health instruction.
3. Methods of health instruction.
4. Presence of certain health education issues.
5. Health education in terms of the student's behavioral choice and decision-making.

Each of these five factors is described below.

The organizational structure of the health program includes all aspects of the health education program that administer, plan, and provide health education to students, parents, instructors, and the community. Examples of organizational structure components include a health education advisory board, inservice education to teachers, evaluation of the health education program, integration of school health services (ie., school nurses) into the overall health education program.

The content of the health education program refers to the substance of the curriculum being provided to the

students. Components of a health education content include nutrition education, family health, safety, and community health. A comprehensive health education content is defined by the Michigan Department of Education as meeting the Essential Objectives for Health Education in Michigan. These objectives represent the ten topic areas of health education: nutrition, safety, personal health, family health, consumer health, community health, disease prevention and control, substance use and abuse, emotional and mental health, and growth and development.

The methods of instruction refer to the instructional technology being used to teach the health education. Some of these methods include hands-on experience, audiovisuals, textbooks, discussion, etc.

The issues of health education refer to relevant issues that concern individual and social health. Examples of health education issues are conserving food, respecting the rights and privileges of others, being responsible for the health and well-being of others.

The key factor of behavioral choice and decision-making refers to the content of health education being presented in terms of the student's personal behavioral choices and decision-making. This framework enables the student to be aware that (s)he is responsible for her/his own health as well as affecting the health and well-being of others....

It was also evident in the observations of the three health education programs that there is a "nesting"

effect within these five main factors. The term "nesting" means that some of these factors are interdependent and enable other factors to be present. For a high quality health education program certain factors are necessary, but not sufficient. For example, an adequate organizational structure is necessary for a comprehensive health education program, but it is not enough; other factors such as a health education content, methods, and the content being presented in terms of behavioral choices and decision-making must be present. Figure 1 illustrates this nesting of the main factors found in the observations.

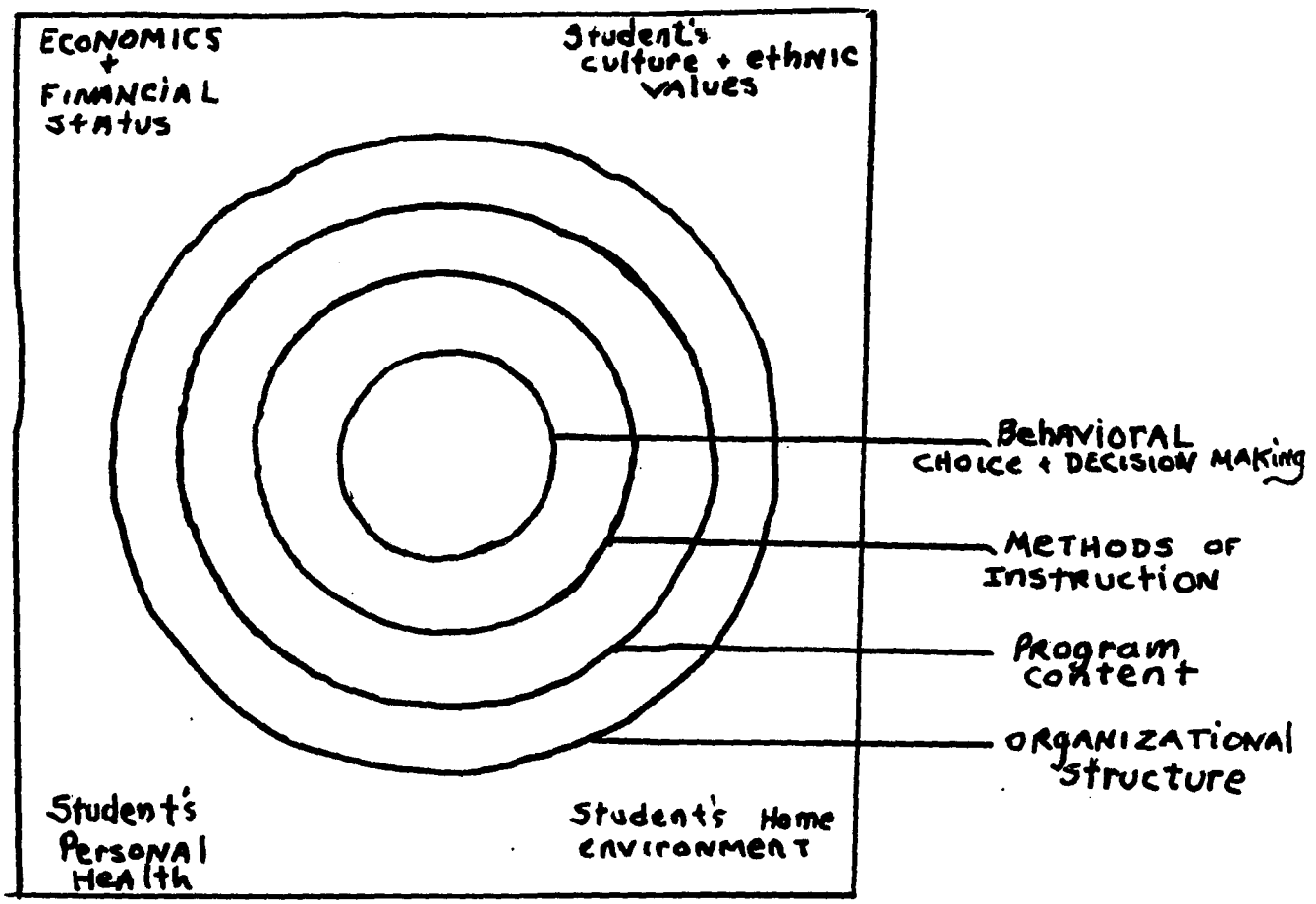


Figure 1. Nests of the 5 Health Education Factors

As can be seen in the diagram, the outer sphere represents the main factor of the organizational structure of the health program. The organizational structure is the foundation upon which a health education program is built. Organizational structure is in the outer sphere because it enables all other components to be present.

The second sphere represents the factor of health education content. The content of the health program is dependent upon what materials and training have been provided by the organizational structure, and also enables other factors such as methods, issues, and behavioral choice and decision-making to be present.

The third sphere represents the instructional methods being used to teach the health education program. This factor is dependent upon the content, since certain health topics are better taught with a particular method.

The fourth nested sphere represents certain health education issues. The issues being addressed depend on the content being taught as well as the methods with which they are being taught. For example, in family health, the issue of a test tube baby may be discussed.

The innermost sphere represents the key factor of behavioral choice and decision-making. This factor is seen as the most important concept because for the student to practice and apply the learned health education content, the student must go beyond the simple learning of facts and internalize them to be used as a contributing reference for

making personal health decisions. It is not enough just to know a certain health fact, one must base one's choice and decisions on this fact as well. For example, knowing that we need each of the four food groups daily to have a balanced meal is not enough. We must choose to be sure we eat each of the four food groups as well.

Figure 1 also illustrates that there are several other subsidiary factors or variables outside the health education program that have a major influence on a student's choice of health behaviors. Perhaps the most important of these variables is the student's home environment, and her/his personal health. What the student sees and learns at home both before and throughout her/his school years, and their general health status, has a tremendous influence on the student's ability to make her/his own health decisions. (Lindsay and Norman, 1972) (Mussen, et al., 1969).

Integrally linked to the home environment is the student's cultural and ethnic background. The values that are characteristic of certain ethnic and cultural groups tend to become internalized into the student's own personal values and subsequent choices of health behaviors. (Giordano, 1982).

Another subsidiary variable that affects the student's ability to learn health education and to make positive health decisions is the student's ability to learn how to go to school. Particularly in the kindergarten and lower elementary grade levels, some students have a culturally shaped

interpretation of the world that does not compare with the demands and expectations of the academic classroom. These students are often evaluated as developmentally deficient when in reality, these student deficiencies are actually differences in interactional styles or patterns.

In addition, the economic and financial status of both the student's family, and the community within which (s)he lives, necessarily affects the selection of health choices a student may make. The community and/or neighborhood within which the school is located also presents an influence on the students within the health education program. Demographic factors such as the student enrollment, ratio of teacher and students, urban and/or rural location, etc., also determine what options students make within a given health education program.

There are several issues that are relevant to each of the five key factors. These main issues for each factor are discussed below.

For the key factor of organizational structure, the main issues surround whether a certain component is even present in the organizational structure, and if it is present, what degree of influence does it have on the overall structure? For example, parent involvement may be an issue for some health programs. If parents are involved, what degree of influence do they have on the overall health program... Are parents included on the policy decision-making? What authority do they have within the health

education structure?

The main issue within the factor of content of the health education program is whether or not the content meets the Essential Objectives for Health Education in Michigan as is stated by the Michigan Department of Education. Another issue is whether the content is presented in a way that is applicable to the student's own personal experience. Basing education upon personal experience allows students to comprehend the material of instruction in a way that is linked to the student's immediate concerns and is able to influence the student's later experiences. (Dewey, 1938).

One of the main issues that affects the factor of methods of instruction is the type of relationship or level of bonding that exists between the students and the teacher. This student-teacher bonding, or lack of it, influences how receptive the student will be for the health instruction. Certain instructors are more comfortable teaching health using one or more particular methods. Also, certain content topics lend themselves to a particular instructional method.

There are two main issues within the key factor of positive health choices and decision-making that affect the quality of health education program. One issue concerns the degree to which the health instruction is used by the student as a reference from which to make personal health decisions. The data from which a student may make a particular health decision depends on a multitude of factors which may or may not include previous health instruction. Some of these

factors may include behaviors learned from significant others, cultural and ethnic values, peer pressure and support, community and environmental conditions, economic status, etc. Some of these factors are illustrated in Figure 1 as subsidiary variables.

A second issue within the key factor of positive health choices and decision-making is whether the health instruction has helped the student realize that (s)he is responsible for her/his own decisions, and that these decisions will affect her/his own health as well as the health of others.

In order to better understand how these key factors and main issues apply to the three observed health education programs, let us now turn to a general overview of the three sites and the major issues and key factors in each.

GENERAL OVERVIEW OF THE THREE SITES

The three sites at which observations took place were Hobart, Botham City, and Urbandale. Each of these three sites was different in several ways. Perhaps the most important difference in the three health education programs was the size of the student population which the health education program served. As can be seen in Table 14, Hobart's health program served approximately 902 students, taught by 37 teachers, located in three elementary schools.

The Urbandale health education program for kindergarten students served 330 students, taught by six teachers, in eleven different classes located in six elementary schools. This same health program also had a separate curriculum for 2,130 students in grades 3-6, taught by 65 teachers, located at 21 schools.

The Botham City health education program served approximately 13,974 elementary students, taught by 450 teachers, at 45 elementary schools.

The size of the towns or cities that contain the school health education programs also differ. Hobart is a small rural town with approximately 7,000 residents. Urbandale is a city with approximately 131,400 residents, and Botham City has approximately 197,650 residents.

Because of these differences as well as the amount of time I was able to spend observing each program, my observations at the three sites necessarily differed in

intensity. The observations at the Hobart School District were the most indepth, followed by Urbandale which was medium depth, and finally Botham City, which was the least indepth of the observations. Because each of these sites had quite different health education programs, the questions guiding my research also differed.

In my observations of the Hobart school system, I was able to investigate the five key factors of organizational structure, content, instructional methods, issues, and behavioral choice and decision-making.

Table 14. Comparison of Size for the Three Sites

	Hobart	Urbandale	Botham City
Community Population	7,000	131,400	197,650
Number of Elementary Students in Health Program	902	(Kindergarten) 330	13,974
Number of Elementary Schools	3	6	45
Number of Elementary Teachers Teaching Health	37	(11 classes) 6	(Estimate) 450

In Urbandale, my observations were centered more on the organizational structure, and the content of the health program. In addition, several subsidiary factors were investigated such as the impact of certain aspects of the health program such as student nurse home visitation on "target students" success in the classroom.

For Botham City, my observations focused on the key factor of organizational structure and the methods used to teach health education. The content of the health education program taught at Urbandale is predominantly based on a textbook series for K-6 students, published by Laidlaw. In addition, Botham City utilized a closed circuit television to teach health for one hour twice a week.

The following table gives a description of the main issues investigated in each site.

As can be seen in Table 15, each of the three sites varied greatly in their health education program's organizational structure, content, methods, behavioral choice and decision-making, size, funding, and emphasis.

The three sites also had several factors in common. First, each site had as its foundation an organizational structure that was directed by a district health education coordinator. Although each of the three sites had a different structure, with a separate influence or control within each component, still, the organizational structure was the main foundation upon which all of the other aspects of the health program were built. Thus, the organizational structure was found to be the key factor which characterized what type of health education program was functioning.

Second, although each site disseminated a different health education content, all three sites used a particular method (instead of a multitude of methods) for delivering health education. For Hobart, the methods used to disseminate

Table 15. Main Issues Investigated in Each Site

	HOBART (K-6)	URBANDALE (K)	BOTHAM CITY (K-6)
Organizational Structure	Validated by MDE as comprehensive, recognized by MSHA as being comprehensive, in-service education to instructors, includes emphasis on parent handbooks and parent involvement. Community involvement, MEAP testing, advisory board volunteers, and District Coordinator	Inservice education, school health services are integrated, toy take-home program, community participation. Parent involvement only when problems arise	Hierarchy from school board to instructional council, to district and building health coordinators, parents not involved, community resources identified, but generally not utilized
Content	Was validated as being comprehensive, meets the MPO's or EO for health education in Michigan	Not a health content at kindergarten level	Textbook was cross-referenced with MPO's, community resources, supplement program cable TV on health topics
Methods	Films, hands-on experiences most enjoyed. Audiovisuals emphasized	Small group hands-on motor and visual discrimination exercises.	Textbook often not used, cable TV, outside resources from Dairy Council
Choice and Decision-making	Considerable emphasis on personal choice and decision-making. No evidence that their choices affected the health of others. No emphasis on motivations for certain decisions	Theorized that positive health choices need to have positive self-esteem, therefore, emphasis was on self-esteem building	Not addressed
Issues	Several issues such as test tube babies, double standards for male and female, respecting other's rights, non-health messages in the media	Not a health content being taught to kindergarten	Not addressed
Main Finding	Organizational structure enables all other factors to be present, facilitates the comprhensive nature of health education	Learning how to go to school is a prerequisite for success in health program	Scattered utilization of textbook inhibits uniformity of health instruction and learning

the health education was predominantly the use of audio-visuals, such as films and filmstrips, along with associated hands-on activities. Urbandale used a hands-on approach emphasizing small group interactions, manual dexterity, and visual discrimination skills. Botham City used a health textbook supplemented by a closed circuit televised health education program.

A third common finding between the three sites was the observation that students seemed to enjoy hands-on educational experiences the most. A hands-on health education activity allowed the students to actively engage in their learning, instead of passively absorbing the material. When students were encouraged to perform an activity, they seemed to enjoy it more.

A fourth common finding between the three sites was the observation that the bond between teacher and student seemed to be an important ingredient for student learning. A positive bond between teacher and student allowed the student to feel cared for and to show care and receptivity to the teacher. This positive bond seemed to have an impact on how receptive the student was to the health education information being taught.

Now, let us turn to a closer look at how each of these three health education programs reflects these major issues. The first case study discussed will be on the health education program at the Hobart Public School. This program was the one studied in the greatest depth. This will be

followed by the second case study of the Urbandale Health Program, which was the site studied in moderate detail. Finally, the third case study described will be of the Botham City School Health Program, which was the site studied in the least depth.

Each case study contains a section on the research question and site description, and a section containing descriptive vignettes with an analytical commentary following each vignette.

ANALYSIS AND NARRATIVE VIGNETTES OF HOBART HEALTH PROGRAM

The next section contains the analysis and narrative vignettes for the observations at Hobart. The main issues for this site center around the key factors of organizational structure, and how this structure enables the other factors of content, instructional methods, and behavioral choice and decision-making, to be functional. Issues that will be addressed in this section include:

1. The integration of the community into the overall health education program.
2. Is the content of the health lesson applicable to the student's own personal experience?
3. How the presence of a student teacher affects the authority and bonding level between students and teachers.
4. Do the students recognize that their behavioral choices affect their health and the health of others?
5. Student reactions to the teaching of reproductive health.
6. The issue of responsibility in the decisions and choice about sexual relationships.
7. The issue of whether or not to separate genders for the teaching of certain topics of reproductive health.
8. The issue of how one's choices affect the rights and privileges of others.

The first part of this chapter is a description of the settings observed at the Hobart Health Education Program, followed by a statement of the research questions used to guide my investigation. I have also presented a rationale

as to why these questions were chosen. The analysis portion is broken down into each of the key factors with its pertinent issues of each factor. Following the analysis are the ethnographic vignettes which illustrate how the key factors and main issues are evidenced in the observations.

DESCRIPTION OF THE SETTING

The main factor for the observations of the Hobart Health Education Program revolves around the organizational structure of the program, and how this structure enables additional factors, such as a comprehensive health education content, various health instructional methods, and behavioral choice and decision, to be present.

Hobart is a small semi-rural town with a population of approximately 7,000 persons. Hobart is industrial, having fifteen manufacturers. Several of the manufacturers have either closed or reduced their work load, leaving a high rate of unemployment. Hobart is a town comprised predominantly of white, Catholic families. Hobart is located on one of the Great Lakes of Michigan, and is often considered an out-of-the-way vacation spot. Hobart has several recreational facilities, including six city parks, one State Park, four playgrounds, and a city recreational program.

Hobart has three health care facilities. One is a general hospital with 105 beds, and the other two are extended care facilities, with 102 and 121 beds respectively. The three major health problems present in Hobart (and surrounding county) are heart disease, cancer, and alcoholism.

(Approximately one in ten has an alcohol problem.)

Hobart Public Schools, like many other public schools in Michigan, are plagued by declining enrollment. Hobart has lost a part of its school population from unemployment where the parents moved out of town. Because of this lowered enrollment, the Hobart Public Schools had to close two of their five elementary schools. Instead of having K-6 elementary schools as they had in previous years, Hobart Schools tried a new program, where one of the elementary schools became K-2, one 3-4, and one school 5-6. This restructuring of the elementary schools forced all the students and some teachers to become newcomers to each school. Students who had previously attended the same school lived in the neighboring community. The restructuring forced all students within the same grade throughout the town to attend the same school.

Teachers also were reassigned to various grades and schools, based on their grade level teaching assignment.

The restructuring meant that students and teachers who had previously aligned themselves in a particular social order had to become realigned with a new group of peers and colleagues.

The researcher observed two classrooms intensively, and three classrooms very lightly between November and March of the 1981-82 academic year. All three elementary schools were observed. The 6th grade was the most intensively observed, followed by another 6th, 3rd, 1st, and 2nd. In

addition, the researcher attended several meetings conducted by the Health Project staff, which pertained to the teaching of health education in the Hobart Public Schools.

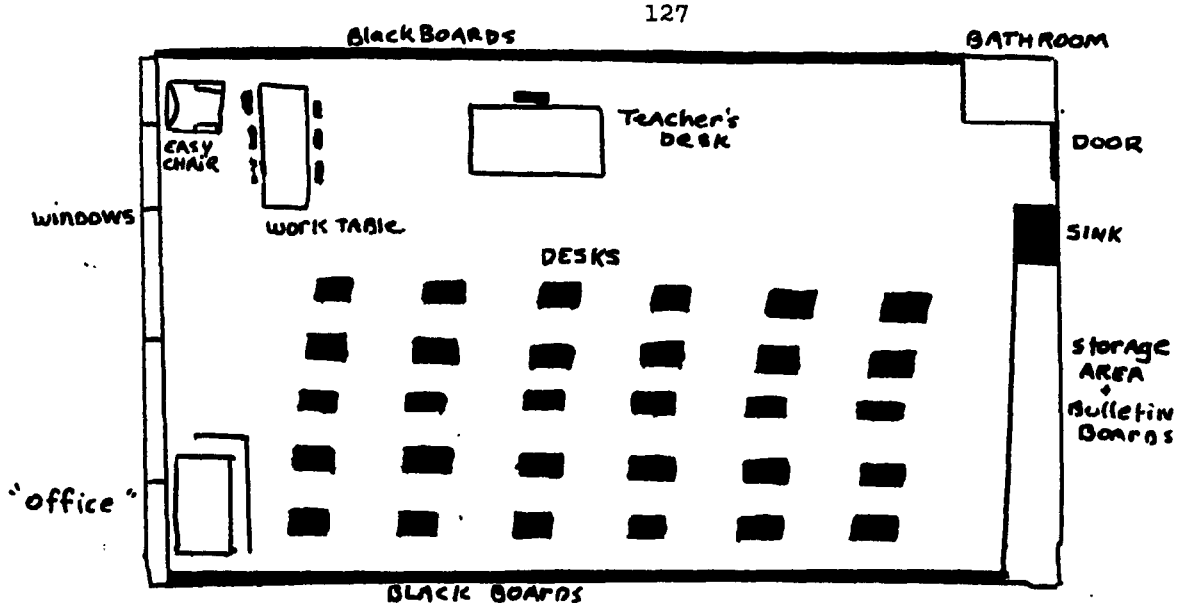
THE THIRD GRADE CLASSROOM

This class had approximately twenty students, one teacher, and one student teacher. The room was square, with a desk at the front, and six rows of desks, all facing the front. In one of the rear corners was a desk behind a wooden partition. This was called the "office" for students who wanted to do their work in private. There was a table on the side of the room next to the windows, and an easy chair belonging to the teacher. (See Figure 2).

THE SIXTH GRADE CLASSROOM

The second intensively observed classroom was a 6th grade class. In this classroom, there were approximately 25 students. The 6th graders rotated classrooms for a couple of classes, and another class (with a different homeroom) came in. The 6th grade teachers work together in pairs, so the students of one teacher rotated to the other for two classes, then returned to their "homeroom".

The classroom was square, with the students' seats lined up in rows facing the front. The teacher's desk was at the side of the room, but (s)he did most of the actual teaching from the front of the classroom.



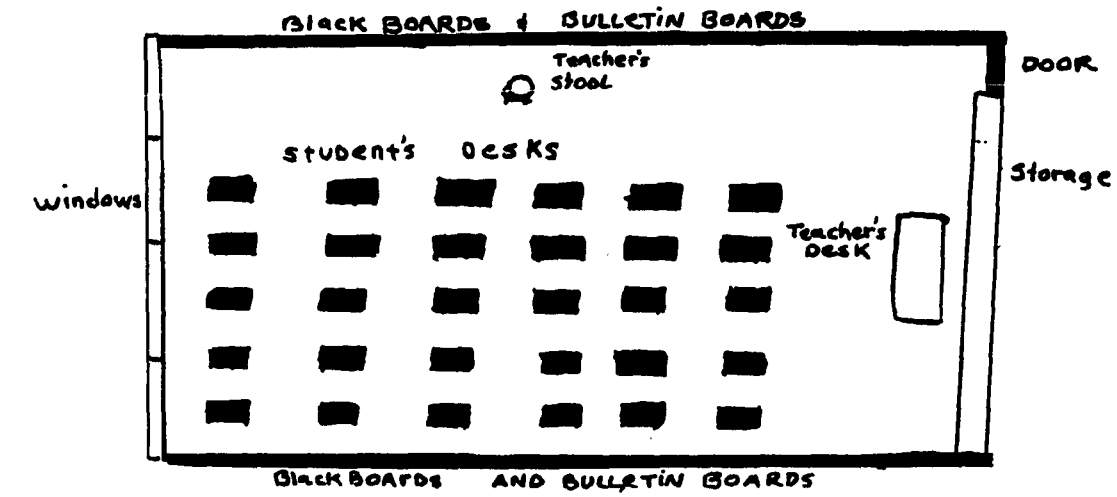


FIGURE 2 HOBART 3rd & 6th Grade Classrooms

GENERAL RESEARCH QUESTIONS FOR HOBART HEALTH PROGRAM

QUESTIONS - 3RD AND 4TH GRADES FOODS FOR HEALTH UNIT

1. What are the organizational structural components which seem to influence the teaching of Foods For Health?

2. What are the main themes generated in the teaching of Foods For Health section? ie., four basic food groups, foods labels, etc.

3. What issues involving foods and nutrition such as snack foods, preservatives, and malnutrition are discussed in the observed classes?

4. What behavioral choices were discussed in relation to the Foods For Health section? Did the students indicate understanding of self-responsibility in food choices?

5. What different types of methods of teaching were used to teach the Foods For Health section?

QUESTIONS - 6TH GRADE GROWING UP UNIT

1. What are the organizational structural components which seem to influence the teaching of the 6th grade Growing Up unit?

2. What are the main themes generated in the teaching of the Growing Up unit?

3. What issues involved in growing up such as puberty, infatuation, sexual reproduction are discussed in the observed classes?

4. What behavioral choices were discussed in relation to the Growing Up unit? Did the students indicate understanding of self responsibility in their behavior?

5. What different types of methods of teaching were used to teach the Growing Up unit?

WHY THESE QUESTIONS WERE CHOSEN

The researcher selected five areas of investigation of a health education program. These areas were: Organizational Structure, Content of Health Instruction, Decision-making and Behavioral Choice, Issues of Health Education, and Methods of Instruction.

These areas are in descending order of importance in the investigation. The Organizational Structure was chosen as a priority because it has a direct effect on all other areas of investigation. The organization of a comprehensive health education program is the foundation upon which the content is organized and made available (disseminated) to the health instructors. The Behavioral Choice component and the issues that are identifiable in the instruction are secondary components to the Content of Health. The Methods of Instruction are other factors that influence the teaching and learning of health.

The rationale behind this selection of topics is as follows:

The researcher theorized that for health instruction to be most effective--that is, to have a positive impact on the health of the student, the student must go beyond the simple learning of health facts, (s)he must practice and apply these positive health concepts to her/his personal experience. To practice health means to be capable of learning and making positive health choices in everyday human living. The student must learn to accept responsibility for her/his

own decision-making and resulting health consequences.

In addition, the researcher was interested in identifying particular health issues that may (or purposely may not) have been addressed in the teaching of health. Some of these issues were: motivations for choosing non-healthful behavior, certain aspects of reproductive health such as birth control and abortion, non-typical social issues which may affect a student's life such as moving and mobility, drugs, crime and violence, domestic assault, child abuse, unemployment of parents, contradictory health messages in the media, etc.

The Content of Health Instruction was investigated in relation to the main themes generated, the questions students asked, any evidences that the health education knowledge was inappropriate or detrimental to students' growth, and the opportunities students used to relate the health instruction to their own personal experiences.

The rationale behind these questions was to examine what were the areas of the content that could be applied to the student's present experience. The experiences of the students and their own "story telling" in relation to the content of the health instruction is evidence of their understanding and ability to apply the health instruction to their everyday lives. It is this ability of the student (to be able to relate the health education to personal experiences) that makes it more meaningful and most likely to encourage her/his positive health decision-making.

The "Methods" research questions were included because the methods in which health instruction is delivered is the ultimate "pivot-point" on how the students receive the information. For example, if the students sense that the instructor is uncomfortable and nervous about discussing reproductive health, or that there needs to be special formats (ie., separating the genders), then the students get additional messages about reproductive health than are in the actual instructional content. These messages can generate anxiety and emotional confusion and alter the purposes of instruction.

In addition, certain methods such as visiting a school kitchen or grocery store can be more informative than any classroom instruction in nutrition. Again, the student's personal experience is more apt to affect her/his health decision-making in the future.

The following section contains a series of ethnographic vignettes that illustrate the main issues and key factors found in the observations of the Hobart Health Education Program.

The key variable for the Hobart Health Education Program is the organizational structure of the program. The organizational structure provides several key components for the operation of the curriculum. One of the most important aspects of the organizational structure of Hobart is that the curriculum implemented in the schools has been validated by the Michigan Department of Education (MDE) as being a comprehensive health education program. The main requirement for being a comprehensive program is that the curriculum has met all of the Essential Objectives for Health Education in Michigan. (MDE, 1974). In addition, the Michigan School Health Association (MSHA) has also recognized the Hobart Health Program as being comprehensive. The recognition standards for Michigan School Health Association require several minimal standards including: (1) the health program must meet the Essential Objectives for Health Education in Michigan, (2) be prevention oriented, (3) have a sequenced curriculum, (4) have a variety of methods and materials employed in the curriculum, (5) utilize local resources, and (6) have a teacher training and evaluation component. (MSHA, 1981).

Because the Hobart Health Program is comprehensive and has been validated by the Michigan Department of Education and recognized by the Michigan School Health Association,

Hobart's Health Program is one of 2 elementary health education programs that has been promoted as a model health education program for Michigan Public Schools. Being a model program means that other public schools wishing to implement a health education program may contact the Hobart Health Program Director to adopt or adapt the Hobart model.

Behind the organizational structure of the Hobart Health Education Program is a project director who is very involved in local, state, and national health education policies. The director of Hobart's Health Program is a member of the American School Health Association (ASHA), and a board member of Michigan School Health Association, and has represented Michigan in a number of national health education initiatives.

This link between the Hobart model health education program and various state and national health education organizations and persons is enabling comprehensive health education to be promoted and disseminated to school districts throughout the state and country. This link between state and national health education politics has had an impact on the health education program in Hobart. The Hobart community has generated considerable pride and support, evidenced by frequent articles and photographs of the health program in the local paper, as well as participants from the community being involved in several aspects of the health education program.

Some of these aspects of community involvement in

the health program are representatives on the health advisory board, volunteers from the community help with supplementary health programs (ie., fluoride rinse). The parents of public school children are given a special preview session of reproductive health films, parents write and receive a newsletter, and parents have been included in the health education program through the dissemination of parental handbooks.

There are also several administrative functions of the organizational structure of the Hobart Health Program that enable comprehensive health education to be provided. One of these is the provision of an instructor's notebook and periodic teacher inservice training. The instructional notebook contains the 5 units of the health curriculum: Foods for Health, My Healthy Community, My Safety, Growing Up, and Decisions for Growth, and each unit has objectives and suggested activities for the students.

Another vital aspect of the organizational structure is the collection and coordination of materials that are used in the teaching of the health curriculum. Because there are three elementary schools, and all materials are shared between schools, considerable organization must be developed to assure that the right class gets the proper materials at the appropriate time.

Other functions of the organizational structure of the Hobart Health Education Program include coordinating parent volunteers, evaluation of the health education program, blood pressure screening for all 6th grade students during the

Decisions for Growth unit, Michigan Education Assessment Program (MEAP) testing, the distribution and processing of state-required permission forms for students participating in reproductive health classes. The following table summarizes the different components of the Hobart Health Education organizational structure.

Table 16. Components of Hobart's Health Education Organizational Structure

Community Integration	Health Education Curriculum	Teacher Education	State and National Factors
Community Resource Persons used in Curriculum	Delivery of Materials	Inservice Education	Validation by Michigan Department of Education
Health Education Advisory Board	Grading of Health Tests	Representatives on Advisory Board	Recognition by Michigan School Health Association
Parent Volunteers	Resource Materials		Michigan Education Assessment Program Testing
Parent Review of Reproductive Health Materials/Films	Blood Pressure Screening		Director on Board of Michigan School Health Association
Media Coverage of Health Program	Evaluation of Health Program		Director Member of American School Health Association
Development of Parent Handbooks	Permission Forms for Reproductive Health		Director Promoting Adoption or Adaptation of Hobart Model to other School Districts
Supplementary Health Programs, such as Fluoride Rinse	Health Education Instruction		
Parent Newsletters			

As can be seen from the table, the organizational structure of the Hobart Health Education Program is multi-dimensional in that it functions to promote comprehensive health education on several different levels. The community of Hobart is influenced in several ways such as through the advisory board, community resource persons, media coverage, parent handbooks and newsletters. The students are influenced directly through the curriculum instruction, teachers are included both through inservice education and membership on the health education advisory board, and outside health education organizations are influenced through state and national factors.

The first vignette; "An Afternoon at the Advisory Board Meeting" describes the typical activities and conflicts that the Advisory Board confronts. The Advisory Board is an integral part of the organizational structure of the Hobart Health Education Program. Some of the board functions are to review the health curriculum and make suggestions for its improvement, serve as a community "sounding board", promote parental participation and education, be a source of volunteers for project activities, and make recommendations for health education policies.

Members of the board represent industry, hospitals, parents, professionals, and teachers. One of the main issues illustrated in this vignette is how different representatives from the community assert their political power in hopes of affecting policies regarding the teaching of reproductive

health to 5th and 6th grade students. The vignette shows that the policies regarding the teaching of reproductive health in the schools is regarded as a highly controversial issue.

AN AFTERNOON AT THE ADVISORY BOARD MEETING

At 3:15, the monthly Advisory Board meeting for the health project is ready to begin. The director of the project is not here yet; she is on her way here from Harrisburg and will be a few minutes late. Nine people have assembled around an oblong table in the health project office. The people there include representatives from the County Drug Abuse Agency, Social Services, an Extended-Care Facility, two parents, two teachers, and an administrator from the local hospital.

We have just informally introduced ourselves as the Director of the Health Project arrives. "Glad to have you all here. Sorry I'm late, I'm just arriving from Harrisburg, where I've been helping the schools up there build their own health education program."

"We have here representatives from industry, hospitals, parents, professionals, and teachers. In order to increase the knowledge of the people in the community about our health project, to do some in-service on the ten topic areas in the curriculum, and to promote parental education, we have developed a parental handbook on the health project."

The minutes of the last meeting are read by the secretary, and they are adopted without changes.

"Today we need to discuss the parental review sessions coming up on the 5th and 6th grade reproductive health films, newsletters to parents, bicycle safety, and substance use and abuse."

"I need some help with the newsletter," the director says. "I also need someone to help at the parental review session. We plan to show the film A Family Talks About Sex. Sex is not an easy subject to talk about, and we want a parent and a public health representative to talk about the film with the parents as they finish reviewing the film," the director said.

The public health representative and a parent give the advisory board members a summary of the film, and encourage that the film be shown.

"Parents can see how all age groups deal with the questions on sex education," a parent adds.

"Let's publish an article in the paper about the movie to get more community support," the director suggests.

The director then tells the board members about a "wellness profile" now under construction, in which the Hobart Schools are participating. Three teachers in the district have volunteered to give the profile to their classes. The "wellness profile" is a self-health test that students can complete and learn about their own health.

"The cancer materials have gone out to the schools, but there's no word on how they're doing; more about that later as it gets underway," the director reports.

"I need two people to volunteer to look over the high school health team plan."

Two persons immediately volunteer.

The director then takes out a copy of the

instructional notebook for 5th grade and describes each of the health units, and what each unit contains. "Each unit has objectives, activities, and sample tests; please feel free to take out copies and study what is being taught."

There is a short break before the review of three films for the 6th grade reproductive health unit Growing Up.

After the first film Human Growth III, a parent attending the meeting seemed quite upset. "I was not happy with that film. Wouldn't it be more appropriate for junior high school age children? Would a sixth grader raise those thoughts? I mean, are they really ready for this film by 6th grade?" (There was a short scene in the film showing an actual childbirth.)

A teacher who taught 6th grade last year replies, "I know 6th graders do think of these sexual thoughts, and they do want to know. It's better they get the facts than the jokes and rumors from the locker rooms. One student last year even asked how a person would have sex with a cadaver!"

"MY GOODNESS!" answered the woman from the Extended Care Facility.

The director then brings out a stack of cards with previous years' questions on them. "Beyond a doubt, those students were seeking answers to sexual questions. Some of those questions were pretty sophisticated."

"I was thinking just the opposite. These kids don't know what's going on by the tone of these questions."

Then the one parent who was against the film all along

replies with anger and disgust, "I'm certainly not going to let my children see this! Maybe by thirteen or fourteen, they might be more aware of it."

A 4th grade teacher replies, "Kids are different now than we were at their age, they are older a lot younger. They need to know what the truth is--why, someone in my class told me a classmate was already smoking pot."

A second film is shown; From Boy to Man. After it was over, the one parent who protested the first movie again started to object. "I must not belong here, this should not be seen before 7th grade, because it is too much for 5th and 6th graders to handle. Maybe I'm old-fashioned, but they shouldn't see this! When we were in school, we didn't find out about "that stuff" until high school."

Whenever any other board members would speak out in favor of the films being shown to 6th graders, this parent would disagree loud and persistently.

The discussion became almost difficult; the director tried to shift back into the task of reviewing a third film.

"Are you going to watch another one???! I mean, are you going to stay here? I have to go fix dinner for my kids; my husband and I are going out tonight, I really don't belong here anyway." With a huff, the parent scrambled for her coat and walked out.

The director voiced her opinion. "These films are factual and informative, and the students need to know the facts instead of rumors and junk from the streets."

A third film, From Girl to Woman, was shown, and a discussion of the film followed. The issue was raised by the public health representative whether to postpone the showing of these films to 7th grade. The director of the health project suggested that she look at the whole unit's films and see them in context before deciding.

The representative from the nursing home said, "We older ones really don't know what it's like today in the schools; I'd rather have them get the facts."

The teacher replied, "Students are much more mature today than they were before. The more factual the better. If I weren't teaching, I'd be like the woman who walked out, but my 4th graders are really mature."

The hospital representative says, "That is why there is an option for the parents to choose not to have their kids see the film or participate in the discussion. Besides, the parents do get a chance to review the film."

"Yeah, but how many show up?"

A woman who worked with juvenile delinquents said, "I have been out of school only five years, and the kids put me back for how advanced they are. We have no idea how much these kids do know. The woman who walked out kept saying, "When we were in school....," but she hasn't been in school for a long time, and it's very different now."

The director called for a vote, and counting the woman who walked out, the tally was 7 in favor and 3 against. The director recommended to the superintendent that the films

remain in the curriculum. Meeting adjourned.

This advisory board meeting provided a structured environment where the decision of what grade level is appropriate for the dissemination of reproductive health could be discussed. In this case, the content of the reproductive health curriculum, the methods in which it will be disseminated, and the issue of what is an appropriate age or grade level for its dissemination can be aired and resolved.

The vignette also illustrates how imperative it is to have a sound organizational structure, and specific rules or guidelines for making alterations in the curriculum. In this case, one visitor to the advisory board who is opposed to teaching this reproductive health curriculum in the 6th grade monopolizes the discussion, and attempts to persuade the group that the films are inappropriate for the 6th grade level. "Wouldn't it be more appropriate for junior high school age children? Would a 6th grader raise those thoughts?" she suggests. Feedback from teachers of 6th and 4th graders, as well as other community members, respond an affirmative yes: "We older ones really don't know what it's like today in the schools; I'd rather have them get the facts." "Kids are different now than we were at their age, they are older a lot younger. They need to know what the truth is..."

Then as the group was getting ready to review a third film, the same individual sensed opposition to her perspective and complained bitterly: "Are you going to watch another one??! I mean, are you going to stay here? I have to go fix dinner

for my kids; my husband and I are going out tonight. I really don't belong here anyway."

The organizational structure of the advisory board allowed for discussion and dissent without getting stalemated over philosophical differences. The group continued their business of reviewing the films and discussing their content, purpose, and appropriateness. After discussion, the advisory board director called for a vote on the group's recommendation to the superintendent. The advisory board voted more than 2 to 1 in support of the current health education curriculum.

There are five main themes that are evident in the observation of the Hobart Health Program: organizational structure, content, methods of instruction, health education issues, and behavioral choice and decision-making. As described in "An Afternoon at the Advisory Board Meeting", the organizational structure is the key factor that enables the other factors to be present. In order to understand how these other factors affect the health program, it is important to first see the context in which the health program takes place. To illustrate this context, the next vignette describes what a typical day is like for a third grader in the Hobart Schools.

A DAY IN THE LIFE OF A THIRD GRADER

School normally begins at 9:05 AM. Today, school was postponed an hour because of heavy fog. At 10:00, the bell rings as a few students are still coming in through the door. After everyone is seated, the teacher, Mr. O'Brian, signals the students to stand for the Pledge of Allegiance. This morning's fog will mean a postponement of gym class until 10:30, with Listening Skills scheduled until that time.

The students all receive a ditto that corresponds to the Listening Skills exercise. There are sixteen students present today, ten boys and six girls.

"You will need your crayons today for the exercise," says Ms. Jones, the student teacher. The students are asked to be quiet and listen to a story Ms. Jones reads to them, and then on the ditto they are to circle appropriate answers to questions she asks at the end of the story. (Ms. Jones is a student teacher who is just beginning her teaching practicum.) The students listen to three stories in all, and complete their worksheets.

With five minutes until gym class, Mr. O'Brian begins to explain a diagram on the chalkboard that has the face of a clock, with the date 1794. "In 1794 Eli Terry invented the clock in America. He "patented" the clock. A patent is a legal document that certifies someone has invented or created something, and ensures nobody else can steal his ideas."

At 10:30 the students line up for gym class as

Mr. Whistle, the gym teacher, comes down to meet them and escorts them to the gym.

At 10:45 the students return from gym class and all line up at the drinking fountain.

Ms. Jones then tells the class to be seated to work on their spelling list. The lesson involves alphabetizing words that have a certain prefix or suffix. One student goes up to Ms. Jones. "I don't know what to do, will you help me?" "You know what to do; you're just being lazy." The student persists in wanting help. "Okay, what are the seven long vowel words? Underline them and I'll tell you if you're right."

At 10:55, the students are still doing their seat work, but are not being quiet.

"Put a zipper on your mouth before you get into trouble," Ms. Jones warns a student. "Alex, nothing to do? Want another page of work to do?" Alex quickly returns to his seat. One student is told to move to the front table to do his work. The class continues to be too noisy. "Alright, the next one who talks gets his name on the recess list." The class immediately quiets down. (The recess list is the list of students who miss their recess as a punishment.)

By 11:30, the students are again growing restless and are acting out. Mr. O'Brian returns to the room and reinforces Mrs. Jones' discipline: "Your mother would be most upset if you didn't finish your work. If she's upset, you will be also. <u>Take</u> the hint!"

At 11:45 the students are excused for lunch.

At 12:30 the students are back from lunch and Ms. Jones is reading a story. It is a story about a whale who has washed ashore in Newfoundland, and is waiting to die. At 12:50 the story has ended, and Mr. O'Brian goes to his closet and pulls out a recording of Humpback Whales that was in a National Geographic magazine. The students listen very attentively to the whale recording.

It is 1:00 and time for the daily math lesson. There is a chalkboard discussion, book questions to answer, and a ditto to do. This seat work is worked on until recess at 1:45.

At 2:10 the students come clamoring in and have difficulty settling down.

For the remainder of the afternoon, the students either have Social Studies or Health.

Today is Social Studies, and Mr. O'Brian asks the students some questions about the Division of Labor. To help him explain the concept of money and labor, Mr. O'Brian appoints Joseph as a banker, and Darla as a store owner who needs to borrow money from the bank to open her store. "Now, if there are layoffs at the factory that makes the goods that Darla wants to sell at her store, what does that do to the price of her goods? How many here have had parents laid off from their jobs?" Five students out of sixteen raise their hands. "See how that may make Joseph less willing to loan Darla some money? What if Darla can't sell her goods, will she be able to pay Joseph back?" "Nooo!" The bell rings, and the day is done.

Typical day for a 3rd grader:

9:00	School day begins
10:00	Listening/Reading skills
10:10	Listening Skills
10:30	Gym class
10:45	Spelling
11:45	Lunch
12:30	Story reading
1:00	Math
1:45	Recess
2:10	Health or Social Studies
2:30	Day is over

The vignette illustrates what a typical day is like for a 3rd grade student. The students learn a variety of subjects every day, of which health may be just one. Health education is usually taught 2 or 3 times a week for approximately 30 minutes. If a particular health subject needs more time, ie., a visit to the kitchen, then the instructor teaches health in the morning, and allows for more time.

Now we will see how some of the main issues investigated in the observed health classes are to be found in the teaching of the 3rd grade health lesson on nutrition. A filmstrip is being shown, entitled <u>The Need for Healthy Habits.</u> The content of the filmstrip contains several of the Essential Objectives for Comprehensive Health Education in Michigan. The content is also taught in a way that is applicable to the student's own personal experience. The organizational structure of the health program has enabled an outside resource person, in this case, Mrs. Cook, to provide a different perspective on their nutrition lesson. As will be seen in the vignette, both the filmstrip and the

kitchen visit emphasized that the students make their own food choices, and that they must be responsible with their food choices so they will get a balanced meal.

A DAY AT THE KITCHEN

Mr. O'Brian begins the morning class with having the students rise and say the Pledge of Allegiance. "Okay, today we will be on a very tight schedule. At 10:30, we are all going to the gym to hear Velma Rathbun tell stories. We will also be watching some filmstrips on nutrition, and will be visiting the kitchen to see how meals are prepared. Recess will be at 10:15 instead of 10:30. Jason, get the lights; Marvin, pull the curtains, and let's get underway!"

"The filmstrip is on The Need for Healthy Habits," Mr. O'Brian says to the class, "and you do know the difference between good and bad habits. What are some good habits?"

One student raises his hand and says "eating right." Mr. O'Brian agrees, and says, "yes, and keeping your hands clean. Some bad habits are staying up too late, eating junk food."

Alex, a student in the class, shouts out that "Brad has dirty hands!" Mr. O'Brian ignores him and continues to talk as he threads the filmstrip into the projector.

The filmstrip is shown while a record plays along for narration. The filmstrip mentions the four food groups--meats, vegetables and fruits, grains and cereals, and dairy. "Meats give us proteins," the filmstrip says.

"SPELL that word to yourself," Mr. O'Brian adds. All of the students in the class are attentive to the screen.

Mr. O'Brian stops the record and the filmstrip to

talk about the four food groups. As he turns on the lights, he points to the bricks in the wall and says: "Imagine these bricks are the proteins of your body. If these (proteins) bricks were just stacked up on each other, what would happen?"

"They would fall down," say several students.

"Right! - Now, what's needed?"

"Cement," says a student.

"Okay, that's right. These bricks would fall down if there weren't something holding them together. That something is the fruits and vegetables, from which we get our minerals and vitamins. Milk products give us strong bones and teeth, and the breads and cereals are our energy foods."

The filmstrip continues to talk about having balanced meals and concludes that we need healthy, happy meals free from stress.

"Okay, recall some key words which were in the filmstrip," Mr. O'Brian asks the class.

The students begin to shout out several answers: "fruits and vegetables", "meats", "milk", "breads and cereals", "protein", "snacks", "habits", "scale".

Mr. O'Brian stops the class from continuing by asking: "Why was the scale important?"

No answer from the class.

"Why did they need the scale?" Pause. Mr. O'Brian gives them a hint "what is the bal----?" Oops! He covers his mouth as he starts to give it away. "BALANCE!" the kids shout. "Okay, we need to have balanced meals, don't we?"

"Alright, what is your lunch room like? What is it like in the gym where you eat lunch?"

"It's noisy," says one student. "It doesn't taste good," says another student.

The noise answer was the one Mr. O'Brian was looking for. "If you're uptight and in a hurry, your body can't keep up with the food. When you eat a meal, and then run outside and exercise too much, what happens? You don't feel too well," Mr. O'Brian continues. "Quiet, slow eating allows your body to get its full nourishment from your meal."

"Suppose you have two hamburgers, both the same size, and one you eat slowly and quietly, the other you eat the next day when you are rushing around. Your body can't get its full amount of nutrients from the two same hamburgers."

"Okay, let's look at the school lunch menu and see if we are getting a balanced diet," Mr. O'Brian suggests.

"Chicken" - meat and poultry are our proteins.

"Vegetables give us our vitamins."

"Milk" - strong bones and teeth.

"Roll" - that's our breads and cereals. "Is our lunch going to give us a balanced meal?"

"Yes," some students say.

"Yes, a balanced meal only if .....," Mr. Obrian pauses so the class can finish his sentence.

"If we eat it all," several students say.

"I don't expect you to eat everything of every meal," Mr. O'Brian says, "but during the day you should be sure you

eat some of each food group each day. It isn't balanced unless you eat one of each food group."

"Okay, now it's time to go to the kitchen and visit the cooks, but first, some rules:

Number One - Don't touch anything.

Number Two - Be polite and don't tell them what Uncle Benny or your Mom does, ask questions like how they get the menus or about the equipment."

All 19 students, 2 teachers, and myself file down to the kitchen and line up around a large, oblong cutting table. A large, overweight woman, who is one of the cooks, seems delighted to talk to us, and is smiling very much.

The students are all looking around at the many objects hanging from hooks or clamped to tables, and large stoves and dish dispensers. At first, Mrs. Cook gives a small tour: "The bread is kept here, and this is where your chicken is that you'll have today," as she opens the storage ovens and shows them the chicken.

"Here are the sweet potatoes, how many of you like them?" Mrs. Cook asks. Almost all of the students raise their hands. "Well, be sure and eat them today. See, here they are with brown sugar on them."

"What's that?" a student asks.

"That's an egg beater. That's where I make all the mashed potatoes and mix the bread dough."

"How do you decide the menus?" another student asks.

"Well, I have only certain things I can get from the

government, such as cheese, chicken, and vegetables, and I know you hate vegetables..."

"Nooooo!!" the students all shout.

"You don't? Well, it's with your vegetables that you get a balanced diet."

"How long does it take for you to make rolls?" a student asks.

"About 6 hours. The rolls take so long to make that I make them all the day before."

"If you make the rolls the day before, don't they get moldy by the next day?" a student asks.

"No, no, they are still fresh. I cooked them just yesterday, and the rolls will still taste good. They are not the store-bought kind with all the preservatives in them. They are homemade."

Mr. O'Brian asks the cook, "How much flour do you use for different foods?"

"Well, 28 cups for cookies, 58 cups for bread, and 28 cups for the rolls." (She obviously had this memorized.)

"What if you're not ready before lunch comes? another student asks.

"I know when lunch comes and we hurry to make sure it's all ready before lunch time."

"What's that?"

"That's a food grinder or a garbage disposal. Now don't you ever come in here and turn this on, because it has very sharp blades that will cut you," as she goes and turns

it on to demonstrate.

"Why do you need all those pots and pans hanging up there?"

Mrs. Cook takes down a double boiler and shows how the water goes in the bottom and the potatoes go in the top. "And this is how we can keep the potatoes warm until they are ready for you to eat..."

"What's that?"

"That's a fire blanket; if I get burned I wrap that around me and the fire goes out."

"Do you like to work here?"

"I love to work here, I love to cook, but I taste too much!"

"How do you make menus?"

"I have a menu paper," Mrs. Cook says as she pulls one out, "and a weekly menu planner. There are three head cooks, and we decide what we have in the refrigerator, and what you kids like. Even though I know you like tacos and pizza, we can't have that all the time. We have to use up what we have."

"What if there's a fire over there and you can't get to the blanket?"

"Then, there's a fire extinguisher over here," as she shows it to the students.

"What's on the menu for tomorrow?"

"Grilled cheese."

"Will there be chocolate milk?"

"I don't know, we only have chocolate milk when the milkman brings it, and he brings it whenever he can get it, and we don't know when that will be."

Mr. O'Brian tells the class to walk on through the kitchen slowly so they can look at everything; it is time to return to the room.

The students had lots of questions, even as they were leaving, several students continued to ask more.

"What's that?" pointing to a bowl with white stuff in it.

"That's flour and water for gravy."

"What's that?"

"That's a steam table. That's how we keep your food warm. The steam comes out here and keeps your food hot."

"Doesn't it get hot in here?"

"Yes, it is hot in here every day."

The students file out of the kitchen.

"You kids eat good today," says Mrs. Cook.

Once the students are back in their room, Mr. O'Brian asks them to tell him what they can recall.

"Okay, what do you remember?"

The students begin to call out things they remember.

"Mixer", "stoves", "how many stoves?" "three", "fire blanket", "vents", "exhaust vents", "garbage disposal", "dishwasher", "trays and pans", "can opener", "where she keeps the trays", "refrigerator", "sky light", "steamer", "that's important," Mr. O'Biran says, "it's how she keeps the food warm", "storage", "silverware", "pots", "soup bowls", "menus".

"How do they make menus?" asks Mr. O'Brian.

"They have some ladies, and they each vote on what food they like."

"What's left in the freezer." "They have to check what they got first."

"Do the cooks really know what milk is coming?" asked Mr. O'Brian.

"Nope," "most often we have white, but once in a while there is chocolate."

Mr. O'Brian asks, "What did she use to make the cookies?"

"An ice cream scoop."

"Now let's get back to the menus, what else do they do to get it ready?" asked Mr. O'Brian. "They make a first draft, don't they? They make a balanced meal."

"What do they get from chicken?"

"Protein." "Meat."

"What does protein do for you?"

"It's healthy."

"What does it do for your body?" "It builds strong..."

"Muscles!"

"What else did we see there?"

"Sweet potatoes, that comes from vegetables."

"What do we get from vegetables?"

"Vitamins", "minerals".

"Have you ever tried to tie a shoe with one hand? Well, it takes two hands to tie a shoe. Vitamins and minerals

are the same way. It takes two."

"Francis, what else?"

"Bread."

"What does bread give us?"

"Energy."

"Right, athletes eat good breads and cereals. They used to stress eating proteins before a big race, but now they know that proteins build muscles and the athletes have lots of muscles--what they need is the energy foods; breads and cereals."

"It's like a super car. If it doesn't have gas, it won't run. Breads and cereals build strength and supply energy. Without the muscles, the carbohydrates turn to fat."

"What else?"

"Jello."

"Okay, time for recess, everybody out!"

One main theme that was emphasized in this vignette was that the students learned that they are responsible for their own health and that they make behavioral choices that contribute to their own health. In this case, the students learned that they need to choose certain foods to eat in order to have a balanced diet, and it is through having a balanced diet that they help themselves to stay healthy. The filmstrip emphasized that the students need to eat right to feel good, and described the 4 food groups that must be represented in their diet for it to be balanced.

The kitchen visit enabled the students to apply their nutrition lesson to their own school lunches. The students were able to see how the kitchen is operated, and how the cooks plan their menus to assure the students receive a balanced diet for lunch. Mr. O'Brian reinforced the students' lesson on choosing a balanced diet by asking the students to name the nutrients in each of the items for that day's lunch menu.

A second main theme illustrated in this vignette is the method of instruction used to teach nutrition education. Through a kitchen visit, the students were able to apply their nutrition education to their own experience, and see how their lunch menus are planned, and their food prepared. The students were very enthusiastic about their visit, and asked several questions. Through allowing the students to actually experience their nutrition education, it enables the students to comprehend the material in a way that is linked to their immediate food choices, and more able to influence their future food selection.

One issue which was not mentioned in this vignette was the concept that the students' food choices may affect the health of others.

The concept that if the students waste food, it is lost food or wasted was not taught. Nor was the concept taught that there is a finite amount of food available, and that if the student wastes the food, it is not available to anyone else. I did go to lunch with the students, and ate

with them at one of their tables. I observed that the students wasted a considerable amount of their lunches. The noise level in the gym where they eat is very loud, and most of the students were in a hurry to eat and get outside to play.

The students did receive a message about wasting food the day I observed. As they formed a line to dispose of their trays, the principal was scraping uneaten food into a large dish tub. When there was a lot of food uneaten, the principal scowled and shook his head from left to right, displaying disgust, as he scraped the uneaten food into the tub.

The concept that the students' health, or lack of it, affects others was also not observed. If a person is sick, especially a youngster, someone has to take care of her/him. This is an energy imposition, and quite expensive as well. In addition, if one person is sick, (s)he can spread her/his illness to others, thereby affecting her/his health as well. There was also no mention of germs in food, either by food spoilage or contaminating food during preparation.

One student asked if the rolls weren't moldy by the next day, and understood that contaminated food was a health hazard. The cook responded, "no, no, they are still fresh, I cooked them just yesterday and the rolls still taste good. They are not the store-bought kind with all the preservatives in them." The message here is twofold; one is that day-old rolls are still fresh enough to eat, and two, that these rolls are made without preservatives, and are better for their health without preservatives. No mention of the concept of preservatives

being a health hazard was made during the discussion afterward.

The next vignette will illustrate 2 main issues. First, behavioral choice and decision-making is emphasized both in the filmstrip and the subsequent discussion. The students are made aware of the need to choose a proper breakfast in order to have enough energy to win a "race among friends". The second issue involves classroom discipline. In this instance, one student in the class has an emotional outburst at the teacher and is subsequently told to leave the class. This disciplinary action or method leaves the rest of the students in the class quiet and inattentive to the remainder of the health lesson.

NUTRITION AND YOU - CHOICE

Today's health lesson is on nutrition. We are watching a filmstrip of Winnie the Pooh and Nutrition and You. The filmstrip stresses that to be healthy enough to win a race, one has to make good food choices. It is very important to have a balanced breakfast. Winnie the Pooh has chosen to have honey for breakfast instead of a balanced breakfast. Mr. O'Brian stops the filmstrip and asks "How many did not have breakfast?" Four out of seventeen students raise their hands.

Pooh and his friends have decided to have a "race among friends". When Pooh goes to get honey instead of a proper breakfast, the other characters in the film say "A choice made is a choice made." Mr. O'Brian stops the film and asks "What is the key word?" "Food" guesses one student. "Nope, choice, that's the key word," says Mr. O'Brian. Pooh Bear is late for the race but crosses the finish line anyway because a swarm of bees is chasing him. This filmstrip is over, and Mr. O'Brian starts a second one on the variety of foods.

There has been a disruption in the class. Two of the students had been fighting during recess, and now one of them is crying because his hat was thrown up on the roof. "I don't want to lose it!" shouts Gerald at the teacher. Mr. O'Brian tells him to leave the classroom. "Gerald had a choice too, and now he can choose to cool off outside," Mr. O'Brian says to the class.

The students have grown quiet as they sense Mr. O'Brian's anger. Mr. O'Brian signals to Ms. Jones, the student teacher, to take over the health lesson as he goes out to talk to Gerald.

The class watches the next film quietly. Four students are not watching the screen at all.

In the second filmstrip, Pooh Bear wants to eat honey and only honey, but honey isn't a balanced meal. Pooh is very tired and doesn't feel well. Pooh's friend, Owl, says that Pooh isn't sick, he just has to eat balanced meals and then he'll feel better. The characters in the filmstrip decide to put on a food choice display showing each of the 4 food groups.

Ms. Jones stops the projector and says, "Okay, what were the 4 things that the filmstrip said you needed?"

"Bread and cereal."

"Milk."

"Fruits and vegetables."

"Carrots."

"Fish" and "eggs."

"Poultry."

"Milk."

"What else did the filmstrip say is important besides just eating a balanced diet?" Ms. Jones asks.

"Dress warm."

"Exercise."

Mr. O'Brian enters with Gerald and signals for Ralph

to come out into the hall.

With only three minutes to go until the end of the day, Ms. Jones tries to keep the class talking about health. "Why do we need a balanced diet?"

Mr. O'Brian enters the classroom. "Where did Ralph go?" a student asks Mr. O'Brian.

"I kicked him out," Mr. O'Brian says.

The class grows quiet as they wait for the bell. Some students are whispering to others. Health questions go unanswered. The teachers talk to each other as the bell rings to end a long day.

Behavioral choice and decision-making was the main theme emphasized in both the filmstrip and the classroom discussion. In the middle of the filmstrip, Mr. O'Brian shuts off the projector and record and asks: "How many did not have breakfast this morning?" Four out of seventeen raised their hands. At one point, the filmstrip says: "A choice made is a choice made." Mr. O'Brian again stops the filmstrip and asks the class, "What's the key word?" "Food," guesses one student incorrectly. "Nope, choice, that's the key word," says Mr. O'Brian.

The students are taught that they have a choice to make regarding whether or not they eat breakfast, and what type of a balanced meal they have. Although many students aren't given much of a choice at home in what they may have to eat, the student does choose whether or not to eat what is provided to them.

The second main theme illustrated in this vignette was classroom discipline. As could be seen from the vignette, the emotional outburst of one student in the class has disrupted the health lesson for the entire class. Although this student was removed from the class, the drama of his expulsion and subsequent private conference with the teacher was enough to distract the other students' attention for the remainder of the lesson. Classroom discipline is the foundation for appropriate student-teacher behaviors. When the student shouted at the teacher, this was viewed as an inappropriate student response that violated an understood rule of student-teacher respect. The student's behavior prompted the disciplinary action of his expulsion. With this expulsion went the lesson to the remainder of the class: "Gerald had a choice too...and now he can choose to cool off outside."

The following vignette is about a third grade lesson on the physiology of the human digestive system. In this vignette, three main themes are identified. First, the methods used to teach this lesson generate intense enthusiasm and interest; second, the content of the lesson applies to the student's own experience (in this case their own bodies), and meets several nutritional Essential Objectives for Health Education; and third, the organizational structure of the health program also plays an important, but less obvious role.

THE HUMAN BODY

The bell rings as most of the students are filing in to take their seats. In the back of the room, three students are intrigued with a large cloth-covered object. "What is it?" "It's a dead body!" says one of the students. Mr. O'Brian, what is that?" "Go look for yourselves," Mr. O'Brian says. Four students peek suspiciously under the cloth drape. "Oooh, it is a body!" The "body" is a plastic mannequin that has models of the internal organs of the human body. "We will be using the mannequin for today's health lesson."

The health lesson begins with a filmstrip featuring Donald Duck on the Digestive System. The filmstrip traces the path that food follows when we eat. Beginning with the mouth, the food travels down the esophagus to the stomach, then to the small and large intestines, the liver, kidneys, and bladder. Donald Duck is not feeling well, he has eaten too much pizza. The filmstrip says there are 6 ways Donald can get an upset stomach; the attitude we have when we eat, germs in our stomach can make us ill, we can eat too much, playing too soon after we eat, if we eat too fast, and nervousness.

Mr. O'Brian stops the filmstrip. "What happens when you talk while you are eating; what can happen then?" "You can choke!" Mr. O'Brian then explains there is a little trap door at the top of our lungs that closes when you eat and opens when you breathe. If you get food down your trachea, you'll choke.

"How long does it take to digest one meal all the way through?" Mr. O'Brian asks the class and lets several of the students guess. Most of the answers were one hour, three hours, six hours. Mr. O'Brian starts the filmstrip again and it tells that it takes a whole day to digest a meal all the way through. The students all underestimated the time it takes to completely digest a meal.

The filmstrip is over. Mr. O'Brian brings the human organ mannequin to the front of the room. The students begin to leave their seats and crowd around Mr. O'Brian. They shout "I can't see," "Can we touch it?" Mr. O'Brian begins by describing the pathway food follows. Again he is interrupted by the students who are too eager to see it and block others' view. "Back, back!" Mr. O'Brian directs the class. Still, there is commotion. "Okay, everyone back in their seats so we all can see." Mr. O'Brian starts again to explain the food pathway. After he traces the pathway, he asks Stella to help him explain the functions of certain organs. Mr. O'Brian takes out the stomach and shows the class how large it is by holding it up to himself. "Wow, look at that!" a student says. "Where are the kidneys?" another student asks. Stella pulls out the liver to show where the kidneys are. "Ooh, can I touch it?" asks one of the girls.

Another student asks, "Well, how does food get down to the stomach?" "The esophagus has muscles that squeeze the air (making a hand over hand motion) down the tube to the other end," Mr. O'Brian answers.

A student gives an account of when she was in the hospital to have her appendix removed. Another student asks, "Well, how does the inside of your body get bigger?" "That's a good question," Mr. O'Brian says. "It goes right back to the four food groups you've been studying. The four food groups make us grow." "But where do the extra pieces come from?" "They come from what you eat. The food breaks down into protein, carbohydrates, fats, minerals and vitamins. That's what makes us grow."

It is time for recess. As the class lets out, several students come up and touch the different body parts as Stella is reassembling them in the mannequin. "Look at how big the liver is!" "That's one of the most important organs there is," I say.

As could be seen from the vignette, the students were very enthusiastic to learn about the insides of their bodies. This enthusiasm was encouraged by the teacher who let the students' curiosity stir them into their own discovery. "What is it?" asks a student about a large cloth-covered object. "It's a dead body!" says another student. "Mr. O'Brian, what is that?" "Go look for yourselves," Mr. O'Brian urges. "Ooooh, it is a body!"

The methods of instruction of first using a filmstrip that explains the digestive system, followed by a hands-on experience using a mannequin showing the internal organs was very effective in generating student interest and participation.

In fact, the students' overzealousness prompted the teacher to repeatedly ask them to take their seats to allow others to see and touch the mannequin.

The content of the digestive system with a follow-up discussion using the mannequin allowed the students to apply their nutrition education to their own bodies. The application of the information to themselves allowed the students to understand the connection between their own growth and the need for proper nutrition. This connection was illustrated when one student held up the large stomach of the mannequin to his own body and asked: "Well...how does the inside of your body get bigger?" "It goes right back to the four food groups we've been studying. The four food groups make us grow" replies Mr. O'Brian. "But where do the extra pieces come from?" "It's our food that supplies the extra pieces," says the teacher. Up until that point, the student hadn't quite understood that it was our food that makes us grow--both inside and outside. In addition, the content of the information being presented also meets some of the Essential Objectives for Health Education in nutrition.

Another main theme, but less obvious was the role played by the health program's organizational structure. It was through the organizational structure that allowed the purchase and distribution of the materials used in the health lesson.

There is only one mannequin of the digestive system for three elementary schools. The mannequin must be obtained

and delivered to the appropriate school at the appropriate time by the health education coordinator. All classes must share the mannequin, and see to it that it is returned for use by another class. This behind the scenes obtaining and delivery of appropriate health education materials depends fully on the organizational efforts of the health education coordinator. It is this organizational structure that enables all other factors such as content and methods to be provided.

The 6th grade health education unit I observed was the Growing Up unit. According to the instructional notebook provided to the teachers by the health education coordinator, the objectives the students are to achieve for this unit are:

1. Identify the male and female reproductive systems.
2. Discuss ovulation and the fertilization cycle of mammals.
3. Identify that the ovary is in the female and the sperm is in the male body system.
4. Define fertilization as the joining of an egg and sperm to start a new life.
5. Identify that a human baby grows in the mother's uterus.
6. Identify that it takes about 9 months before a human baby develops before birth.
7. Spell human, life, growth, and puberty.
8. Identify the physical changes of puberty.
   Examples: growth of pubic and underarm hair.
   increase in perspiration.
   beginning of menstruation for women.
9. Identify the emotional changes of puberty.
   Examples: change in moods, needs for friends.
10. Discuss love and infatuation as not having the same meaning.

11. Discuss the rights and privileges of others.
12. Spell heredity, family, caring, and person.
13. Define heredity, as characteristics passed on from one generation to another.

The first vignette for the 6th grade is "A Day in the Life of a 6th Grader"; it gives an overview of what a typical day is like for a 6th grade student. There are two main themes that are apparent from this vignette. First, the methods used by the instructor to motivate the students show considerable discipline and control. Second, the organizational structure of the health program allows for additional health programs; in this case, one for dental health to be made available for all students.

A DAY IN THE LIFE OF A 6TH GRADER

At 9:06 the bell rings, and the students stream in and take their seats. In the back of the room there is a bulletin board with an Honor Roll list which a few students check for their names.

Laura is asked to write Page 30 on the board so all the students will know what page the reading lesson is on. The next hour will be for Reading.

"What do you feel about the pictures in the story?" asks Mrs. North.

"His face is sad," a student replies.

"How do you know it's sad?"

"A happy face would curve up, wouldn't it?"

The story is on cats. The students read the text, and discuss the theme and pictures. The students only speak when they raise their hands and are called on.

"Who decides whether your pets can come inside or not?" asks Mrs. North.

"My Mom."

"Why can some pets come in and others can't?"

"It's too big of a mess!"

After the story is over, the students do a worksheet. The worksheet is handed out by the "Leader for the day". The class is divided into four teams which compete for points by getting correct answers.

Several more students enter the class from their different reading class. Some students go to different

reading classes depending on their skills. All the students take out their English books and turn to the correct page without being told to do so. Today's English lesson is on past and present participles.

In the middle of the lesson, a knock at the door is heard, and in come two women from the Fluoride Rinse Team. One woman is from the health project, and one is a parent volunteer. They come in wheeling a cart with about thirty small fluoride-filled cups and napkins.

Mrs. North stops the English lesson abruptly, and everyone, including Mrs. North, does a fluoride rinse in her/his mouth. Sally, from the Health Project, directs them to rinse first one side of their mouth, then the other, then swish it all around. She then goes up and down between the aisles with a garbage bag and collects the cups.

Mrs. North gets back immediately to the English game, as each of the four teams compete for points by giving correct participles. English lasts thirty minutes, and at 10:30 all the students get their Social Studies books out.

"Today's lesson is on Buddhism in the Eastern Countries." Mrs. North emphasizes to the class that she is not teaching the class to believe in Buddhism, but that they are learning what some Asians believe. They have to make their religious choice for themselves.

10:45 is time for recess, and it lasts for 19 minutes.

At 11:04, it is time for the Health lesson. Today's lesson is on prenatal development in the Growing Up unit.

There is a filmstrip that discusses the different gestation periods of different animals.

"What is it called when the baby is born too early?" asks Mrs. North.

"Test tube baby," answers a student.

"No, not a test tube baby. What is it called, Jerry?"

"Premature."

"Right, is there anyone here who was a premature baby?"

Two girls raise their hands.

"What is a test tube baby?"

The Health lesson lasts until 11:45, when all 6th grade students break for lunch.

Lunch is over at 12:35. The students enter from outside. Some take their seats, and others grab books and leave. The students rotate to another classroom. The students who leave are going to another teacher to learn mathematics and science. The students who stay are from the math teacher's homeroom, and they will stay to learn English and Health with Mrs. North. Between 1:45 and 2:05 is afternoon recess.

At 2:25, the students from Mrs. North's homeroom return and begin a handwriting exercise.

At 2:40, the day is almost over, and Mrs. North reads some poetry until the final bell rings at 2:50.

Typical schedule for 6th graders:

	9:06	Day begins with Reading
	10:00	English
	10:34	Social Studies
	10:45	Recess
	11:05	Health
	11:45	Lunch
Classes rotate	12:35	Class rotates to another teacher for Math and Science, while other class comes in for English and Health
	1:15	Health, other class
	1:45	Recess
	2:05	Health resumes
	2:25	Handwriting exercise
	2:35	Open time
	2:50	Day is over

As can be seen from the vignette, the students have a definite subject schedule they follow. All students speak only when they have raised their hands and are recognized. The class is divided up into teams and each team competes for points awarded for correct responses. The methods for teaching health also use team competition. Another aspect of the organizational structure is represented by the provision of the fluoride rinse program entitled SWISH. All students who have returned permission slips may participate in a fluoride rinse program that is conducted once a week throughout the school year. The health program coordinates parent volunteers and obtains and delivers fluoride to every student participating in three elementary schools.

The next vignette, "A Human Being is Born" contains several key factors. First, the content of the filmstrip and discussion contains aspects of the Essential Objectives

for Health Education in family health. Second, the methods used to teach the health content using a filmstrip with a discussion provides the students with an opportunity to demonstrate their own knowledge of reproductive health. Third, the content represented several issues where the students could recognize that their behavioral choices and decisions make an impact on their health as well as the health of others.

A HUMAN BEING IS BORN

Does anyone know what it's called when a baby doesn't come out with its head first?" asked Mrs. North. The class of twenty-four students is silent; no one knows the answer. "Breech was the answer I wanted. Today we will watch a filmstrip called A Human Being is Born."

A woman who is nine months pregnant is featured in the filmstrip. She has her bags packed and is ready to go to the hospital. The baby is fully mature. The baby has grown to full size in the mother's uterus or womb, the filmstrip says. The mother wonders if her baby will be a girl or a boy. "Males and females are different--they have different sex organs at birth," the film strip says. "The differences are that females have eggs, Fallopian tubes, uterus, and vagina. The males have testicles, scrotum, and a penis. Born healthy, this baby will have all the right part."

The filmstrip ends with a picture of an artist's drawing of how a baby descends down the birth canal to be born.

Mrs. North goes to the front of the room and writes: A new life in the mother is called a f--------- e-- c---. "What is the answer?"

All students are very disciplined; speaking only when their hand is raised. No one guesses the correct ending. Mrs. North writes in: fertilized egg cell.

I have been observing the class for several days and the teachers and students have often included me in their

discussion. (I am 8-1/2 months pregnant at the time of this discussion.)

Mrs. Hansen's baby is to be born, how does she know?" Mrs. North asks the class.

"Contractions," a student replies.

"Of what?"

"The uterus."

"Yes, the uterus is a muscle and it contracts, forcing the baby to be born. What's the next step?"

"Call the doctor."

"That's right. I had a job once at a medical clinic taking telephone calls, and I remember if I ever got one from a mother in labor, I was supposed to give the call a red flag insignia and contact someone immediately."

"Okay, what's next?"

"Pack your bag," says a student.

"I don't know about that; Mrs. Hansen, is your bag already packed?"

"Yes, it has been packed for two weeks now."

"Yes, I don't think it's wise to leave packing for the last minute. What should be in the bag?" asks Mrs. North.

The students answer: "clothes", "nightgown", "toothbrush", "book", "rattle", "housecoat", "baby book".

"Okay, anything else?"

"Birth announcements," I add to the pool of answers.

"Okay, now what?" asks Mrs. North.

"Leave for the hospital."

"That's right, and when you get there, doctors and nurses will assist you. The doctors and nurses don't make the baby born, the mother and baby do. The mother and baby do the work; the doctors and nurses assist," Mrs. North explains.

Mrs. North asks, "Now what happens at the hospital?"

A student answers, "The muscles of the uterus have to use more strength."

"What has to happen before the baby can be born?"

Silence.

"What has to break?"

"The uterus has to break."

"No, not the uterus, what has to break?"

"The egg has to break." (A couple people in the class laugh.)

"No, the egg is what the baby is now."

"The sac with water."

"Right! What's it called?"

No answer.

Mrs. Hansen, help us out, what are the two things that have to break?"

I explain to the class that the amniotic membrane is also called the bag of waters, and before the baby is born, the sac is usually broken or ruptured.

"Yes, I remember when I was waiting for my baby to be born and I was home when the bag of waters broke and water came out, and I knew that I was going to have the baby soon."

"Okay, then the baby comes out, usually head first, and the head is very soft, so that the compression of birth often leaves the baby's head somewhat pointed. It doesn't hurt the baby, and soon it goes back to its normal shape."

One student offers a story: "My Mom had a friend who spent fifty-two hours in labor."

"Is that a long time?" Mrs. North asks the class.

No answer.

"Yes, that is long," she replies.

"Sometimes when a baby doesn't come out as it is supposed to, or when it is a difficult birth, they can use forceps; Mrs. Hansen, will you explain what forceps are and how they work?"

"Forceps are an instrument that is like large spoons that are inserted up the birth canal to grab the baby's head and pull it out. They are used when the baby must be taken out of the mother soon," I say.

"I was delivered with forceps," a student says.

"Both me and my brother were born Caesarian."

"What's that?" asks Mrs. North.

"It's when they take the baby out (?)" a student answers with a question (unsure).

"Yes, a Caesarian is when they make a surgical cut on the mother's tummy."

"Where's the cut, Mrs. Hansen?"

"It's in one of two ways, either horizontal or vertical across the belly, but usually horizontal."

"Is there anything any of you want to share?" asks Mrs. North.

"I heard about a baby that they didn't get out in time and they think it might be retarded," a student says.

"Another trouble is when the cord is sometimes pinched in the baby, and that cuts off the baby's air. Things do happen and brain damage can result. Fortunately, it doesn't happen very often. Birth is a hard trauma; the cord can wrap around the neck or the baby may have trouble," Mrs. North explains.

"Sometimes they need to get the baby out fast and they can make a cut, does anyone know what it is called?"

No answer.

"An episiotomy," Mrs. North answers her own question.

"Mrs. Hansen, would you explain how they do an episiotomy?"

I go to the chalkboard in the front of the room and make two drawings:

I explain: "There are two ways of making a cut, one is directly down from the vagina--almost to the rectum. Another way is to cut on an angle off to one side of the vagina and down toward the rectum. The reason they do this is to prevent tearing of the peritoneum, the tissue surrounding the vagina. There is not always a need for doing this, because

the peritoneum doesn't always tear, but it is done routinely anyway."

"If the mother is dead, can the baby still live?" a student asks.

"Yes, if the baby gets air to breathe in time before it suffocates. The mother's oxygen is what supplies the baby with air. If the baby is born soon, and can use his own lungs, then he can live."

"There's a problem oftentimes when the baby doesn't develop right--a defect, it is sometimes caused by a mutation, or an error in the chromosomes."

I add to the conversation: "There are lots of mutations, but we don't see them, the bad ones are usually miscarriages (or when a baby is conceived but dies and is bled away). There are lots of good mutations. It's what gives us variation and change in our generations, but most of them go unnoticed."

Mrs. North refers back to the episiotomy explanation: "When the doctors make an episiotomy, they use a drug similar to the novocaine that dentists use when filling teeth. This numbs the tissue so they can sew up the episiotomy after the baby is born."

Mrs. North senses that the class has been somewhat reluctant to ask questions and to feel at ease about reproductive health.

"There are very natural words that we should not be embarrassed to say: ovaries, Fallopian tubes, uterus, vagina,

penis; can we say these out loud?"

The class does not respond--it is time for recess; the health class is over.

The content of the filmstrip and the discussion following it illustrates three main themes that recur throughout the teaching of the 6th grade Growing Up unit. The first main theme is responsibility for behavioral decision-making. In this vignette, responsibility is implicit in the atypical issue of who makes the baby born. "That's right, and when you get there (the hospital) doctors and nurses will assist you. The doctors and nurses don't make the baby born, the mother and baby do. The mother and baby do the work, the doctors and nurses assist." Mrs. North is emphasizing that the mother is responsible for birthing her baby, and the doctors and nurses are there to help. This perspective is contrary to previous medical associations where the mother was not considered to be responsible for the birth of her child; instead, the doctor was perceived as being the one in charge who is responsible for childbirth. In today's medical practice, unless it is a Caesarian birth, the mother is given the main focus and responsibility for the birth of her child.

A second main theme in the vignette is that the content of the filmstrip and discussion following presents the students with straightforward factual information regarding the male and female reproductive system. From the content of the students' questions and answers, it was apparent that this information provided the students with an improved

understanding of human reproduction. For example, when Mrs. North asked: "What has to happen before the baby can be born?" The students did not reply. "What has to break?" asked Mrs. North. "The uterus has to break." "No, not the uterus, what has to break?" "The egg has to break." "No, the egg is what the baby is now, what has to break?"

The level of understanding evidenced by these student responses indicates that these students lack a clear understanding of reproductive health. The content of the information being taught to the students not only provides them with needed factual information, it also meets the Essential Objectives for Health Education in Michigan. The presence of myself as an outside resource also contributed to the content of the class. Because I was 8-1/2 months pregnant during the observation of the Growing Up unit, I was often asked by the students and teacher to share my knowledge and experience about pregnancy and childbirth. "Mrs. Hansen's baby is to be born, how does she know?" "Mrs. Hansen, help us out, what are the two things that have to break before a baby can be born?"

Mrs. North also used students' questions as a basis for further discussion. Comments from the students, such as: "I was delivered with forceps", "Both me and my brother were born Caesarian", "I heard of a baby that they didn't get out in time and they think it might be retarded", "If the mother is dead, can the baby still live"? often prompted detailed discussion about the process and problems of childbirth.

A third theme present in the observations of the Growing Up unit was the students' reluctance to ask questions and discuss reproductive health concepts and issues. One reason may be due to the level of friendship, or familiarity between the students. The students are relatively new to each other, as the restructuring of the school districts brought most of these students together for the first time. Another reason for the students' reluctance to discuss reproductive health may be due to a historical precedent, where reproductive health was considered a very private and "non-discussed" topic. Breaking new ground in the teaching of reproductive health may make it difficult for some students to discuss reproductive health in an open, factual manner. The health instructor discussed this problem in an interview. She said: "The hardest part about teaching reproductive health to these students was that the students did not know each other. This year they are coming together for the first time from all over town. Perhaps nudity in the films was difficult for them, but they still need to have this information, even if they are uncomfortable at first."

The next vignette, "From Girl to Woman" contains several key factors and main issues. First, the method of teaching this lesson is to separate the genders. Boys see a complementary film entitled <u>From Boy to Man</u>. After the film, the girls and the boys have a discussion in their separate gender classes. Second, the content of the film and the

discussion meets the Essential Objectives for Health Education for family health, and it is particularly applicable to the 6th grade girls' personal experience. Third, the content of the film and discussion is presented in terms of their own behavioral choice and decision-making. In this case, the content refers to the girls' lack of choice regarding how and why they are not permitted to stay out as late as their brothers, and what choices they make to express their emotional changes.

GIRL TO WOMAN (GIRLS ONLY)

"I've noticed that this class seems to be reluctant to speak out about issues and topics we are discussing in class. I was proud of Susie and Rosey and April, who asked some really good questions yesterday," said Mrs. North.

"Maybe it's because you don't know each other very well, as you are all coming from five different schools. I want you to feel at ease to ask questions and make comments. I want everyone to think of one question, even review-type questions that you may know the answer to, that can help the class. I'll give you a plus on the health booklets for good participation. Today we are going to see a film entitled From Girl to Woman."

The film has several different adolescents being interviewed. A short summary of the main points of the film follows:

- A girl can't go out and stay out as late as her brother.
- One girl talks about going steady with a boy who dropped her and went back to his previous girl friend. She felt depressed and cried a lot.
- We (adolescents) aren't mature enough to have relationships of big seriousness.
- One girl says she is glad she is flat-chested because the guys won't be after her for her breast size.
- Adolescence is a time when feelings unfold and many changes take place.
- It's a time for growth spurts; boys mature slower than girls and may seem shorter, then suddenly they catch up.

- If you are uncomfortable with your differences from your peers, take heart, you are normal even if you have a different shape and size.
- New glands are functioning, and sweat and pimples will emerge. Take lots of baths and scrub face and change clothes regularly.
- The physiology of a pimple is discussed.
- Eat right, get lots of exercise, and get enough rest to be healthy.
- The pituitary gland is the growth clock of your body; it is located at the base of the brain. It sends out hormones for sexual development. When this happens, breasts develop, body hair grows, hips get wider, and the ovaries begin to produce and emit eggs.
- Anatomical description of the labia, hymen, clitoris, urethra, vagina, uterus, ovaries, Fallopian tubes. All these parts are ready for a mature egg.
- Finally the egg is released from the ovary, and it travels down the Fallopian tubes to the lining of the uterus. If it does not get fertilized, menstruation begins.
- Menstruation cycles are usually every four weeks, often three to five weeks, and irregular at first.
- Good health can help prevent cramps.
- Sometimes the egg encounters sperm from the male, and fertilization occurs.
- The path is traced that the sperm follows. Millions of sperm develop in the testicle, mix with fluids from mens' glands, and then are released through the penis during an erection.
- An erection of the penis is caused by a muscular contraction of the penis as it engorges with blood.
- During intercourse, the sperm is released in the woman's vagina.
- A microscopic enlargement of sperm swimming toward an egg is shown.

- A fertilized egg implants itself in the uterus lining. Embryo grows and will mature into a baby.
- Many changes must occur in your body, especially one's feelings.
- These changes take time.
- Your feelings about boys will change; there is uncertainty, there is joy. Film ends. (About ten minutes.)

"Okay," Mrs. North says as she moves her stool to the front of the room, "If I talk, I'll take your questions away."

No response--pause.

"Health credits?"

No response--pause.

"How about the girls who were talking about their boy friend who was going with one girl, and dropped her and went back to a previous girl friend. How did she feel?" asks Mrs. North.

"Depressed," answers one student.

"What does depressed mean?" asks Mrs. North.

"What do you do when you're depressed?"

"Unhappy."

"Cry."

"Lock myself in the bathroom."

"Okay, those are all things we can do. How would you feel if that happened to you, or if it has, how did you handle it?"

No response.

"How many have had boyfriends already, or do have them now?"

Three students raise their hands.

"You may not think we know what's going on, but your teachers know who likes whom, and who your boyfriends are, we see....."

"Do you think it's unusual for a 6th grader to have a boyfriend, and end up marrying him? Would you like that if you had a boyfriend now and were going to make plans to marry him?" asked Mrs. North.

The majority of the class all say "no".

"Why?" asks Mrs. North.

"If you get married, you would get sick of each other soon and end up in divorce," says a student.

Several of the students say how long their parents have been married, including one student who volunteers that her parents are divorced.

Mrs. North says she would prefer not to have just one boyfriend, and end up marrying him. It was better for her to have relationships with more than one boy, so she could know what other boys are like. "How do you know what it's like out there if you only have one boyfriend?" she asks.

"My Mom and Dad have been going together since 9th grade," a student says.

I join in the conversation and add: "Marriage isn't always a good indication of how happy people are together. Lots of time people stay married to each other, even though

they aren't happy."

"Yes, not everyone who is married is happy; what is the divorce rate now, one out of two, isn't it, Mrs. Hansen?" "Religion also has a lot to do with divorce; some religions are against divorce and people stay together regardless. Sometimes there is just too much fighting and they get divorced," Mrs. North describes.

"Another part of the film showed the girl having to be in earlier than her brother; is that true for you? Can your brothers stay out later than you?" asks Mrs. North.

"My sister had to come in a lot earlier than I do when she was my age," a student replied.

"Why? Why does the girl have to be in earlier, or why can boys at sixteen drive to Florida for spring vacation, whereas girls are not permitted to do so?"

"My Mom doesn't like the idea of me staying out too late."

"Why?"

No one replies.

"Boys can take care of themselves," answers Mrs. North. "Let's say a girl in 11th grade has intercourse, and gets pregnant. She has some options as to whether or not to keep the baby, but the boy doesn't have to take the responsibility. Although there are some who will, it is not mandatory for the boy to be responsible, but it is for a girl."

"How many girls have guys who are good friends?"

One student raises her hand.

"What do you talk about with girls that you would only talk about with your girl friends? Not the content, but what topics do you only talk about with girls?"

"Boys," says one girl.

"Yes, boys, and perhaps how you're feeling about yourself, what's happening in the home, perhaps how you feel about your own developing, whether it's early or late..."

No response from students.

"How many have a body part they don't like, that it's either too big or too small?" Pause--no answer. "How many of you feel your butts are too big?"

Six students raise their hands.

"How many of you are comfortable with your breast size? Would you rather have them small, or large like Dolly Parton?"

"Small," the majority of the girls all respond.

"How many of you think you will probably be pretty good looking by the time you're sixteen?"

One student raises her hand.

"Why do you think that?"

"Well, my Mom is too skinny, and my sister is too big, so I will probably be somewhere in between."

"You may be disappointed," Mrs. North says, "no matter how good we look, we are generally not satisfied."

I add, "The media is responsible for giving us a lot of this insecurity, that we are not good enough as we are,

in order to sell us their products."

"Yes, we hear how much better we appear with that cigarette in our mouth, and it's just a gimmick," Mrs. North says.

"How many of you would date and/or marry a boy shorter than you?"

Five hands go up.

"How many want a guy much taller than you?"

"I married a man about the same height as I, and it doesn't bother us at all. If I wear high heels, he still doesn't mind even if I appear taller, he can handle that. I'm not sorry I married someone my height."

"Another thing mentioned in the film was sweat and skin problems; how many of you notice extra oil on your skin?"

Almost everyone in class raises their hands.

"What did the movie say about why we sweat more?"

"Nervous," answers one student.

"Yes, and tense and afraid the film said."

"How many use deodorant?"

Six students raise their hands.

"Well, get in the habit," says Mrs. North. "And how many wash your hair more often than you used to?"

The whole class says yes.

"What did the film say to do? Wash your face at least two times a day, and use soap and warm water, and if it's really oily, go see a doctor for some special soap."

Class is over.

There were several main themes illustrated in this vignette. The most important main theme discussed was in relation to the girls' behavioral choice and decision-making. Some of the behavioral decisions discussed included: the decision of how they choose to cope with rejection and depression; the decision of whether or not to wear deodorant, and to take care of their personal hygiene. Mrs. North also asked the girls why they are not given certain behavioral choices. Mrs. North asked the girls: "Why does the girl have to be in (home) earlier than the boys?" "Why does the girl have to come in earlier, or why can boys at sixteen drive to Florida for spring vacation, whereas girls are not permitted to do so?" asked Mrs. North.

One student replies, "My Mom doesn't like the idea of me staying out too late."

"Why?" asked the teacher again.

No one replies.

Mrs. North then explains that the boys can take care of themselves, but girls could get pregnant, and then the baby is their responsibility and not necessarily the boy's.

The message behind this question is that the choice, to be able to stay out late and possibly engage in sexual relations, is not given to girls as easily as to boys. Girls are not being allowed the opportunity to decide for themselves; they must be "in" at a certain time, so they can be "safe". Perhaps what is even more implicit in this situation is that girls must learn that as they grow older, they will

have increased sexual desires, and boys and men will also look to them to be a possible partner for sexual relations. Thus, they must learn to be responsible for their own sexual experiences.

One question is, "what does this rule do to the girl's sense of self-responsibility?" Does the rule imply that she cannot be responsible enough to refuse sexual relations, therefore, she must be at home early, so she won't have to decide?

To complicate the "message" even further, the rule to be in early may be for her own protection, because she could be forced to have sexual relations, (ie., rape).

This point is emphasized because the decisions of maturity and responsibility revolve around an individual's ability to control her/his own sexual desires. The appetite for sexual experiences and relationships is very strong in the young adolescent. Our Western culture exaggerates this sexuality focus in the media, in the double standards for boys and girls, and in the advertising market to sell products. Everywhere a person turns, there are sexual messages that imply "if you choose a certain product, you will be sexually attractive". Mrs. North exemplifies this by her efforts to detoxify sexuality in advertising:

"Yes, we hear how much better we appear with that cigarette in our mouth, and it's just a gimmick."

Perhaps what the students need to believe (especially females) is that they are okay if they are without girl

friends or boy friends, and that they can have friends of the other sex and not be involved sexually.

In the film, From Girl to Woman, it shows girls at the same age, but at different stages of physical maturity (also in From Boy to Man film). The message is: "If you are uncomfortable with your differences from your friends, take heart, you are normal even if you have a different shape." This message is trying to ease the students' sense of self-consciousness about their differences. Learning how to filter out the messages of: "you're not good enough unless ....." is what will make the adolescent choose a healthy, responsible life style. Also, if they have not learned this sense of self-security, their lives inevitably will be spent in search of social approval. Whether or not health education can influence the student's sense of self-affirmation is debatable. What it can do however, is emphasize that the decisions the students will make will necessarily affect their health and the health of others.

A second main theme illustrated in the vignette "From Girl to Woman" was the relevance of the content. Both the film and the discussion included some of the Essential Objectives for Health Education in Michigan, as well as being relevant to the student's own personal experiences. For example, when the instructor asked the girls how many felt their butts were too big, six students raised their hands. Other students volunteered how they coped with rejection and depression, and the whole class of girls agreed that they

had washed their hair more often. The film also included physiological changes associated with puberty, and encouraged the girls to "take heart" if they felt uncomfortable about their differences, as everyone matures at different rates, and differences are normal.

A third main theme worth noting in the vignette was the various methods used for instruction. The genders were separated for the viewing of the film. The boys saw a complementary film entitled From Boy to Man. This separation of the genders allowed the girls and the boys to discuss concepts and issues they might not feel comfortable discussing in front of the other sex. Even with the gender separation, the girls were still reluctant to discuss reproductive health concepts and issues. Mrs. North was able to get the students to participate by offering them extra credit in their health notebooks, and by making the discussion relevant to the girls' own experience.

The next vignette, "A Human Being is Born" contains two major themes or key factors. First, the methods used both in the film and the subsequent discussion allow the students to ask questions by recalling questions that were prompted by the film. Second, the content reflects information that meets the Essential Objectives for Health Education in family health, and is presented in terms of behavioral choices and decision-making. Unlike any other previous films, this film includes a very brief clipping showing an actual childbirth.

HUMAN GROWTH III

Today's health lesson will feature a film entitled Human Growth III. It is the same film that was reviewed at an advisory board meeting.

The film begins by showing lots of different students running and exercising. What makes these kids grow? Glands produce hormones that affect their growth. Several boys are shown who are different sizes, but all six years old.

When boys grow, they get broader shoulders and bigger muscles; girls' hips get rounder and they get taller.

"What's so hard about growing up?" the film asks, and then interviews several kids who answer:

"Learning right from wrong."

"Problems with myself."

"Problems with the opposite sex."

"Don't know about the future, and I'm uptight about how hard it is out there."

"Trying to understand myself."

The film talks about how some religions and cultures have a special ceremony to demarcate the onset of adulthood, and then interviews some students as to whether they think it is a good thing to do. Some of the students' responses are:

"No, the body and mind are not grown at the same time."

"In my religion, boys have a ceremony for adulthood, but just because they are thirteen years old doesn't mean they are grown.

There is a drawing of the penis and it is diagrammed

how sperm cells travel through the urethra and ejaculation occurs through masturbation, sleep, or sexual intercourse. Sexual intercourse is when the sperm travels from the penis through the vagina and meets with an egg cell. There is a drawing of an embryo and says it will develop into a baby.

The film interviews several couples talking about what it's like to be either pregnant or the father of an unborn baby. Several couples are interviewed who have decided not to have children and describe why.

An actual childbirth is shown, with the baby sliding out of the mother. The film ends with several students asking questions, without giving them answers.

Mrs. North takes her stool and moves it to the front of the room and begins the lesson by asking the class to recall some of the unanswered questions at the end of the film.

One student replies: "There was a question on diabetes, if the mother has diabetes and is pregnant, will the baby necessarily have diabetes?"

Mrs. North asks the class to answer it. One student says: "No, my mother had it and I didn't get diabetes."

"Diabetes is an inheritable trait, but doesn't always show up until later."

"Another question?"

"Why does the woman have the baby instead of the man?"

"Okay, what's the answer?" asks Mrs. North.

"Because nature made it so," a student answers.

"Yes, you can say that, or God made it that way, or

it's just our nature, but it is always true."

A student disagrees, "In the seahorse, the male bears the young."

Mrs. North and myself correct him and say that the female seahorse bears the young and then the male carries them in a pouch.

"What other animals do things differently?" asks Mrs. North.

"Certain fish chase females away and the males take care of the offspring."

"Yes, sort of like the Dr. Seuss book, Horton Hatches the Egg."

"Another question?"

"Can a woman already pregnant get repregnated again?"

"Okay, and what's the answer?"

"No, because the woman doesn't produce more eggs."

"Yes, another one?"

"If a Japanese and an American mate, will the children be Japanese or American?"

The students answered:

"Japanese."

"Both."

"Combined."

Mrs. North says, "Yes it would be a combination of the two races." "I have always had a theory," says Mrs. North, "that if all the races intermarried, we'd have one race that was beautifully tanned and golden. But

certain traits are going to be lost, because other traits are dominant. Dominant and recessive genes means that if there is a mix of, say, brown eyes and blue eyes, the child will most likely be brown-eyed because brown eyes are dominant."

"Another question?"

A student replies: "If the mother is an addict, would her baby necessarily be deformed?"

"Not whether deformed, but addicted," another student corrects him.

"What's the answer?"

"Yes, necessarily deformed."

"No," replies Mrs. North, "the baby would not necessarily be deformed."

"How about addicted?" asks Mrs. North.

"No, not addicted."

"Yes," another student disagrees.

"Mrs. Hansen, help us out, would the baby be addicted if the mother were?" asks Mrs. North.

"Yes," I explain, "the baby would have to go through withdrawal just like an adult, after (s)he were born."

"How about cigarettes?" asks a student, "would there be an effect?"

The students answer, "No effect."

"Yes, there would be."

"No effect, because it would stay in the mother's lungs."

Mrs. North says, "Yes, it probably does affect the

baby, Mrs. Hansen, what do you think?"

"Yes, I agree, the effect would be a diminished oxygen supply, because the mother's oxygen supply is affected by the smoke, which would affect the infant's air supply."

"What about alcohol?" another student asks.

"Yes, alcohol also affects the baby."

"How about another question from the film?"

"How do they get twins?" "Or only some people have twins?"

Mrs. North explains the difference between identical and fraternal twins. A student tells about seeing Siamese twins joined at the head on television.

Another student asks: "How do they get multiple births?"

Mrs. North replies: "Most multiple births today are drug-induced via a fertility drug that women may take to induce the likelihood of pregnancy. Before the fertility drug, quintuplets were a marvel; now drugs can induce the egg to keep splitting."

One student remarks that she heard about a baby who was a test tube baby. Mrs. North says that test tube babies were conceived in a test tube and then implanted in the mother's uterus, where it grows into a baby.

I add that there are many parents who are waiting to have such a procedure done, but it is very new, and very expensive, and done only when the mother's Fallopian tubes are damaged or absent, and it is the only way for them to

conceive a child.

"Okay, one last question from the film?"

"Why do the mother's breasts start to make milk?"

"You tell me," Mrs. North replies.

"It's just like in a dog, when they have puppies, the milk comes."

"It's because of chemicals in the body."

"I read that by drinking milk when you're pregnant helps your milk to come."

Mrs. North replies that milk is needed to supplement your calcium level, because the baby is growing bones and teeth and will take the mother's calcium.

The vignette illustrated how the film used a new method to stimulate student participation regarding reproductive health. The film featured students asking questions that all students of a similar age may wonder about, without answering them. This method allowed the instructor to ask the class to recall and answer the questions prompted by the film. As described in the vignette, the students didn't always agree with each other on some of the answers. When the question arose whether the baby would be addicted to drugs if the mother were, the students differed in their opinions.

The film showed interviews with a series of people who have chosen different options regarding childbearing. By presenting different perspectives, and why they chose

them, the students were able to realize that sexual relations and child bearing requires decision-making and lifetime responsibility for their behavioral choice.

The film also showed a graphic description of how fertilization occurs, as well as a clipping of an actual childbirth. When I interviewed four of the students after the unit was over, three out of four said that out of the entire unit, they best liked seeing a real child being born. By actually seeing what a child being born is like, the students have a much clearer understanding of the results of their behavioral choices and decision-making.

ADDITIONAL ANALYSIS OF THE HOBART HEALTH PROGRAM

In addition to the vignettes, interview data and specific observations also contributed to the analysis of the Growing Up unit of the Hobart Health Education Program. The following section summarizes these findings.

ORGANIZATIONAL STRUCTURE

There were specific organizational structural decisions that influenced the methods of instruction and content for the Growing Up unit. One of these decisions was to separate the genders of the class for separate film reviews. The girls of two classes assembled in Mrs. North's classroom and reviewed the film From Girl to Woman. The boys of two classes went to Mr. Olson's class and reviewed the complementary film From Boy to Man. The theory behind this gender separation was to help the students to feel more comfortable discussing reproductive health issues and topics by having a girls or boys only class format.

I interviewed four students as to whether or not they preferred this gender separation. The students had the following responses: "I didn't think it was a good idea, but it saved time". "Kind of yes, and kind of no, better to learn together the personal questions; it might help prevent pregnancy". "The boys' classes dealt with boys, that was good, but the filmstrips weren't as good". (Male student response.)

Another component of the organizational structure was my presence as a participant observer.

I feel that my participation as a resource person and/or guest speaker was also very well received and enjoyed by the students. The students asked lots of questions about my baby soon to be born, and during the lessons I participated in, some students even stayed in from their recess for a short time to ask me questions on a more personal level. Also, during the student interviews, some of the students asked me more questions such as: "What is it like being pregnant"? After my daughter was born, I returned to the class and gave a talk on what her childbirth was like. The students seemed very attentive and asked questions such as:

"Did it hurt?"

"How long did it take?"

"Did the baby look around when she was born?"

"Did her head come out first?"

"What did she look like?"

METHODS OF INSTRUCTION

There were also several different teaching methods employed during the 6th grade Growing Up unit. Some of these methods were:

1. Films and filmstrips.
2. Using a game approach with teams and points.
3. Outlines of main points in the films.

4. Letting students answer the questions in the film.
5. Health project notebooks.
6. Having the students tell stories of their personal experiences.
7. Bulletin board with health questions.
8. Resource persons, such as myself.
9. Separating the genders.
10. Anonymous question asking.
11. Special permission forms needed to be signed by the parents for students to be able to participate in the reproductive health classes.

The most enjoyable methods seemed to be (in my perspective) using the film with unanswered questions at the end as an incentive for discussion, and also myself as a resource person or guest speaker. The film with the unanswered questions allowed the students to answer questions they themselves may have wondered about, but did not spontaneously ask.

BEHAVIORAL CHOICE AND DECISION-MAKING

Behavioral choices and decision-making seemed to be an integral part of the Growing Up unit for 6th grade. Students were confronted with many decisions and behavioral choices during the teaching of the Growing Up unit. Some of the more important decisions that were discussed in the observed classes were:

1. The decision to breast or bottle-feed a baby.
2. Decision to respect other persons' rights.

3. Decision of how to cope with depression and rejection.

4. Decisions to wear deodorant, keep clean.

5. Identify decisions they make that involve maturity and responsibility.

6. Realization that the decision regarding being <u>able</u> to have a baby and being <u>ready</u> to have one are two separate decisions.

7. Decision of marriage, and number of boyfriends/ girlfriends.

Behind identifying a decision the students will need to make as they mature, is examination of the motivation for a particular decision. For example, the student who chooses to cope with rejection/depression by locking herself in the bathroom has a motivation for doing this behavior. Perhaps it is to gain privacy, or to be able to wash away one's tears and have her crying go unnoticed. During the observed classes, several motivations for certain decisions were also discussed. Some of these were:

1. To make their mother, father, brothers, or sisters proud of them.

2. To gain the respect of their peers.

3. Being able to earn money and be responsible as a prerequisite for having a baby.

4. To avoid pregnancy may be a motivating factor as to why parents may require girls to be in earlier than boys.

ISSUES

For the 6th grade Growing Up unit, several issues were discussed. Some of these issues were: infatuation is not the same as love, test tube babies, the mother and baby make the baby born, not the doctor (unless it is a Caesarian birth), girls usually have to be in earlier than boys, age doesn't necessarily signify maturity, and most chores need to be non-sexist.

The students' reactions to these issues varied from looking up a word in the dictionary (infatuation), to having a lengthy discussion about the issue. For example, during the discussion regarding whether a baby is necessarily affected by the mother's use of drugs, several students told of their own perceptions, and disagreed that their health could be affected by their mothers who smoked during pregnancy.

"What is infatuation?" the teacher asks.

"If you don't like a person much, but you buy them something."

Mrs. North then adds: "When I was in 5th grade, there was this red-haired boy, and I really thought he was neat. That was infatuation, not love."

"Infatuation is when you give them attention when you don't really care," another student adds.

Another student looks up infatuation in the dictionary, and he tells the class: "It is foolish love, in the dictionary."

"Infatuation might be thought of as, I had a crush on him or her," Stella added.

"Yes, you can have a crush on anyone, your teacher or doctor, or a girl or boyfriend," said Mrs. North.

There were also some issues that were purposely not addressed. During an interview, a teacher acknowledged that abortion and venereal disease could not be mentioned at this time, and it really hindered the presentation of the full picture.

The issue of the rights and privileges of others was also discussed in the 6th grade Growing Up unit. In a filmstrip entitled Growing and Learning it says: "We learn to be responsible and to respect the rights of others. We learn responsibility through helping our families. By twenty years old we stop growing, but we don't stop learning." In the discussion following the filmstrip, the teacher asked the class to recall a memory where they wanted to help their mothers. The students replied:

"I remember wanting to help Mom wash the dishes."

"I remember trying to vacuum the house, and I vacuummed the cat instead."

"I remember trying to wax the floors while Mom was gone."

"I remember trying to make popcorn and spilled oil all over and made a mess."

"I remember using my toy lawn mower to try and mow the lawn."

"I remember trying to help bake cookies."

The teacher also asked the class to tell how they expressed respecting the rights of others. The students responded:

"Don't cheat!"

"Don't steal from others, or take somebody else's mittens."

The teacher adds, "Yes, part of growing up is learning to wait your turn. We all have to be able to wait for the things we want."

One issue involved in the teaching of reproductive health is whether the level of material is appropriate for 6th grade students, and if so, how was this evidenced?

Overall, the students seemed fairly comfortable with the concepts discussed in the Growing Up unit.

During the discussion on prenatal development, the students seemed quite comfortable. They shared experiences of having seen animal births.

During the baby's developmental stages, the students were asked to tell their own experiences and first memories--giving them considerable opportunity to apply it to themselves.

During the discussion of male and female reproductive system physiology, the students seemed to feel comfortable. They were not asking many questions, but they did not behave uninterestedly either.

During one of the student interviews, one student replied that learning about reproductive physiology and

prenatal development were the best parts.

One student during the interview confided that he was a bit uncomfortable when the film showed the doctor cutting the umbilical cord of the newborn baby. This same student spent half of his recess (following this film) asking me to explain how the baby got food, water, and air through the cord. He thought it was directly "piped in" through the umbilical cord.

Another female student replied she was a bit uncomfortable talking about developing in front of boys, but also said that maybe being in a mixed gender class will help prevent pregnancy.

An interview with one of the 6th grade instructors gave the perspective that "the hardest part about teaching reproductive health to these students is that the students do not know each other. This year, they are coming together for the first time from all over town. Perhaps nudity in films was difficult for them, but they still need to have this information, even if they are uncomfortable at first."

When asked whether the content level of the material presented seemed appropriate, the instructor replied, "Yes, these students are at a prime development point, and this information is very pertinent to what they are now experiencing. Their understanding is observable in the class by their questions and answers."

One of the leading psychologists in American education is of the opinion that the teaching of reproductive

health to young adolescents will encourage sexual experimentation, increased unwanted pregnancy, and increased veneral disease rate. (Bettelheim, 1981.)

Searching for evidence to this effect showed very little support of this theory. It would be impossible to verify either support or non-support of this theory.

I did ask the instructor what she felt about this theory, and she replied, "The more they (the students) know, the more the students are allowed to choose. They are not trapped by not knowing what they are getting into. Some youths don't realize they can get pregnant from sexual relations until it's too late. The students need to know that their bodies are their own, and they don't have to be touched in any way unless they want to be. In some years, we have also talked about sexual abuse in the home or family (not this year). It is a difficult subject, which may actually be interfering with home life. It is important for the students to know they can come to me, as their teacher, that if they are being touched in undesirable ways, that we can help."

I also asked the instructor for any general comments she wished to make regarding the teaching of the Growing Up unit. She replied: "The students of today will still receive the stereotypical garbage of past generations as long as their uncles and family members--even teachers--keep telling the students the same false ideas they were raised on. An educational program like ours can only do so much to correct these false impressions."

PATHS NOT TAKEN (6TH GRADE)

The role of reproductive health in the overall health education curriculum is in the researcher's view, essential. The students are bombarded with sexual messages everywhere they turn. If they do not understand the impact of their decisions, they are doomed to pay dearly for their consequences. Not only are the individual students going to pay, so will our society and the world at large. For a person to engage in sexual relations because they are hungry for self-affirmation is often a tragic predicament. The students pay a price with their own lives, and the society pays a high price through social services and intervention measures.

It is not enough that the student learns how they reproduce, they also must learn why the choice to engage in sexual relations is so appealing. Once they can see behind the motivations for their own decisions, they are more likely to make a choice with full knowledge of both the consequences and the reasons for doing/choosing their decisions.

SUMMARY

The analysis and vignettes of the health program of Hobart focused on five key factors: organizational structure, content, methods, behavioral choice and decision-making, and health education issues. The key factor identified as organizational structure enabled other factors or linkages to be present. The organizational structure was multi-dimensional in that it promoted comprehensive health education to the Hobart community through community integration, to the students through provision of a comprehensive health education curriculum, to the instructors through health education inservice training, and exchanged relevant health education information through state and national organizational networks.

The content of the Hobart health education program was investigated in relation to the main themes generated by the curriculum, and the opportunities offered to the students to relate the content to their own personal experience. The content that was observed was recognized as meeting some of the Essential Objectives for Health Education in Michigan.

The different methods used for instruction were examined in relation to what effect they had on student behavior and learning. Certain methods, such as films with unanswered questions and hands-on experiences, encouraged more student participation than other methods, such as

watching a filmstrip.

Behavioral choice and decision-making was investigated as to whether the students recognized that their decisions and behavioral choices affect their health and the health of others. The presentation of health education concepts in terms of the student's behavioral choice and decisions allowed them to recognize that they are responsible for their own health and that their health choices affect the health of others.

Issues that were investigated such as motivations for choosing non-healthful behaviors and certain aspects of reproductive health such as abortion and contraceptive health, and venereal diseases were not discussed in the observed classes. Other issues such as rights and privileges of others, double standards for curfew hours of boys and girls, and the issue of responsibility for one's health choices were observed.

The five key factors of organizational structure, methods, content, choice and decision-making, and issues were interrelated in that some factors such as organizational structure and content enabled other factors of choice and methods and issues to be present. These five factors were identified as necessary for the students to learn comprehensive health education concepts in terms to the students' role and responsibility for their own health as well as the health of others.

INTRODUCTION TO URBANDALE

The next section is the analysis and ethnographic vignettes for the observations of the kindergarten health program at Urbandale. The main issues for this site center around the themes of organizational structure, methods of health instruction, and learning how to go to school. Also, the subsidiary factors of ethnic and cultural differences within the class, and sex-role stereotypes appear as minor themes affecting the students' ability to succeed in the learning of the health education curriculum. Issues that will be addressed in this section include:

1. The integration of school health services and community resources into the overall health education program.
2. The lack of health in the health education curriculum.
3. The prerequisites involved in learning how to go to school as a necessary ingredient for being successful in the health education curriculum.
4. The merits and problems resulting from a teacher-based curriculum.
5. The effects on self-esteem and self-confidence that sex-role stereotyping plays.

The first part of this section is a description of the background of the Urbandale kindergarten health program, followed by a description of the setting of the observations.

The second part contains the ethnographic vignettes and commentary of the health program observations. Each vignette illustrates one or more main themes that were

evident in the observations. Let us now turn to a brief description of the background of the Urbandale Health Education Program.

URBANDALE SCHOOL DISTRICT

The health education program in the Urbandale School District was divided into three components: a kindergarten health component, an elementary health component, and a high school component.

My participation as an observer of the Urbandale School District was organized through a course on Participant Observation taught at Michigan State University by Profs. Buschman, Florio, and Erickson. I was a part of a three-person research team directed by Prof. Erickson to study and observe the Urbandale Health Education program. The director of the Urbandale Health Education program asked that each of the three researchers choose a different component of the health project to observe. The component I observed was the Kindergarten health program. The following is a description of the Urbandale Kindergarten Health Education program.

The Urbandale Health Education program for kindergarten students is based on two main assumptions: one, that health behavior is affected by self-esteem, and two, that health behavior is affected by health knowledge. The underlying assumption is that kindergarten students are in need of improved self-esteem, and health knowledge, and that the

Urbandale School District Health Program can contribute to improving a student's sense of self-esteem and health knowledge.

Several services were provided by the health program to improve the students' self-esteem and health knowledge. Some of these services include: appraisal of the health status of students through regularly scheduled vision and hearing screening, counseling students and parents concerning health needs, clarifying to teachers the health needs of the students, providing a referral process for the correction of identified problems, prevention and control of disease. The mechanism in which the health program provided these services was through three main components: the teaching of a health curriculum, home visitation by student nurses, and inservice training for the kindergarten instructors. Each of these three components are discussed below.

DISSEMINATION OF THE HEALTH CURRICULUM

The health curriculum being implemented in the kindergarten health program was developed by Eileen Earhart, Ph.D. This curriculum does not have a health content, but instead consists of a series of games and tasks to help the students improve their gross motor, auditory, and visual discrimination skills. This curriculum is theorized to help the kindergarten student improve her/his self-esteem by having success in completing the tasks of the curriculum.

The students meet in groups of four or five students

and participate in the lesson for fifteen to twenty minutes. Because the kindergarten student's attention span is relatively short, the games or tasks in the curriculum do not last for more than five or ten minutes. The health lesson is organized so that half of the class of seventeen students had the health lesson on a given day. Four of the students met for fifteen minutes, and then switched with four other students after their turn was over.

The teacher aide was the health instructor for all of the times I observed the health lesson. The teacher also worked with a small group of four students on reading skills during the health lesson. The remainder of the class was kept busy working at their tables.

The main issue regarding the dissemination of the health lesson was that the lesson did not have a health content. The content of the lessons were designated to help prepare the students for reading and math placement tests that are given to all of the kindergarten students. These placement tests were referred to as the IMS objectives, and the evaluation of the health project for kindergarten students was previously based on how well students who had the health lessons compared to students who did not, on the IMS objectives. Neither the evaluation team hired by the Urbandale School District, nor the health program staff based their curriculum or evaluation on an actual health content. Therefore, to refer to this program as a "health education" program is somewhat misleading.

HOME VISITATION BY STUDENT NURSES

The home visitation program is a joint effort of the Director of School Nurses, and the Health Education Program Coordinator. These individuals arranged for a team of student nurses from a nearby college to conduct home visitations into the homes of kindergarten students identified as having developmental deficiencies. These visits were to obtain birth and developmental history in order to gain more understanding of the student's present health status, behavior, and performance. Reasons for ongoing visitation of students' homes were varied. Teachers were advised to refer students for home visits based on skill development, behaviors, family situations, or medical conditions. Following a school nurse contact, other support personnel within the school may also be summoned to assist the student. These personnel include reading teacher, counselor, bilingual specialist, community coordinator, and a multi-disciplined diagnostic team.

One of the main issues regarding home visitations is the possibility of misidentifying students with developmental problems. What may be considered a developmental deficiency may actually be the teacher's misinterpretation of culturally learned pattern of performance. Once a student has been identified as being developmentally deficient, the implementation of remedial services may influence the student's self concept in undesirable ways.

INSERVICE HEALTH EDUCATION

A second important component of the organizational structure of the health education program is the provision of health education inservice to instructors. The inservice education served to help the instructors learn how to identify students with developmental deficiencies and bonding problems between their peers and/or the instructor. Some inservice education sessions focused entirely on one student and what could be done to help the student improve her or his skills in the kindergarten classroom. Other sessions were round-table discussions where each of the health instructors shared their experiences with students in their classes who had developmental deficiencies.

There were two main issues relevant to the inservice education sessions. One was motivation for the instructors to participate in the inservice sessions. The Urbandale instructors were compensated for their time and participation from the health project funds, and the sessions were always scheduled after the school day so the kindergarten teachers would not have to leave their classes and get a substitute. The financial compensation and the scheduling seemed to encourage the teacher's participation. The instructors who did participate regarded the sessions as worthwhile and enjoyable.

A second issue regarding inservice education was the fact that although the instructors received the inservice education, the teacher aides were often the instructors for

the health lessons. Inservice education needs to be directed toward whoever is doing the health instruction, whether it be the teacher or the teacher aide.

Because of time and accessibility limitations, I was not able to equally investigate all three of these health program components. I instead focused my observations primarily on one component: the teaching of the health curriculum. The other two components were investigated secondarily only in relation as to how they affected the implementation of the health curriculum.

URBANDALE RESEARCH QUESTIONS

1. What evidences of health behavior does the health curriculum profess to teach?
2. How can these health behaviors be identified and measured?
3. Do the teacher training inservice programs for kindergarten teachers help them to identify health behaviors which may be affecting the student's ability to learn? (self-esteem, bonding)
4. What additional factors seem to be affecting learning during the activities of the health curriculum?
5. Does the information from a school nurse visit change the manner in which the student is exposed to the health curriculum?
6. How do particular students who are identified as being target learners behave in the classroom? Do these students seem to be able to have a positive bond with the teacher? Other students? What is their behavior like during the health lesson?

The different components and the expected outcomes of the Urbandale Health Education Program for kindergarten students is illustrated in the following diagram.

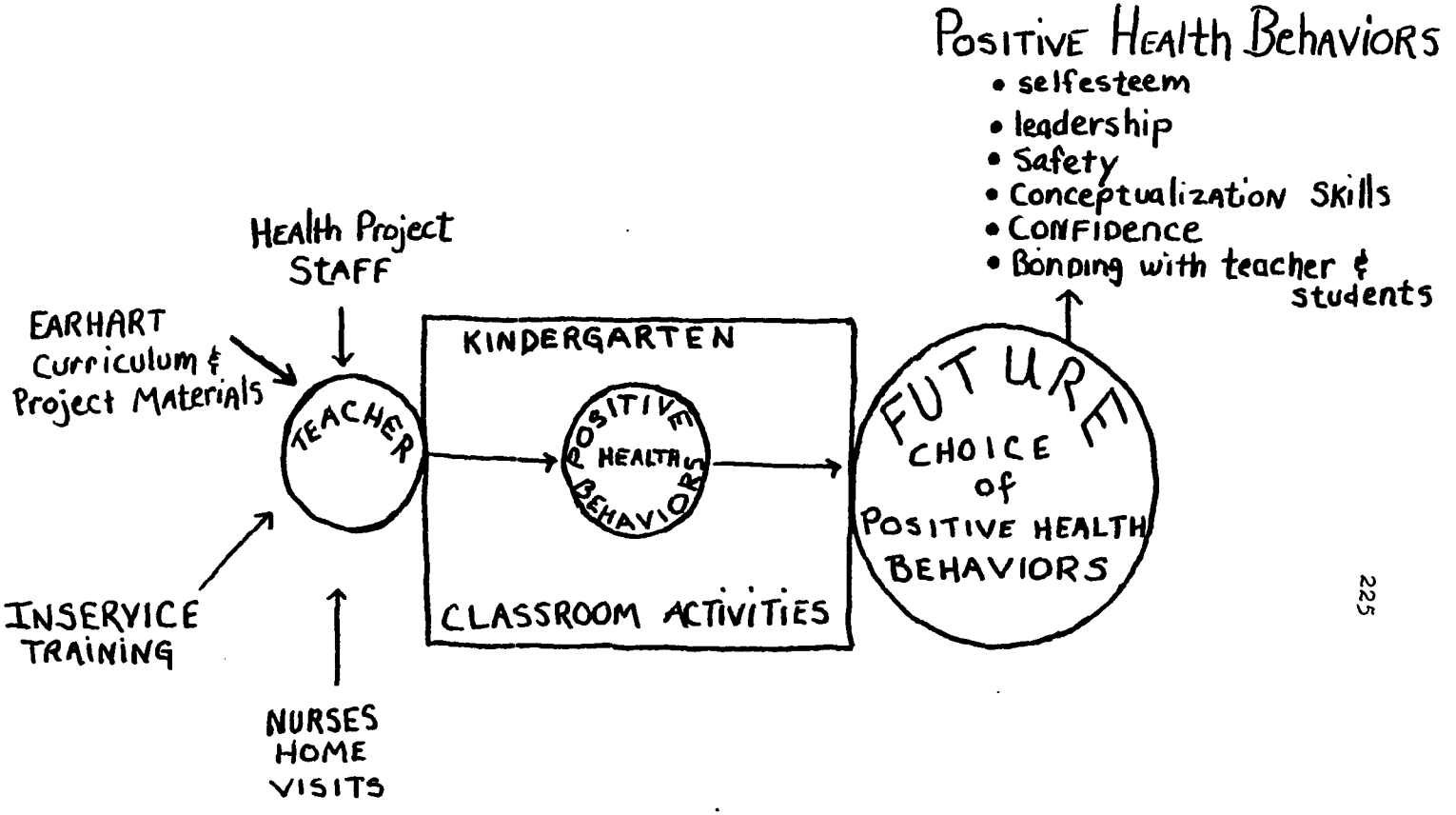


FIGURE 4 Urbandale Kindergarten Health Project

DESCRIPTION OF THE SETTING

The field observation was conducted at an Urbandale School District elementary school situated in the center of a renewal project underway by the city of Urbandale. The community surrounding the school contained several low-income families who were being forced to move because their houses were condemned for renovation. The environment around the school also contained a large power plant which frequently expelled noxious smelling fumes to the area.

The classroom I chose for study contained approximately 17 kindergarten students, teacher, teaching assistant, and a student teacher who was present occasionally. The racial content of the classroom consisted of:

3 Black
3 Hispanic
1 Oriental
10 White

The teacher and teacher aide were both white women in their last year of teaching prior to retirement. The student teacher was a white woman, considerably younger.

The classroom was set up as is shown in the diagram. The room contained six tables with approximately three students to a table. Large group classroom activities such as seat work predominantly took place at the six tables, group discussion was often done on the carpet, and small group activities, including the health curriculum were done in the two corners, one with a table (A) and the other with chairs behind the piano (B).

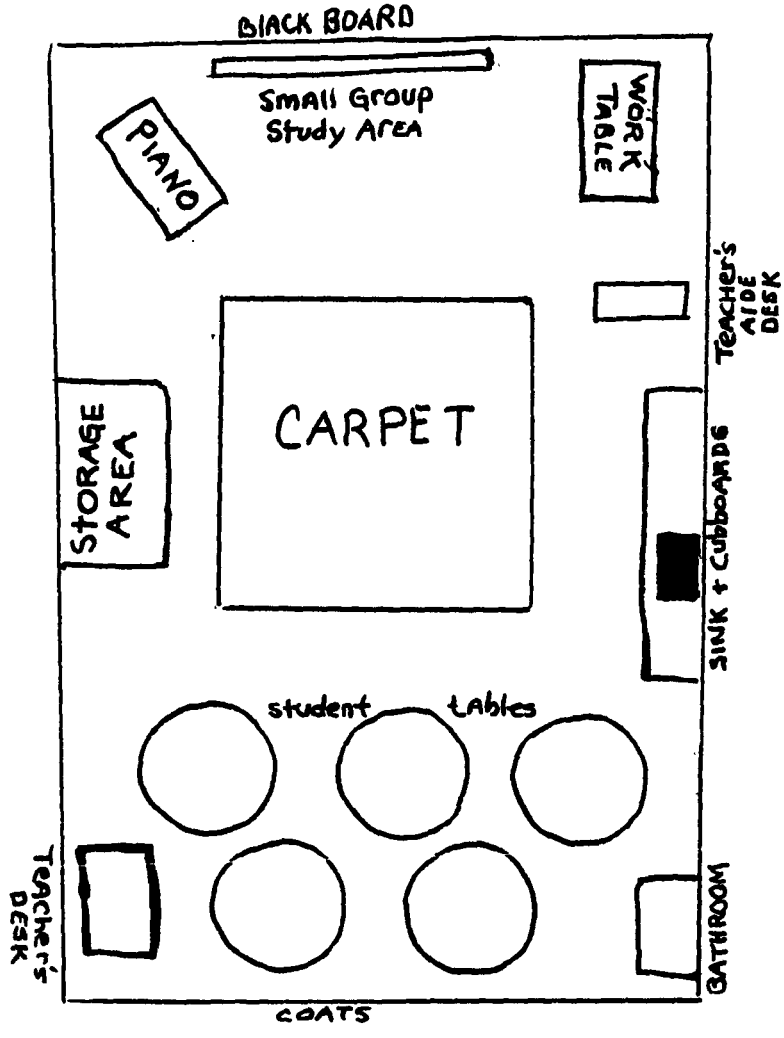


FIGURE 5. URBANDALE KINDERGARTEN CLASSROOM

The first vignette of the Urbandale Health Education Program illustrates what a typical day is like for a kindergarten student. Throughout all of the Urbandale vignettes there are two target students who are featured: Carlos, and Raymond. These students were selected for particular focus because the kindergarten instructor requested additional information on these students.

There are three key factors evident in this vignette. First, the wide range of kindergarten activities requires that the students understand verbal and non-verbal cues that signal appropriate behavior. In essence, the students must learn how to go to school and what their roles and obligations are. Second, the methods in which the two teachers and students use to relate to each other show a strong sense of bonding. Third, the organizational structure of the health class enables only half of the students to get a health lesson on a single day.

A DAY IN THE LIFE OF A KINDERGARTEN STUDENT

At 12:15 pm. the bell will ring, and just a minute before that Carlos comes in the front door from the hallway. Mrs. Smith, the teacher, reprimands Carlos and asks him to come in through the outside door with all the other students. For the next few seconds, Carlos gets a chance to tell Mrs. Smith what he did the night before. Carlos is small, with very long, shoulder length hair. He is wearing glasses, and is acutely cross-eyed.

All of the children enter boisterously and immediately take their coats off and take their seats at one of the six round tables at the edge of the room. Mrs. Smith awaits their attention, and then goes over to the "leader chart" hanging on the wall and asks the class to tell her who the new leader is for the day. Each day the name of a new leader is chosen, and the name of the student who will be the leader the following day are both placed on the chart. Each student gets a turn to be the leader.

Mrs. Smith then goes over to Ronald and asks him to count with her the number of students who are present in class today. Together they count to 16, one student is missing; it must be Patty. Mrs. Smith then asks several of the students to practice counting to 16.

Mrs. Smith then walks across the room to the chalk board, and awaits their attention for the lesson on the

number "8". "Oh, how I like to see everyone's eyes," says Mrs. Smith, calling for their attention. Mrs. Smith calls on several students during the next five minutes to help her draw the numbers they will be studying today. Mrs. White, the teaching assistant, begins to pass a worksheet to each student, with the numbers on it that they will be studying. For the next 20 minutes, the students all begin to color and work on their worksheets.

As the students are finishing their papers, and becoming restless, Mrs. Smith goes over to the piano and begins to play. This music is a cue for the students to put away their papers, and to come and stand on their designated square surrounding the big carpet in the middle of the room. The students then march, skip, hop, jog, or walk according to the appropriate music. Carlos has not joined the group yet; he is still working on his paper with Mrs. White. After about five minutes of music, Mrs. Smith goes over to the ABC board next to the piano and asks the class to sit on the carpet in front of her (in their assigned spot). Mrs. Smith then takes a pointer and asks one of the students to point to the right letter as she goes back to the piano and plays the ABC song. The kids all sing, while the student points to the right letter of the alphabet. Then the leader for the day goes over to the flag and the class all stands and says the Pledge of Allegiance. The kids again sit down and do a singing, clapping exercise on the letters of the alphabet board. Each student with his or her name

beginning with that day's letter group gets up and puts his name tag on the letter board. After about fifteen minutes of questions about the alphabet, the students sing another song, and it is time for "show and tell".

Three students get to give their "show and tell" each day. The rest of the class tries to guess the object. "Show and tell" lasts about fifteen minutes and then Mrs. Smith holds up an object cut out of construction paper (a house) and asks the class to tell her its shape. After five minutes of questions, it is time for milk and crackers. The class returns to their seats at the round table for snack time. Snack time lasts another fifteen minutes, and as they finish their snack, Mrs. Smith and Mrs. White hand out another worksheet.

Not all of the students work on the worksheets. Four students go with Mrs. Smith, and four students go with Mrs. White, to have a small group work session. This is the time for the health lesson. For the next fifteen minutes, the two small groups and the remainder of the class each do a separate lesson. After fifteen minutes a shift change is called, and the students who were in the small groups go to their seats at the round tables, and the students who didn't have small group go to their lessons. The schedule of a typical day is as follows:

12:15 Bell rings, kids go to tables and do leader chart.
12:26 Chalkboard exercise.
12:27 Questions on the numbers.
12:33 Students all work on papers for "numbers of the day".
12:40 Students busy working.
12:43 Students getting restless.
12:53 Students finish paper and line up around carpet.
1:00 Students go to ABC board.
1:07 Interruption--principal comes to door with new student.
1:10 Pledge of Allegiance.
1:15 Names are being placed on letter board.
1:30 Kids sing a song, and "show and tell" begins.
1:50 Milk and crackers--snack time.
2:03 Students work on drawings.
2:08 First small group is called.
2:37 Shift change, second small group is called.
2:55 Bell rings, end of the day.

The strong level of bonding between the teacher Mrs. Smith, and the student Carlos, was evident in the way Carlos enters the classroom early from the hall in order to have a private talk with Mrs. Smith. The students are supposed to enter the classroom from the outside door, but Carlos always enters from the hall. Throughout the afternoon's activities, the students experience a continual series of rules and regulations, which guide their school-going behavior. Certain songs on the piano cue the students it is time to play a game, or sing their ABC song. The leader-for-the-day has particular roles and obligations by virtue of her/his position. The students go through a complex maze of verbal and non-verbal cues that help them know their appropriate behavior.

The organizational structure of the health lesson

establishes that only half of the seventeen students have the health class on a single day. Each lesson has four or five students who attend the small group lesson for approximately 25 minutes.

LEARNING HOW TO GO TO SCHOOL

Learning how to go to school was identified as a main theme for the Urbandale health education program. All aspects of the health program: inservice education, home visitation, implementation of the health curriculum, and overall success in the classroom depend on the student's ability to understand and perform the appropriate activities required in the classroom. The students must learn how to conform to the rules of the classroom, such as answering a question when called on, responding to non-verbal cues, being attentive, following directions, being socially acceptable to one's peers, performing tasks when told to do so, etc. All of these behaviors must be learned for a child to have academic success in school. In kindergarten especially, learning how to go to school is a critical step in a student's future of academic success, trust in the school (teachers), self-esteem building, and optimal body functioning.

When a five year old enters the classroom, particularly a multi-racial, low-income, urban school such as the classroom observed, the student comes in with a vastly different pre-school education. Some students are aggressive, and some are very passive. Some don't speak English, or have

proper nutrition, and some students, particularly minority students, have a culturally shaped interpretation of the world which is not comparable to the demands and behaviors expected of them from the school environment.

The results of this enormous variety of student backgrounds is that some students find the roles and obligations of school a totally alien world from what they have previously known. Some students are understandably insecure and have difficulty conforming to the requirements of the academic environment. The time it takes for these students to "bridge the gap" between themselves and their peers varies for each individual.

Crucial to this process is the student's ability to bond with her/his peers, and with the instructor(s). The students who can form positive esteem-building relationships with the others have an improved chance for learning how to go to school and ultimately improving their self-esteem. As will be seen in the vignettes, there were several students identified as having difficulty learning the appropriate school behaviors. In particular, my observations of Raymond and Carlos point to the conclusion that a student's ability to learn how to go to school is a critical step in the process of being successful, both academically and socially, in the school environment.

The response of the teacher and the health program staff seem to be to label these students deficient, when actually, the student's deficiencies are differences in

cultural interactional competencies. Having different cultural and ethnic definitions of what is appropriate is not the same as having mental and physical deficiencies. The institutional response to these students however, has been to treat them as deficient, and in need of special services. The impact on the students of these remediation efforts is unclear.

The next vignette is an introduction to one of the target students: Raymond. Raymond has been identified by the instructor as being a possible retainee for repetition of kindergarten. Raymond has continually demonstrated that he does not understand several of the roles and obligations of kindergarten. In this case, Raymond doesn't follow the proper rules of hand-raising for answering a question. In his behavior, Raymond shows that he seeks teacher approval very intensely. Further analysis of Raymond's thinking however, shows that he may not follow all of the rules, but he is sophisticated enough to read behind the lines.

THE WEEKLY READER

Mrs. Smith begins the day's work by discussing the Weekly Reader called "Zip". "And do you know who we are going to read today?" asks Mrs. Smith. "What is his name? They begin with the initials J.B." "Jelly Bean!!" the class shouts. "The name of this worksheet is Jelly Bean Jamboree. Can you say this?" asks Mrs. Smith.

I am focusing on Raymond intensely; he is watching Mrs. Smith, and is following the discussion attentively. Raymond lips the words "Jelly Bean Jamboree" to himself while the other kids say it or think it aloud. Raymond is a target student by the observer because of comments from Mrs. Smith that she would like more information on him, as he is a potential retainee. His gross motor skills have been poor, he has not been able to write his name correctly or color and stay within the lines. He is slower than other students in the classroom. Raymond has tried to answer several questions but has not succeeded in saying the right answer. Mrs. Smith explains to the kids that this Weekly Reader can come to the students' house during the summer, if their mothers say it is okay. The students are asked to take home to their mothers a subscription notice, and maybe their mothers will let Zip visit them at home this summer. Raymond asks, "How much does it cost?" Mrs. Smith takes a second look at Raymond and replies somewhat hesitantly, "$3.00".

Raymond may not at all times be able to get the correct answer, but he has realized from Mrs. Smith's language that when she says "mother has to decide whether Zip can visit you at home", what it really means, is that it depends on whether or not mother is willing to pay for the subscription. Raymond was the only one to verbalize this assumption.

Mrs. Smith continues to quiz the students on the picture on the cover of the Weekly Reader. "What starts with the letter "T" in this picture?" Raymond raises his hand and gets called on by Mrs. Smith. "Beaver", he says. Mrs. Smith asks Raymond, "What letter does Beaver start with?" Raymond shakes his head "no". Mrs. Smith points to a tennis racquet and asks, "What is this object?" "Tennis racquet", the kids shout. Then Mrs. Smith points to the shoe on Zip's foot and asks the students to tell her what about this object starts with the letter "T". Raymond starts to shout: "Socks!! Foot!!"..but doesn't get the right answer. Mrs. Smith has to tell them she wants to hear "tennis shoe". Next, Mrs. Smith points to the piece of luggage Zip is carrying. "What about this starts with a "T"?" Nobody guesses the right word, which is "tag". "What does Zip do to his shoes?" "What begins with a "T"? "Tie" they answer after a few wrong guesses. Raymond has answered correctly on this question. During the question and answer period before Mrs. Smith lets them color and circle the objects which start with a "T", I have noticed that Raymond keeps raising his hand to answer the questions asked by Mrs. Smith. When

Mrs. Smith calls on him, he doesn't know the answer, yet he keeps raising his hand; he doesn't take it down, even when he is called on.

Raymond has shown that he does not understand that when he has an answer to the question being asked, that is when he must raise his hand to get called on. When he gets the "floor" he no longer needs to raise his hand. Raymond behaves like he is very anxious to get the floor, and to succeed by answering the questions correctly. Even when he does not know what is being asked of him, he still raises his hand to be called on. Raymond has not learned to know when it is appropriate (in the teacher's perspective) to raise his hand, and to subsequently get the floor, and to be prepared with an answer to the question.

As could be seen from the vignette, Raymond demonstrated that he doesn't understand the appropriate roles or format of question and answer time. Repeatedly, Raymond raises his hand to answer the teacher's question, and when he gets called on, he doesn't have the right answer, yet he does not take down his hand. Learning how to go to school is one of the main issues evident throughout the Urbandale Health Education Program. The kindergarten students must first learn how to go to school with all of its rules and cues, before the student can be successful in any subject content, including health.

Although Raymond has difficulty being successful

during question and answer time, he shows conceptual superiority over his peers by understanding that when the teacher says "If your mother says it's okay, Zip can visit you at home this summer", what she really means is if your mother is willing to pay for a subscription, Zip's worksheet will be delivered to your house during the summer. Raymond understands this implicit meaning, and demonstrates it by asking Mrs. Smith "How much does it cost?" Raymond shows that he understands that money is involved in a subscription, and that Zip doesn't just appear if mother says it's okay; she must pay for it. Now let's take a look at how Raymond behaves in the health lesson.

Two factors will be evident in the next vignette. First, the methods used to teach the health lesson allow a much less formal teaching format. Raymond had much more success in this format than in the methods used for the question and answer lesson. Second, the organizational structure of the health lesson is represented by the fact that the teacher aide, Mrs. White, is the instructor for all of the observed health education lessons. Third, the content of the health lesson is not a health content, and does not meet any of the Essential Objectives for Health Education.

RAYMOND IN THE HEALTH LESSON

"What shape is this, Raymond?" "A square", Raymond answers correctly. There are four seated at the square table with Mrs. White and myself. Mrs. White goes over the design each student has before him or her, and asks each one of them "What color is this square?" Raymond answers his questions correctly. I am watching Raymond put his blocks on the design to the matched color; I notice he has done one row of his four rows incorrectly. "Can you look at that <u>really</u> close, Raymond, and find one that is a little different?" Raymond finds that one of his rows has a block with the wrong color up and corrects himself. On the next design, Raymond again has trouble getting the blocks to match the colors on the design. He is helped again by Mrs. White, and gets them on correctly. Frequently Raymond is able to do his design correctly except for one small error, which he can usually figure out by himself after he has been told there is a mistake.

In the health curriculum format, the children do not have to raise their hands, and get called on, but instead work openly with the teacher aide, and can ask and be asked questions without the formality of formal classroom "floor" space. Raymond seems to be more able to succeed in this format, although the content which is being asked is also different. He may simply be more comfortable with the informal small group format, or he may understand the

information better, or both. What is apparent in both formats is that Raymond is trying to succeed. He pays attention and seems eager to do his lessons correctly. Perhaps what is more evident than his lack of content knowledge, is his lack of understanding of how to express what he does and does not know.

As could be seen in the vignette, Raymond is more at ease in the small group format of the health lesson than in the question and answer time with the entire class. The small group format allows Raymond to show his abilities through his work in a non-competitive atmosphere. This contrasts to the question and answer time where he has to compete openly with his peers for the "floor" and the correct answer.

In the small group format, learning how to go to school is not as demanding a situation. The appropriate roles and obligations of the health lesson seem to be more easily understood and accomplished by most of the students. This allows more time to be spent on the content of the lesson, than on the mechanics of how to demonstrate mastery or understanding.

The content of the health lesson is not health at all, nor are any of the health lessons for the kindergarten students. Instead, the curriculum consists of exercises for academic readiness. The curriculum is designed to allow the students to progress at their own pace, and be successful in achieving the tasks. This success is theorized to help the

student increase her/his sense of self-esteem.

The teacher aide is the health instructor for all of the health lessons observed, yet, the teacher was the one who participated in the health education inservice education. The organizational structure of the health education and/or inservice may need to be adjusted so the inservice is given to the health instructor.

The next vignette illustrates several major themes. First, the health lesson does not have a health content, instead it is a lesson in visual discrimination and hand-eye coordination. Second, one of the students, Sonja, has little understanding of what she is supposed to do. Her lack of English comprehension prohibits her from knowing how to fulfill her roles and obligations in the kindergarten classroom. Third, the ethnic and cultural differences of both Sonja and Carlos may be a major reason for their lack of participation in the designated tasks. Fourth, the bonding level between the teacher aide and Carlos and Raymond seems to be quite positive. As can be seen in the vignette, both students seek Mrs. White's attention and approval in different ways. Fifth, the methods used to implement this curriculum require a teacher for continuous coaching and encouragement. This "teacher-based" curriculum would not be as effective if the teacher or teacher aide were not present. For this curriculum to be successful in building student self-esteem, the teacher must give each student positive esteem-building

feedback. As can be seen in the vignette, this task can be quite difficult, particularly when the students are disrupting the lesson.

THE HEALTH LESSON

The health lessons begin, and seated around the small table are Mrs. White, the teacher aide, Carlos, Clayton, Raymond, Sonja, and myself. A tape recorder is on behind us. The lesson is to take colored blocks and place the appropriate block on the design sheet in order to match the pattern.

"First, will you take all the blocks out of the box?" Mrs. White asks. "Tell me what color this is at the very top (of your design) Carlos?" After a long pause, "Re::d" says Carlos. "Clayton, can you tell me what color this is? Everyone try to find a different color".

All four students get the same design to copy and begin to fill in the colors. At first, concentration is good, there is not much talking. "What shape is this, Raymond? What is this?" asks Mrs. White. "A square", he replies correctly. "What color is this Carlos?" Carlos answers "blue" correctly. "Raymond, what color is this down here?" Mrs. White again asks. "Yel::low" Raymond drawls. "What color is down here Carlos?" "Purple" he responds. "Well, that's close to purple, but we are going to call that blue". "Can you real::ly put those blocks on very quietly for me?" Mrs. White asks.

As I watch them do their work, Carlos has done one of his rows wrong. Raymond also has done one row incorrectly.

"There's no need to talk, let's see who can get done really good". Clayton has also done one row wrong, but Mrs. White doesn't catch it. Mrs. White sees Raymond's mistake, and asks him to find it. Raymond finds his mistake and corrects it himself. Everyone but Sonja has finished his design, and Mrs. White hands out another design to work.

"Will everyone take his red and white blocks? Okay, everyone got one?" "Can you find a red and white one Sonja?" "Okay, put the red on the left hand side, upper left hand side." "Sonja, honey, can you find a red and white block? Can you turn yours around so the red is up here?"

Sonja is a Vietnamese child, and doesn't speak or understand English very well. She has been recommended for bilingual education, but her mother refuses to let her because of a domestic problem in the family.

"Okay now, we are going to put the white side at the top, and right next to it the red, so the white half is on the top." Carlos is tuned out and is not paying attention to the exercise. "Carlos, Carlos....you put the white side at the top, see if you can turn it around so the white side is on the top". "Can you do that Clayton?" "He's got it!" (referring to Clayton's success). Sonja is not understanding the task, and Mrs. White is directing her; meanwhile Carlos is busy making a tower out of his blocks, and not paying attention to the task. Raymond and Sonja are both having trouble and get help from Mrs. White. Carlos keeps building his tower, and then CRASH!! the blocks fall over on Carlos'

and Clayton's design. "Carlos, uh, uh, (a tonal no), can you let those down quietly?" Mrs. White then works with Carlos, block by block, and helps him finish his design. Sonja is also making her design different from the assigned one, but Mrs. White doesn't say anything to her. Mrs. White hands out a new design to everyone. The new design is to replicate a red cross on a yellow background. Mrs. White wants to see if they can do the design without her coaching them. "I'm going to see if you can make your design just like this one, and I'm not even going to talk this time; I'm going to see if you can do it." Within a few moments, maybe 45 seconds, Mrs. White begins to prod Raymond and Sonja without paying much attention to Carlos. Carlos drifts off into his own world, and is not working on the assigned project. Carlos is far behind the other students and decides to put his blocks away into the box in which they came. As he is halfway through doing this, Mrs. White asks all of the kids to start working on another design. Carlos then decides to take the blocks out of the box, and begins working on the assigned design. Mrs. White tells them this is the design that calls for using the blocks with the diagonals. Sonja decides she has had enough and starts to leave the table. She isn't sure of herself, and comes back to check and see if she can leave. "You all done, Honey?" "Yes, you can go, just put your blocks back in the box," said Mrs. White. Carlos meanwhile is playing with some leather pouches on the floor by the table. Raymond is working on his design and

seems to get it right with enough time. Carlos is the last one to finish, and he has taken approximately nine minutes to finish this design.

The students have a few minutes left before the class is over, so Mrs. White lets them build towers and piles with their blocks. Then it is time for them to put their blocks away. Carlos has put all his blocks away in the box with the yellow side up except for one block. He asks Mrs. White to look, and she responds: "Can you make that last one yellow too, Carlos?" Carlos turns the one block around so now all are in the box with the yellow side up and shows it to the teacher. "That's very good, Carlos".

Mrs. White turns to me regarding the tape recorder: "Did I do all right?" "Yes, that was great.... I hope taping it didn't bother you...." "No, No! I just hope it comes out alright."

Throughout the lesson, Mrs. White carefully tries to encourage each of the students to succeed in their tasks. Carlos in particular frequently tunes out the lesson and drifts into his own world. Several times, Mrs. White has to speak to Carlos to encourage his participation. Carlos seems to succeed when he is coached on a one-to-one basis, but only works hard when he is being surveilled.

Sonja understands very little English and does not grasp what she is supposed to be doing. These two students, Carlos and Sonja, demonstrate that their success in the health lesson, or lack of it, may be due to cultural and

ethnic differences in their perceived roles and obligations.

Each of the students participating in this lesson have their own level of success at completing the assigned tasks. Clayton seems to be able to figure out what is expected of him and has little difficulty completing the tasks. Raymond is able to figure out what he is supposed to do, but has considerable difficulty succeeding. However, Raymond is persistent and is able to complete the tasks with some assistance.

Carlos seems to understand what he is supposed to do but is not able to remain attentive to the task. Eventually, with considerable assistance from Mrs. White, Carlos is able to complete the tasks. It seems as though Carlos repeatedly strays from his exercise and deliberately misbehaves, (ie., building a tower out of his blocks). This misbehavior usually results in one of the teachers giving him special attention to complete the task. My observations of Carlos suggest that he is able to figure out the tasks, but he craves teacher attention, and knows that his lack of attentiveness will reward him with extra one-on-one attention. One of the teachers said that as she was reprimanding Carlos for being too slow, he turned to her and smiled and said: "I love you".

Perhaps some background information on Carlos would be helpful. Carlos is one of several children of an Hispanic family. His mother is pregnant with her fifth

child, and in not very good health. Carlos has an older brother repeating 1st grade; Carlos is repeating kindergarten. Carlos is often late or absent from school. He is severely cross-eyed, and needs surgery. He is supposed to wear glasses, but does not always do so. Carlos has very long, shoulder length hair which often gets in his eyes. Carlos' father is unemployed, illiterate, and doesn't relate well to people. Carlos' mother carries the burden of the family with her, and is the stronghold for the family. When Carlos' mother was pregnant for Carlos, she had difficulty carrying the baby to term. She made a promise to God that if Carlos survived, she would never cut his hair.

The house Carlos lives in is condemned for urban renewal, and the family must move. However, the family is reluctant to move out of the neighborhood, because they like the school.

Several of these details about Carlos' home life were obtained through a student nurse home visitation program that is part of a School Health Services and Health Education Program cooperative effort. This cooperative effort was initiated by the Health Education Program Coordinator, and the Director of School Nurses. These individuals arranged for a team of student nurses from a nearby college to conduct home visitations into the homes of kindergarten students identified as having developmental deficiencies. The student nurse's role is to serve as a health resource for the student's family, and to obtain background information on

the student's home environment that may be helpful for the teacher.

The student nurse works under the direction of the school nurse, and reports to the Health Program Coordinator, the student's teacher, and the school nurse during periodic inservice meetings. These meetings focus on the home environmental problems that may be contributing to the student developmental deficiencies, and what assistance the health program can provide to the student and her/his family.

There are several issues that are evident in the home visitation program. The first issue is the process of identifying kindergarten students who have developmental deficiencies or developmental lags. This process is initiated by the kindergarten instructor, who may refer the student to a number of school professionals such as bilingual specialists, speech therapist, reading aide, etc. One problem with this process is the misidentification of students with developmental problems. What may be considered a developmental deficiency may actually be the teacher's misconception of the student's cultural definitions of appropriateness. The student's definition of what is appropriate is a culturally shaped identification of learned roles and obligations. The student's cultural definitions of appropriateness may not match what is expected of the student in the school classroom. Thus, the student must learn what is expected of her or him in order to succeed in school. In essence, the student must first learn how to go to school

before being able to be successful in school.

A second issue evident in the home visitation program is that once a student is labeled as having a developmental lag, or as being deficient, when it is actually a misinterpretation of cultural interactional patterns, the treatment (s)he receives may severely alter the student's sense of self confidence, and self-expectations in undesirable ways. The student's self concept as deficient, or slow, becomes rooted, and rewarded. The treatments for the student with perceived developmental deficiencies may exacerbate the problem.

A third issue regarding home visitation is the philosophical question regarding the limits of school responsibility for the student's well-being. The student's home environment may be a contributing factor to a student's academic deficiencies, but it is questionable how much a home visitation program can improve the home environment and/or the student's ability to excel in school. The possibility of negative consequences also must be examined.

The following vignette describes an inservice education meeting between the health program staff, the Director of School Nurses, the student nurse who visited Carlos' family, and Carlos' teacher. The purpose of this meeting was to discuss the findings of the student nurse's visitation to Carlos' home.

The vignette will illustrate two main themes. First, the organizational structure of the health education program has enabled this meeting to be organized. The teacher, school nurse, a student nurse, and the health program staff are trying to determine what community and program resources can be summoned in order to help Carlos' family cope with their difficulties. A secondary theme is how a student's home environment and cultural background can affect the student's ability to succeed in school. As will be seen in this vignette, Carlos' home environment places physical and emotional stresses upon Carlos and his family that affects his health, his ability to learn, and how he views the world.

INSERVICE EDUCATION: INTEGRATION OF SCHOOL HEALTH SERVICES

"Mr. Altesco (Carlos' father) seems to be totally paralyzed," said June. "He cannot relate to people, he is very withdrawn to strangers. Mrs. Altesco is having to carry the burden of the whole family alone." "Mrs. Altesco is sick and needs rest." "Can't somebody step in and handle the family for her?" asks the Health Project Director. "Well," says June, "I don't think she would stop worrying unless she handled everything." "My role," said June, "is to help them get through this until the baby is born." "If they move away from the school, they will be unhappy." "Maybe Mr. Rose can help them get a house in this area," the school nurse says. June replies, "The houses next door, 203 and 204, have also been moved or sold. Mrs. Altesco says their house has been sold, and is scheduled to be torn down, but I checked the record of the city and the city did not acquire it. I also checked the register of deeds, and they did not have a record of acquiring it either. I asked Mrs. Altesco if I could ask the landlord what is going on, but she asked me not to. The family is supposed to be out of there before April 1, but they want to move before March 20, when the baby is due".

The Health Project Director and the school nurse discuss how they can contact the urban renewal office and get some help. "The property is supposed to be divided up

to lower the population density," said June, the student nurse. "Bugs and roaches are still a problem in the home; the kids catch them and play with the roaches. The kids don't see it as a problem, but Mrs. Altesco says she didn't want them crawling on the new baby." The Project Director asks, "Do they want to move?" "Yes," June replies. The kindergarten teacher says, "It's going to be really important to know which houses are going to be demolished. You should get the names of the landlords, Mr. Rose can help you."

During a time when Mrs. Altesco was in the hospital with eclampsia, June visited the family. Mr. Altesco's mother was taking care of the children, and Mr. Altesco was showing no signs of motivation. "All the kids were sick when I got there," June said. "They all needed throat cultures and I suggested they all go to a doctor." "I also went to see Mrs. Altesco in the hospital and talked to her about getting the kids a doctor appointment. No appointment was available at the clinic."

The school nurse asked if there was any equipment for the baby. June said no, and it was suggested that she contact the organization called "Operation Stork" and "Faith in Action", to help get the needed equipment for the baby. "This family certainly sounds beyond the take home toy stage" said a member of the Health Project Staff committee. June asserted that when she was at Carlos' home, both he and his brother were very well behaved, and urged very strongly that

the parents love their kids very much. June asked to speak to the teachers of the kids to find out how they were doing academically. She suggested there might be a language problem, because Carlos' family speaks only Spanish at home, and this may be why the kids are slow academically.

Mrs. Smith, Carlos' teacher, says as she shakes her head, "He's going to have trouble the whole way through." June says she will be with the family until school gets out in June. "I've only had one visit without a crisis." The conversation then shifted to Mr. Altesco, and suggestions were made to help him improve his skills. "Perhaps by giving him a third grade packet it will help." "Do the kids have a language problem?" asks June. "No, but gross motor skills," replied Mrs. Smith. "Carlos wasn't toilet trained until Headstart."

As the meeting was closing, June said, "Mrs. Altesco asked me if she could have my phone number in case she moved."

As could be seen in the vignette, Carlos' home environment places considerable constraints on his ability to relate to a kindergarten classroom. In his home, the language spoken is Spanish. His mother is ill, and his father is unable to fill in for his mother and function adequately. The house Carlos lives in is condemned, and is considered a health hazard. The family seems to go from crisis to crisis and has not been able to meet their needs adequately, let

alone provide a home environment conducive to academic achievement.

The health program has provided an organizational structure that has enabled several community resources to be contacted and mobilized to help Carlos' family overcome tremendous social, physical, and emotional barriers. The student nurses' visits have been a source of emotional support for Carlos' mother, as well as a mechanism for informing Carlos' teacher of his personal life circumstances.

Carlos' lack of participation in kindergarten activities and his apparent developmental lag needs to be viewed in the context of his home environment, and physical, emotional, and social differences. Compared to his classmates, Carlos may seem slow and apathetic. Yet, when his home life is considered, his achievement may be quite substantial. The organizational structure of the Urbandale Health Education Program has enabled a much more wholistic understanding and intervention into the health and education of the kindergarten students.

The last vignette for the Urbandale Health Education Program features three major factors or themes. First, the methods used to play the card game seem to generate conflicts between the students (regarding who will be chosen to play next), boredom, and discipline problems. Second, the instructor gives one of the students, Patty, a very strong sex-role message that is supposed to cue her on appropriate

social-school behaviors. This message suddenly backfires when Patty begins to sing a song with strong sexual implications. Finally, the instructor changes the rules of playing the game that motivates the students to improve their attention and participation. Third, as all of the health lessons in this curriculum, the content of the health lesson does not contain a health topic area.

ANOTHER DAY IN THE HEALTH LESSON

I arrive a bit late to the lesson. Seated at the table is Mrs. White, George, Susie, Patty, and Harry. The game underway is to draw a card from a deck and if the two shapes on the card are alike, they go in the "alike" pile, if different, they go in the "different" pile. Then the drawer chooses the next player. George picks two rectangles alike and puts them in the correct pile. Susie draws two triangles alike and does the same. Harry draws two circles alike, and puts them in the correct pile. The students seem to easily get the correct pile. Mrs. White senses this, and asks some questions to stir interest. "How many sides does a triangle have?" "Three" Patty replies, as the kids keep drawing cards. Susie picks two spools on her card. "What are those called?" asked Mrs. White. No one knew the right answer. "Spools", Mrs. White finally answers. "Now Susie's going to pick someone to go next..." "Harry, don't make me sad," says Mrs. White. Harry was not paying attention and was looking around behind him. "Oh Harry, I'm sad, I don't think you want to play our game." Harry stops misbehaving. Patty didn't get chosen to pick a card and is upset. She says in a vicious voice: "Harry already had a turn!" The next round Patty got picked to draw a card and Mrs. White says: "See Patty, you were a little lady and he picked you." "That sounds like a lady now." "Oh Harry, I'm glad you were looking our way." "What is that object?" asks Mrs. White.

"Half a circle," George answers. "What color?" "Yellow," says Susie. Harry is looking anywhere but at the game. He's looking at the wall behind him, then he talks about an object on the floor. "Harry, we're having our game--don't talk!" Harry stands up and starts to lean over in his chair. "Harry, please sit down!!" says Mrs. White emphatically. "I don't want you to fall." Harry sits down.

"Patty, how many sides to a square?" "Three" Patty says. "You'd better look again." It's Susie's turn and she gets her card right, then she chooses George. Patty turns around and starts asking a question about the rockets pasted to the wall. Mrs. White tells her to pay attention to the game instead of the wall. George chooses Harry and Patty gets angry again. "George already had a turn," Patty says. "We're all going to have lots of turns," says Mrs. White. Patty bows her head, turns away from the table, sticks her lips out, crosses her arms, and shrugs. Harry chooses Patty on the next round, she brightens up, pays attention, and draws two lollypops alike. Patty then begins to sing: "Come here, come here, my lollypop girl".... This song sounds like a sexual song and catches both my and Mrs. White's attention. Mrs. White looks twice at me with the type of look that says "Oh Oh,..."

George is next and he chooses two boxes. "Which one do they go in, George?" "This one" he replies. "Why?" "Cause they're different colors." "Right". "Let's see who won," says Mrs. White, referring to the two piles. "Let's

count the cards." Mrs. White counts with the students up to fifteen in both piles. "They are tied, what's another word that means they are tied?" No answer.... "It begins with an "E" says Mrs. White. "Equal", the students answer.

The designed game was over with a few minutes left. Mrs. White took the deck of cards and dealt them out to everyone. Each of the students played their card into the correct pile, and the game moved around the table quickly, each student taking a turn. In this variation of the game, all students got the same amount of turns, there was no choosing of the next player, and everyone paid attention, and seemed to enjoy the game and not one mistake was made.

The sex role message that Patty received twice from the teacher aide was that if she was a "lady" she would be chosen to have a turn in the card game. What being a lady means in this context is not defined. What Mrs. White is really asking, is for Patty to be quiet and patient, and not express her feelings of anger or disgust when the other students choose someone else to be the next player. Patty however, does not seem able to avoid expressing her resentment. She feels it is not fair when she is not chosen as often as the others. When Patty is chosen, she brightens up and begins to sing a song "Come here, come here, my lollypop girl..." This song immediately triggers an unusual response in both myself and Mrs. White. Mrs. White looks at me in a way that signals that she recognizes that

Patty has just repeated a sexual message she has learned, and it is not appropriate for a five year old to be singing a song with a sexual proposition in it. Mrs. White does not say anything, but moves the game along.

There was no definition to Patty what was being asked of her when she is asked to be a "lady". Perhaps Patty has interpreted it to mean that being a lady means behaving in a way that is sexually pleasing and provocative.

The message behind the phrase of being a lady is loaded with stereotypical social rules. Both the male and female students are being socialized into a double standard of male and female acceptable behaviors. Learning what is acceptable behaviors for a classroom is essential for a student to succeed academically. However, the value system for appropriate gender behaviors is often used instead of academic behaviors. When Harry misbehaved, he wasn't told to act like a gentleman, he was told to stop misbehaving. When Patty was misbehaving, she was told to act like a lady, not to pay attention or wait her turn. This is an example of a stereotypical gender message that students receive that shape their self-image, self-esteem, and ultimately their choice of health behaviors. (ie., choosing to smoke because it improves their sexual image, or not excelling in school because boys won't be attracted if they are less academically successful).

It was also important to note how a slight change in the methods of playing the game could result in all of the students' improved attention and participation.

CONCLUSION OF URBANDALE FINDINGS

The analysis and ethnographies of the kindergarten health education program of Urbandale focused on three key factors: organizational structure, methods of instruction, and learning how to go to school. The organizational structure factor emphasized integration of school health services through a program of home visitation by student nurses. Although this program seemed well received by the teacher and the student's family, issues regarding the selection of students who warrant a home visitation, and the consequences of this selection have been raised.

Secondary components of the organizational structure are health education inservice training, and implementation of a health curriculum. The inservice education to teachers helped instructors learn how to identify students with developmental deficiencies, and share classroom experiences and solutions toward helping these students.

Although the health curriculum did not have a health content, the small group format allowed the teacher aide to closely observe the students' abilities. The methods of instruction emphasized helping the student to improve her/his self-esteem through having successful experiences with completing the tasks of the curriculum. The teacher aide taught all of the observed health lessons, however, the inservice education was only provided to the teachers.

The key factor of learning how to go to school was determined to be a prerequisite for any student success in the classroom. For minority students who have cultural and ethnic differences, learning how to go to school may take considerably more time and effort than for the non-minority students. A student's lack of cultural interactional competencies may be misconceived as a developmental disability. When this misconception occurs, the institutional response of remedial services may affect the student's self-concept in undesirable ways.

The kindergarten health program of Urbandale is unique in its focus to consider the student's home environment as well as classroom performance, in its efforts to improve the student's self-esteem and ultimately improve the student's choice of health behaviors.

INTRODUCTION TO BOTHAM CITY

The next section is the analysis and ethnographic vignettes for the observations at Botham City. The main issues for this site center around the key factors of organizational structure of the health program, and the methods used to teach the health instruction. Issues that will be addressed in this section include:

1. The prioritization of time, funding, and resources for the health instruction.
2. The integration of outside resources into the overall health program.
3. The issue of "turf-protectionism" expressed by the health instructors toward school nurses and parents.
4. The use of certain methods to teach health, such as textbook, and closed circuit television.

The first part of the section is a description of the settings observed at Botham School District, followed by the research questions used to guide my investigation. The vignettes tell the stories of what it is like in each of the classrooms where the key factors and main issues are evidenced. Following the vignettes are analytical commentaries that describe the main issues and factors found in each vignette.

DESCRIPTION OF THE SETTING OF BOTHAM CITY

The city of Botham is a large industrial town with a population of approximately 197,650. Botham has one of the largest public schools in Michigan. The district has over forty elementary and more than eight secondary schools, and serves a total student population of 22,350.

Within the Botham school district, there is a wide range of economic levels. Some of the schools in the inner city are in low income neighborhoods, whereas the schools in the suburbs may be in neighborhoods that have considerable wealth. Botham schools have implemented anti-segregation bussing for the secondary schools, but this bussing is not done for elementary level students.

The observations of the Botham school district took place at two schools. The first site was at Schultz school. Schultz school, founded in 1848, is in a lower-middle class neighborhood. Schultz is a naturally racially integrated school in that the neighborhood surrounding Schultz comprises both blacks and whites. Schultz school was not originally in the city of Botham, however; as the city expanded its boundaries, Schultz school along with the neighborhood, became an annexed part of the city of Botham in 1960. Because Schultz school was originally a rural independent school, it is equipped with a kitchen and cooking facilities. Schultz is one of two schools in the entire Botham School

District that still prepares its own hot lunches. The other schools in the district have their lunches catered.

There are 106 students attending Schultz Elementary School. Schultz contains grades K-6, including two Special Education classes. I observed five classrooms at Schultz school and interviewed three instructors and the principal.

The second school I observed in the Botham School District was Robin Hood School. Robin Hood School is located on the city's south side, and is in an upper-middle class suburban neighborhood. Robin Hood is one of five "open" schools in the Botham School District. Instead of classrooms, there are four color-coded pods that contain three or more classes in each pod. A pod is a large carpeted room which contains several areas designated for classes, library work, book shelves, and television watching. There are three classes and three teachers assigned to each pod. One pod is K-1-2, another 3-4, and one 5-6. The three teachers in the pod often rotate to other classes within the pod to teach their specialty subject such as health, math, or English. I observed three different classes and instructors at Robin Hood School.

The school structure is shown in Figure 6 , and Figure 7 illustrates the layout of a typical pod. Robin Hood School has a large Vietnamese student population. More than 100 students are Vietnamese, out of a total school population of 270. For these students, there are special tutors and classes taught in Vietnamese.

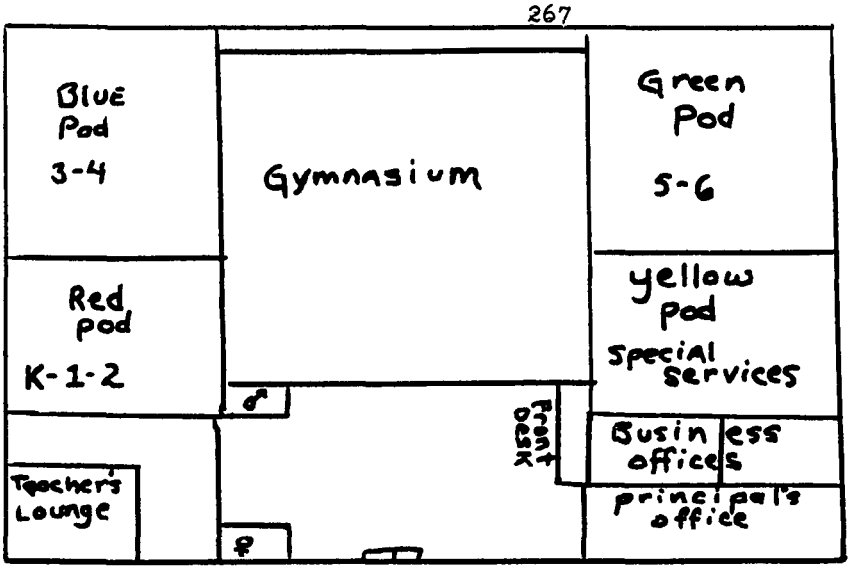


FIGURE 6. ROBIN HOOD SCHOOL STRUCTURE

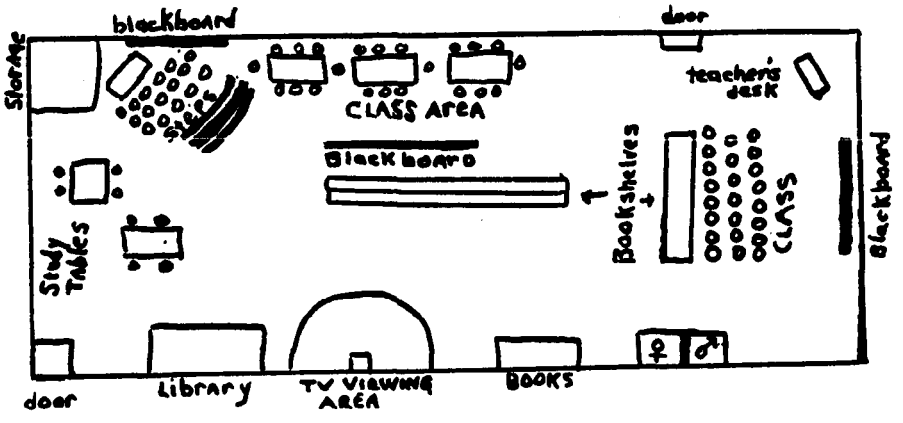


Figure 7 Typical Pod In Robin Hood School

The following research questions were investigated in the observations at the Botham School District.

BOTHAM CITY RESEARCH QUESTIONS - ORGANIZATIONAL STRUCTURE

1. What types of outside resources are included in the health education program?
2. What types of organizational structures are used to prepare for or assist in the teaching of health education?

BOTHAM CITY RESEARCH QUESTIONS - METHODS

1. What types of methods were used in the observed health instruction classes?
2. What kinds, if any, of "hands-on" methods were used in the observed health education classes?

BOTHAM CITY RESEARCH QUESTIONS - CONTENT

1. Were the instructors able to teach all ten topic areas recommended for a comprehensive health education curriculum?
2. What adaptations, if any, were used to teach the various health education areas?

The first vignette, "Health Class in the Yellow Pod" combines observations of a 2nd grade open classroom at Robin Hood School, with an interview of the teacher. Three main issues are apparent in this vignette. First, the methods used to teach health using an open classroom are quite different from the traditional classroom. Second, the content of the health education textbook is seen by the instructor to be insufficient. Third, the organizational

structure components are viewed differently by the instructor. A subsidiary issue is also evident in this vignette; that is, the presence of a large proportion of foreign students expands the boundaries of acceptable or appropriate classroom behavior.

HEALTH CLASS IN THE YELLOW POD
AN OPEN CLASSROOM OF K-1-2

There are approximately twenty students sitting on a carpeted floor around the teacher, Mrs. Johnson. Mrs. Johnson sits in a chair and begins to read them a story. Three students are seated at their desks, coloring a picture as they listen.

"This is a story about a girl named Edie, who didn't want to go to bed. Every time her mother would tell her it was time for bed, Edie would yell, Edie doesn't want to go to bed!"

"Have any of you stayed up really late before?"

Several students reply, "yes".

"How did you look when you didn't go to bed until really late?"

"Grumpy" says one student.

"Red eyes" said another student.

"After being awake a long time, nobody looks very good," Mrs. Johnson replies.

"So after Edie's mother got tired of her fussing, she decided that Edie didn't have to go to bed anymore. In fact, they took down her bed, disassembled it piece by piece, and put it in the garage. Edie was so glad, she said "I'm not going to bed ever again."

That night, Edie's parents went to bed, and Edie was all alone. All she could hear was the tic, tock, tic, tock,

of the ....., Mrs. Johnson stops reading and lets the students answer.

"The clock" the students shout.

Three other classes are ongoing in the same pod, yet the students are very attentive to the story.

A student asks Mrs. Johnson, "Why do you get grumpy when you don't get enough sleep?"

"What does sleep do for your stomach?" another student asks.

Mrs. Johnson responds, "All the parts of our body need to rest. Our ears need to rest, and in daytime our mouths need to rest more than our ears. Our body will hurt if we don't get enough rest."

Mrs. Johnson finishes reading the story, which ends with the fact that Edie is so tired the next day that she doesn't want to go to the park and play with her Dad. All she wants is to have her bed back. Her father reassembled it and Edie goes right to sleep.

After the story ends, Mrs. Johnson asks the students to write her a story and tell her how they need sleep, and what they would be like without it. While the students were working, she came over to talk to me.

Mrs. Johnson said the students generally learn health from the health text, but she expands it in order to have more material. "It is difficult to find time to round up all that is available for a single topic. For instance, the dental unit in the text was expanded. One of the students'

father is a doctor and he came and visited the class. We also had a dentist come in and advise the students on proper dental care. After that visit, the students brought in treats of celery and peanut butter instead of cookies. The students get health lessons through exercise and learning about their feelings," stated Mrs. Johnson.

As she talked, I noticed that a young Cambodian girl was under one of the tables, clutching a Teddy Bear. Another student is coloring her pictures. Students seem to come and go out of the teaching area, while others continue working on their health assignment. The atmosphere is very informal.

"Health is referred to as discovery time," says Mrs. Johnson. There is one teacher who does the health teaching for all the students in the K-2 pod. There are three or four classes ongoing in each pod, and four pods to the school.

In addition, there is a special class of Vietnamese students.

Mrs. Johnson said that health is taught both as a separate class, and integrated into the other courses.

I asked Mrs. Johnson how she would improve on their health program if she could.

She replied, "The first thing I'd do is get a different textbook. The way we do health now is interesting, but there needs to be expansion of the different subjects. The class does quite well with dental health, but there needs to be more stimulation with regard to other subject areas."

I asked Mrs. Johnson if there was any parent involvement in the school's health program. She said, "no, there are a couple who have come in as a resource, but no direct involvement on the planning committee."

Mrs. Johnson said that she has been teaching for twenty-seven years, and she "knew her job". She said, "I'd prefer that the parents leave the teaching and planning up to the teachers. They (the parents) can help by doing their job at home. That would be the best thing they can do. The ones who tend to participate in that kind of opportunity are the ones who have a greater need to be heard than ordinary ones, and that kind of social need will tend to be non-productive."

Mrs. Johnson seemed to be quite emphatic as she continued, "I don't want some parent telling me how to do my job. I know how to do my job. Most parents are just a lot of talk, they don't have the expertise to make constructive changes. The participation of parents is given lip service in the planning committees, but they don't really participate."

I asked Mrs. Johnson if there was any reproductive health taught to their students. She replied, "no, it is not taught, but I wouldn't mind teaching it. Then, the parents' involvement would be appropriate."

Mrs. Johnson mentioned that there is a cable television station they watch that has health on it for

the students. "It had one program on about reproductive health entitled "All About You". They also had one on about elimination that was very well done. They had a show on about tornadoes, and showed all the students going into the womens' bathroom. A lot of the boys giggled a lot at that, which is a very dumb attitude. There is such stereotype about the genders that it's very hard to change. The parents aren't free enough themselves to change it."

Mrs. Johnson says she has to get back to her class now--and collects the health materials. It is time for reading class.

There were several main themes evident in this vignette. First, the methods used to teach all classes including health, were different because of the open school format. The open school has "pods" instead of classrooms. A pod is a large carpeted room that contains several areas designated for classes, library work, book shelves, and television viewing.

The teaching atmosphere in the red pod (K-1-2) seemed quite informal, yet structured. Three classes are ongoing simultaneously, but the students don't seem distracted by noise from the other classes. There is considerable traffic or movement by the students in and out of the teaching areas. For example, while Mrs. Johnson was reading the story about Edie, three students were seated at a table coloring pictures as they listened, another student is seated underneath one of the tables, clutching a Teddy Bear. Other students are seated on the floor surrounding Mrs. Johnson.

There are more than 100 students, or 34% from southeast Asia attending Robin Hood School. Most of the students are Vietnamese, some are Cambodian, and Laotian. There are also Vietnamese tutors who help the students with their school work. The presence of these students had an impact on the overall health education program. Many of these students have difficulty adjusting to the American classroom. For example, as mentioned previously, one student sat under the table clutching her Teddy Bear during the

health lesson. The informal teaching format of the open classroom allows a larger margin of appropriate or acceptable behaviors than a more traditional classroom.

A second methods issue evident in this vignette was the use of a health textbook for teaching health. When I asked Mrs. Johnson how she would improve their health program she said: "The first thing I'd do is get a different textbook. The way we do health now is interesting, but there needs to be expansion of the different subjects. The class does quite well with dental health, but there needs to be more stimulation with regard to other subject areas."

Other teachers in both Robin Hood and Schultz school also felt the textbook was inadequate. One teacher said she doesn't use the text at all, and another simply stated: "the text is a waste". Another teacher I observed at Robin Hood school used the text as an incentive for discussion, and then had his students copy down the main ideas, and answer the review questions at the end of the chapters.

A second method, in addition to the textbook, is a one-hour health education program shown twice a week on cable television. This health education program often features students from within the Botham City School District and/or community resources, and is produced by the Botham School District Health Education Coordinator. The television show addresses various health education topics relevant to elementary students. Mrs. Johnson felt that many of the television programs were "very well done".

An organizational structure issue was also evident in the vignette. This issue is the degree of parental involvement in the health education program. Mrs. Johnson seemed to feel very strongly against parental involvement. "I've been teaching for twenty-seven years and I know my job; I'd prefer that the parents leave the teaching and planning up to the teachers. Parents can help by doing their job at home. That would be the best thing they can do. The ones who tend to participate in that kind of opportunity are the ones who have a greater need to be heard than ordinary ones, and that kind of social need will tend to be non-productive. I don't want some parent telling me how to do my job; I know how to do my job. Most parents are just a lot of talk, they don't have the expertise to make constructive changes."

It is evident from Mrs. Johnson's comments that parental involvement in the health program is not particularly welcomed. Mrs. Johnson also said that parental involvement is given "lip service" in the planning committees, but they don't really participate. The District Health Coordinator seemed to concur with this perspective. She indicated that parents were "not yet" on the Curriculum Planning Committee, but would be included at a later stage. The District Coordinator also said that "when the advisory board has been opened up to parent involvement, there hasn't been much of a response. If some parents do participate, it is usually the squeaky wheels who are

against reproductive health being taught."

Mrs. Johnson seemed to feel differently about parental involvement if reproductive health was taught. Mrs. Johnson indicated that reproductive health was not being taught at the time of the observation, but that she wouldn't mind teaching it. "Then parental involvement would be appropriate," she said.

Parental involvement in the health education program seemed to be somewhat of a heated issue during my observations. For the Botham City School District, it is an issue that may warrant further resolution.

The next vignette describes a 4th and 5th grade health class at Schultz school. One of the most notable features in this vignette is how the student teacher is able to generate considerable student enthusiasm by having the students do a "hands-on" experience of "Name the Nutrient". The content of this lesson meets some of the Essential Objectives for Health Education in nutrition as well as enables the students to apply the content to their own personal experience. The organizational structure is also represented by the utilization of outside resources and materials.

NAME THE NUTRIENT

"I am still waiting," the student teacher says to a very noisy classroom of 3rd and 4th graders. Finally, the multi-racial class of thirty students (ten boys and twenty girls) quiets down. The students are just returning from recess.

"Today, we have a visitor. When you quiet down, I'll introduce her to you. I'd like to introduce Mrs. Hansen. She's here to watch our health class."

"I brought a sack lunch today, and I'd like to find out if I brought a nutritious lunch. I'd like a volunteer to pull out one item, and tell me what food group it's in."

"Me, me," the students enthusiastically wave their hands and lean out over their desks to be called on. The desks are arranged in clusters, with approximately five desks to a cluster. The regular teacher is not in the classroom, and today is the first time the student teacher has taught the class by herself.

"Okay, Rhonda, will you come up and choose one item from my lunch?"

Rhonda comes up and pulls out an empty yogurt carton.

"What group does yogurt belong in?" asks the student teacher.

"Dairy."

"Right, what else is in yogurt that may be in another food group?"

Several students try to guess but can't get the correct answer. The teacher finally says, "a fruit. This is blueberry yogurt. Okay, I need a meat; Steven, will you find one for me?"

Steven comes up and looks a few seconds, and then pulls out an egg.

"Right!" "What are the good things in foods?" asks the student teacher.

No response.

"It begins with an "N".

"Nutrients" guess a couple of students after that clue.

The entire class is very attentive and eager to be chosen to identify another food.

After two more students find a banana from the fruit group, and a graham cracker from the breads and cereals, the student teacher asks, "did I have a balanced lunch?"

"Yes," the class responds.

One student goes up to the student teacher to ask her a question. The student teacher sends the student back to his seat and says, "this is teaching time".

The student teacher then hands out a ditto sheet with one of the four food groups drawn in each of the four quadrants. The sheet is entitled "What did I eat today?"

"I want you to fill in everything you've eaten so far, and then on the back I want you to write to me whether or not you ate a good lunch today. If you ate a good meal,

and it's helping to build your body, then tell me, and tell me why you did or didn't have a good lunch today. Also, color the pictures."

The students get right to work. On the bulletin board on the side of the class is a diagram with each of the four food groups on it. Adjacent to it, there is a "building blocks" display showing that proteins are the building blocks of our bodies. In the back of the room, there is an easel with a large sheet of paper on which is written, "Our Favorite Foods". The students have filled in their favorite food.

While the students fill in their worksheets, the student teacher mentions that the materials the students are working on come from the National Dairy Council book on nutrition entitled: Food: Your Choice. She shows me the health text also used by the class, entitled: Being Healthy.

The health textbook has many pictures of students from all races. There are nine chapters in the book entitled:

1. Ways to Keep Healthy.
2. Families.
3. Growing.
4. Being Safe All the Time.
5. Your Eyes and Ears.
6. Eating Many Foods.
7. Your Home.
8. Safety and Medicine.
9. Activities for Health.

As the students finish their worksheet, the 27-minute health lesson is over; it is time for the math class to begin.

There were several main themes evident in this vignette. First, the methods used to teach nutrition focused on a "hands-on" experience. The student teacher was able to generate considerable student interest and enthusiasm by having the students pull an item out of her sack lunch and name the nutrient. The students seemed to highly enjoy this exercise as they waved their hands emphatically to be called on, saying "me, me".

The hands-on method contrasted sharply to previous observations of using a textbook to teach health. The textbook method generally consisted of having the students read a chapter aloud, and then answer the review questions at the end of the chapter. Both methods may be effective and necessary for the learning of health education, but seemed to differ markedly in the students' expression of enjoyment.

A second theme evident in this vignette is how the organizational structure of the health education program includes outside resources. In this case, the material the students worked on was from the Michigan Dairy Council. The Dairy Council provided both nutrition materials and inservice education to health instructors. The Botham City School District encourages outside resources being integrated into the health education program. The school district provides a directory compiled by Clark County Health Department that lists forty organizations and agencies involved in health education. Some of the entries on the list include: Advisory Center for Teens, Clark County Health Department,

Greater Botham City Epilepsy Center, Michigan Heart Association, Dairy Council. This list has been cross-referenced with the ten topic areas contained in the Minimal Performance Objectives for Health Education in Michigan (MPO's).

A third theme evident in the vignette is the use of a health textbook. One of the reasons the textbook was chosen by the Botham School District was because the publishers, Laidlaw, cross-referenced the text's content with the Minimal Performance Objectives. The publishers established with the Botham School District that their text met the Minimal Performance Objectives and hence was selected for use throughout the school district. The Botham School District recognized that the teachers may not have time to address all ten of the health topics each year. Therefore, the Botham School District has selected certain health topic areas to be stressed at different grade levels. The following table shows the topic recommendations for each grade level.

Table 17. Botham City Health Topic Recommendations by Grade Level

Grade Level	Topic Recommendations
Kindergarten	Personal Health Practices Growth and Development Emotional and Mental Health Safety
1st	Personal Health Practices Safety Community Health
2nd	Nutrition Family Health Emotional and Mental Health Substance Use and Abuse
3rd	Disease Prevention and Control Personal Health Practices Growth and Development Consumer Health
4th	Growth and Development Emotional and Mental Health Safety Community Health
5th	Disease Prevention and Control Family Health Consumer Health Safety
6th	Personal Health Practices Nutrition Growth and Development Substance Use and Abuse

All ten of the topic areas for a comprehensive health education curriculum are eventually addressed by the end of the 6th grade year. Each of the ten topic areas is matched by a possible health activity, and appropriate media materials which can be used to supplement the health education lessons.

One teacher I interviewed felt that the expectations of the school board with regard to health instruction, were still too demanding. "We are supposed to incorporate health with science. Ideally, this is a fine idea, however, it just doesn't work. The teachers aren't given enough time to address it all. There is too much to cover in too little time. Science and Health is given 150 minutes per week (30 minutes a day). Health should be taught separately, in addition to science. I have twenty-eight students who must share a science kit meant for six students, and I only have thirty minutes to do it, yet every student is supposed to get an opportunity to touch the contents and get an understanding of the subject. Simply not enough time! The priorities are English, reading, and mathematics. We have objectives to meet in those areas, too!"

For this instructor and others I interviewed, there seems to be considerable differences between what is recommended by the school board, and what is actually taught in the classroom.

Teachers are finding it very difficult to fit health instruction into an already bulging curriculum.

The lack of time to address all ten topic areas of health education has forced this teacher into selecting only "portions of the recommended portions" of health education for elementary students. This watering-down of the content may be one of the major reasons the District Health Education Coordinator expressed that health education needs to be integrated into other subjects, instead of being taught as an independent, separate subject.

The instructors I interviewed also felt that health education should be both integrated into other subjects, and taught as an independent, separate subject.

A fourth issue evident in the vignette was the content presented in terms of the student's choice and decision-making. "I want you to fill in everything you've eaten so far, and then on the back, I want you to write to me whether or not you ate a good lunch today. If you ate a good meal, and it's helping to build your body, then tell me and tell me why you did or didn't have a good lunch today...."

Through this exercise the student teacher is teaching the students that they must be responsible for their own nutrition, and it is through their food choices that they help build their bodies. The content of the lesson is also put into terms of the student's own personal experience, thus improving the student's opportunity for future reference.

The following vignette will describe a dental health lesson in a special education class for 4th and 5th graders, and an interview with the instructor. Several themes are represented in this vignette. First, the teacher discusses how essential health education is for special education students and how health education needs to be given a higher priority than it presently receives. Second, the organizational structure is discussed in relation to bringing in outside resources, and the lack of participation by the school nurse. Third, behavioral choice and decision-making is seen as an essential component of health education for special education students because they have such high incidence of drug abuse, unwanted teenage pregnancy , and other social and emotional problems. As will be seen in this vignette, some of the students have difficulty being attentive to the health lesson and seem to have other concerns.

DENTAL HEALTH IN SPECIAL EDUCATION, GRADES 4-6

Today's lesson begins as the instructor, Mrs. Kaye, hands out a card to each of the eight students in her class. Written on these cards are answers to the questions she will ask the class.

"A hard, bony material under the tooth," Mrs. Kaye says to the class.

The student with the card replies, "dentin."

"Right," says Mrs. Kaye as she takes the card with dentin written on it.

"Having to do with teeth."

"Dental."

"Correct."

"Hard like bone."

"Enamel."

"How many of you flossed your teeth since this time yesterday morning?" asks Mrs. Kaye.

Five of the eight students raise their hands.

"Today we are going to learn how to floss our teeth properly. I want each of you to take about eighteen inches of floss and pass the box on to your neighbor."

One student opens his desk to take out a ruler to measure the floss.

"A ruler isn't necessary, all you need to do is estimate by the length of your forearm."

The students begin to talk and clamor in their desks, as the dental floss is being passed around.

"Almost everyone is resting their voice," Mrs. Kaye urged.....

One student, a black female, says she doesn't want to do it, and she's not going to.

"Some of your teeth are round and some are pointed," says Mrs. Kaye.

Mrs. Kaye bends down and puts her face right in front of one of the students and shows him how to get the floss between the teeth.

The other students are talking about how to get into a bar, "you need a fake ID," says one student.

"This feels kind of funny doing it in public, doesn't it?" Usually you do this alone in the bathroom. There's no need to be embarrassed, we are all going to practice it."

The girl who said she wasn't going to do it again says, "I'm not gonna do this ----!" She flosses one tooth and says, "I'm all done, can I throw mine away now?" She throws the floss down on her desk and folds her arms on her chest, "I'm done."

After flossing their teeth, Mrs. Kaye tells them they are going to work backwards from the cards with the dental definitions on them. Two of the students can't recall the definition of the word they had.

Mrs. Kaye answers the word for them as she signals

for the other teacher to take over the class for the remaining five minutes until lunch; she spends the time talking with me.

Mrs. Kaye says that teaching hygiene is remedial for these students, but necessary.

"As you could see, their attention span is very short. The students learn dental health, washing their hands, foods they can eat without getting a lot of sugar, exercises, and the different parts of their body. Human growth and development is taught in accordance with the program developed by Lee Lipkey. Reproductive health is also taught. I teach them about the changes they encounter as adolescents, and very straightforward talk about sex."

"For substance use and abuse, we usually bring in resource people; the students usually lack an appropriate role model, so we bring one in."

"Fortunately, in this room, we have good facilities; there is a drinking fountain, and a bathroom, so we don't make a big production of washing their hands. A shower is also available."

"Because our students have problems, the health classes stress that they need to be aware of basic things such as hygiene, food on the table, and emotional problems."

"The students really adore our hot lunch program, it may be the only hot meal they get. Two of our students are obese, so, we try to teach them how to interrupt the cycle of food as an answer to emotional problems."

The teacher does have contact with some of the parents--mostly concerning bathing and food.

"There is a support system, but not as good as last year's. Last year we had a school nurse that was really good, she saw to it that some of the students got some dental care they urgently needed. This year, the older nurse on staff isn't interested."

"Drug abuse is a problem. The students have a real need for positive self-concept, and in 4th and 5th grade, they need to know who they are. Most of these students have parents who have no control, or have pathological control over their lives, or exhibit manipulative behavior. That is the kids' total environment. The parents often don't have money, knowledge, or experience on how to raise kids constructively. That is why we stress food, rest, hygiene, and exercise. There is a rehabilitation center for mental and emotional problems, to which the students can be referred."

"For these students, the human needs aren't being met, so, they compensate by having a high need for affection. This often results in teenage pregnancy. Reproductive health in the schools is very important, but it can only solve part of the problem."

"A bigger problem is prioritizing the subjects in school. Often, the curriculum board listens to the one who is the loudest, and health isn't heard very loud."

As could be seen in the vignette, some of the students in this class were not very receptive to the teacher's health lesson. While the instructor was trying to get the students to practice flossing their teeth, some of the 4th and 5th grade students refused to participate and were instead discussing how to sneak into a bar. The instructor said these special education students seem to have a more urgent need for health education. "Drug abuse is a problem, the students have a real need for positive self-concept, and in 4th and 5th grade, they need to know who they are. Most of these students have parents who have no control, or have pathological control over their lives, or exhibit manipulative behavior. That is the kids' total environment."

Mrs. Kaye went on to mention that "for these students the human needs aren't being met, so they compensate by having a high need for affection. This often leads to teenage pregnancy."

Mrs. Kaye pointed out that even the best health education may not be sufficient to help these students change the course of their lives. This is why the health education content for special education students must start at the individual level of each student. For many of the students, this means learning basic hygiene, nutrition, rest, and exercise.

One of the most important issues evident in this vignette is that for special education students, health is probably the most important subject they could learn. Yet

other subjects such as math, and reading and science are given higher priorities. As Mrs. Kaye points out: "A bigger problem is prioritizing the subjects in school. Often the curriculum board listens to the one who is the loudest, and health isn't heard very loud."

The lack of health education as a priority subject is not just for special education students, but for all students. The prioritizing of subjects as well as the time allotted for teaching, is decided by the upper levels of the Botham School District's organizational structure. In order to better understand the path such a change in policy would need to follow, let us take a brief look at the organizational structure of the Botham City School District.

The highest authority over the entire district is the Botham City School Board. This group of elected officials is the top decision-maker in the district. Within the school board is an educational committee whose main function is to review any new program, including health. This educational committee gives permission for any new program to be implemented. In addition, there is an Instructional Council that operates district-wide. The functions of the Instructional Council are to review all programs within the school district and to keep the school board informed. This Council serves to avoid duplication of programs within the district.

For specific health education matters, a District Health Education Coordinator functions to oversee all health

education programs within the district. This includes monitoring all health education ongoing in more than forty elementary, ten middle and high school buildings, ten special education buildings, and more than three alternative education buildings, giving a total of 22,350 students in the entire Botham City School District.

For health education to be considered a higher priority subject, it would require approval and facilitation from all levels of the Botham City School District hierarchy. The District Coordinator would have to be a strong advocate and vocal proponent of health education as a priority subject. Even with this support, the bureaucracy and complexity of such a large district makes any new change in policy a long and difficult process.

A second issue evident once again in this vignette is the lack of integration of school health services into the overall health education program. "There is a support system, but not as good as last year's," Mrs. Kaye explained. "Last year we had a school nurse who was really good, she saw to it that some of the students got some dental care they urgently needed. This year the older nurse on staff isn't interested."

It is evident from Mrs. Kaye's comments that school health services and the health education program are not cooperating as is optimally possible.

An additional issue evident in the vignette, Dental Health in Special Education, 4-6, is that in particular,

special education students need to understand that they must be responsible for their own decisions and ultimate health status. Because problems such as drug abuse and unwanted teenage pregnancy are so high for special education students, more attention must be paid towards helping these students realize that their choices and behavioral decisions have serious consequences on their health and life course, as well as the lives of others.

CONCLUDING DISCUSSION ON BOTHAM CITY

The main issues that were evident in the observations of the Botham City health education program centered around the main theme of organizational structure. More specifically, there seemed to be differences of perception between what the District Health Coordinator said about the health program, and what the health instructors said.

The Health Coordinator said there were no problems seen between the school nurses and the instructors, and that the nurses could be resources for the teaching of certain health topics.

The health instructors on the other hand, felt that the school nurses would not be interested in health instruction, or were not welcome in the classroom.

The District Coordinator said the texts were chosen after careful evaluation which found the texts met the Minimal Performance Objectives for Health Education in Michigan (now termed Essential Objectives), were copyrighted, multi-ethnic, and avoided stereotypes. The health instructors who were interviewed said the text was "not used", "a waste", or "needed expansion".

The District Coordinator said the teachers need more inservice health education, but it was too expensive, and the teachers probably wouldn't be willing to participate. The health instructors said there is not enough time to

teach health in an already bulging curriculum, and the expectations of the administration are too unrealistic.

These differences in opinion lead to the conclusion that there is a lack of communication and understanding between the administration and the health instructors. This communication problem can only be remedied if both the administration and the health instructors are willing to sit down and hear each other's perspective. The first step to this process is the recognition that there is a communication problem between the two levels that not only hurts the administration and the health instructors, but is the most damaging to the students who, as a result, do not receive adequate comprehensive health education.

A COMPARISON OF PROGRAMS IN THE THREE SITES

This section compares each of the three observed health education programs on three key factors: organizational structure, methods used in the health programs, and content of the health curriculum. These three factors were chosen because all three of the health programs were investigated in relation to these three variables. In addition, the observed health education programs are compared on two different aspects: the major barriers seen in each program, and the major innovations of each health program. Finally, two additional factors are examined independent of any particular program site. First, let us look at the comparison of each of the three health programs on the key factors.

ORGANIZATIONAL STRUCTURE

The organizational structure of the three health education programs was markedly different. The organizational structure of Hobart Health Program is built upon the program providing a comprehensive health education curriculum to the students, and emphasizes integration of the program within the community. Components of the Hobart Health Program reflect this integration effort by the presence of a health education advisory board comprised of community professionals, business people, clergy, teachers and parents; the providing of parent handbooks, parent review sessions, and frequent media coverage of the health program's activities.

The Urbandale Health Program's organizational structure emphasizes integration of school health services into the overall health program. The home visitation by student nurses, and the sponsoring by medical and educational authorities such as Dr. T. Berry Brazelton, MD., and Prof. Frederick Erickson, PhD., to provide inservice education to teachers also reflects this integration of health services into the health program.

One of the more important aspects of the Botham City Health Program was its method of instruction utilizing closed circuit television to broadcast a bi-weekly health education show. This program addresses various grade levels on a variety of health topics and often features students from within the district, professionals and agencies in the community, and the district health coordinator.

Figure 8 shows the formal organizational charts of the three health education programs. As can be seen from the diagram, the Hobart Health Education Program shows direct frequent communication of the district health coordinator to the advisory board, the teachers, the parents, as well as to the school district superintendent. One reason this communication structure is possible is because of the small size of the school district. The district health coordinator meets regularly with the advisory board, parents, and teachers, which would not be so easy in a large district.

The Urbandale Health Program organizational structure

shows a more complex communication flow. One notable aspect of the Urbandale Health Education Program structure is the communication "triangle" between the superintendent, the evaluation team, and the health program coordinator. The health program is evaluated by the evaluation team, who reports directly to the superintendent. The staff of the health program, and the evaluation staff have had numerous conflicts over the evaluation of the program. These conflicts are one reason why the health program coordinator enlisted the expertise of outside community professionals to assist in the provision of evaluation and inservice education. The health program coordinator of Urbandale has strong frequent communication with the school nurses, student nurses, teachers, and the community professionals.

The organizational structure of the Botham City Health Program is more hierarchial than the other health education programs. The district health coordinator has little or no direct contact with the health instructors, and only occasional communication with the building health coordinators, the school nurses (who are frequently the same individuals), and the advisory board. One of the main reasons for this organizational structure is due to the large size of the district.

Organizational structure differences and similarities of the three health programs are better illustrated in Table 18, which compares the organizational structural components of each health program. Several main differences

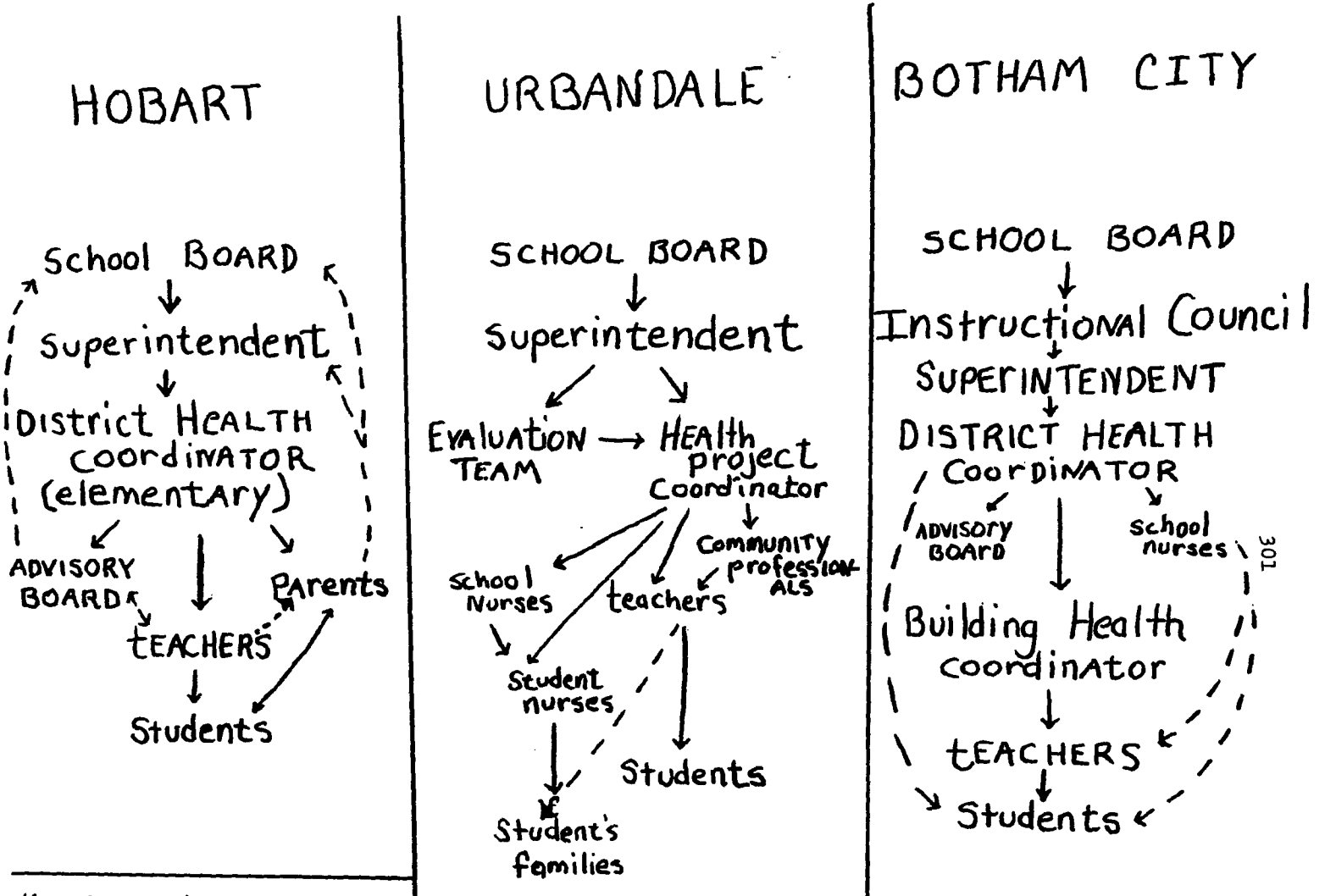


FIGURE 8. ORGANIZATIONAL CHARTS OF THE 3 HEALTH PROGRAMS

Table 18. Comparison of Organizational Structure for the Three Health Programs

	Hobart	Urbandale (K)	Botham City
District Health Coordinator	Yes (1)	Yes (1)	Yes (1)
Building Health Coordinator	No	No	Yes
School Health Advisory Board	Yes	N/A	Yes
Parental Involvement	Yes	No	No
Community Participation	Yes	Yes	Occasional
Inservice Training	Yes	Yes	Yes
Statewide Health Program Participation	Yes	Yes	No
Method of Health Instruction	Comprehensive Health Education Model	Manual Dexterity Skills	Textbook and Closed Circuit Television
Validation by Michigan Department of Education	Yes	No	No

Table 18. (Continued)

Recognition by Michigan School Health Association	Yes	No	No
School Health Services Integration	No	Yes	Moderate
Curriculum Guides for Comprehensive School Health Education approved by School Board	Yes	No	Yes
Same Curriculum Followed Within Grade Level	Yes	Yes	Yes
Student Involvement	Some	No	No

can be seen from the table. First, as previously mentioned, there is a substantial size difference in the three health programs. Even more pertinent is the ratio differences between the program coordinators to the teachers. For the Hobart program there is one program coordinator to 37 health education instructors. For Urbandale, there is one health coordinator to 79 health instructors, six of whom teach the kindergarten health program. For Botham City, there is one health coordinator to 1,907 teachers, 450 of whom are elementary health instructors.

A second notable feature is that both the health programs of Urbandale and Botham City are located in urban centers, have a multi-racial student population, with a wide variety of cultural and ethnic backgrounds. Hobart, however, is a small rural town, with a very homogeneous student population. In the two urban sites, the variety of cultural and ethnic backgrounds of the students makes the delivery of a health education content that is relevant to the student's personal experiences more difficult. This is because the wide diversity of the students' cultural and ethnic backgrounds makes it quite difficult to have a universally applicable content. For example, nutrition education and practices may vary considerably along ethnic lines. Hispanic students may have tortillas with beans for breakfast instead of eggs and toast. Even though both are nutritious breakfasts, the Hispanic students may not learn that their diets are equally nutritious and desirable. When the health

education content is not applicable to the student's personal experiences, it is less likely to influence the student's choice of positive health behaviors.

A third difference in the three health programs is seen in the provision of health education inservice education to the health instructors. In Hobart, health inservice education was given to all instructors upon implementation of the curriculum (in 1979); also, health instructors receive additional inservice on various topics such as cardiopulmonary resuscitation (CPR), dental health, etc. In addition, all instructors are given an instructional notebook containing student objectives, health activities, and sample test items.

The observed inservice education at Urbandale focused on helping kindergarten instructors to identify students with developmental deficiencies who may warrant home visitations. This inservice emphasizes the home visitation program instead of the health instruction.

The inservice education at Botham City was conducted by the Dairy Council for assisting the instructors' use of nutritional education packet provided by the Dairy Council. In addition, some health education inservice has been provided to the instructors through closed circuit television. None of the instructors I interviewed mentioned they had viewed the health education inservice programs.

A fourth comparable aspect of the health programs' organizational structure is the presence and influence of a

school health advisory board. In the Hobart health program, the advisory board is comprised of community representatives from business and the professions, as well as teachers, parents, and clergy. The board meets regularly and makes recommendations on health education policies. All board meetings were open to the public, and any interested persons were welcome to attend. For the Hobart health program, the advisory board is a main structural tool for integrating the health program into the community.

There was not an advisory board observed at the Urbandale program. There may have been one functional at some time, but not during the time of my observations.

The advisory board at Botham City was originally formed to develop a reproductive health program. During the time of observation, the District Coordinator said this board was composed of representatives such as principals, nurses, administrators, and teachers. The advisory board was not presently open to parents. The District Coordinator mentioned that when it has been open for parent participation, there hasn't been much of a response, and if some parents do participate, it was usually those who were against reproductive health being taught. It was unclear what role the advisory board played in overall health program policies. However, the District Coordinator did say that any academic program, including health, must be first approved by the educational committee of the school board, and/or screened by the instructional council.

The presence of an advisory board whose members represent community constituents, and which functions to examine and improve the health program is seen as an essential organizational component for the implementation of comprehensive school health education.

A fifth organizational component compared between the three health programs is the integration of school health services into the health education program. In the Hobart school district, there was not a school nurse on staff at the time of the observations, nor were there any standard school health services. The public health department may work with the schools on a particular health issue, but there was not a school health services component observed in the Hobart health program.

This contrasts sharply with the Kindergarten health program at Urbandale. The main emphasis in the Urbandale program was the integration of school health services into the health program. Through home visitation by student nurses, and the inclusion of school nurses in the inservice education sessions, the school health services was an integral part of the Urbandale health education program.

The school health services for Botham City were not as well integrated into the health program as in Urbandale. School nurses could serve as resource persons for health instruction, but usually did not. Several of the teachers interviewed in the Botham City school district felt that the school nurses were not interested, or not welcome to be

involved in health instruction.

The sixth organizational structure component that is compared in the three health programs is integration of the health program into the community. For the Hobart health program, community integration was one of the most important foci of the program. The coverage by the media, parent involvement, parent handbooks, and open advisory board meetings, members of which represented the community, all served to integrate the health program into the community. The outcome of this process has been a wider acceptance by the community of health education as a priority subject, a source of community pride, and hopefully, a more health-conscious community.

Efforts to integrate the Urbandale kindergarten health program into the community involved the families of students who were recommended for home visitations. There was not a public relations initiative to inform or involve the general public into the health program activities. Professionals such as the inservice education presenters were integrated into the program, but only to provide educational services.

In Botham City, community integration consisted of a list of community agencies provided to the teachers for them to contact if they want additional resources on various health topics. Except for representation on the advisory board, no other efforts were observed to inform or involve the community with regard to the health education program.

In all three health programs, comprehensive health education curriculum guides were approved by the school board. All three health programs followed the same curriculum within a given grade level. Student involvement in the planning process was not observed at Urbandale or Botham City. However, Hobart's health program did have some student participation in an anti-smoking presentation made to all 3rd and 4th grade students.

As can be seen from this comparison of the organizational structure components, the three health programs differed markedly in their organizational structures, and therefore, had resultant differences in their program emphasis. Now, let's look at how the three health programs compare on the key factor of health program methods.

METHODS USED IN THE HEALTH PROGRAM

The methods utilized in the health education programs are compared on three different levels; the methods of instruction, the methods used in inservice education, and the methods used in additional program activities. Each of these three levels is discussed below.

Methods of instruction. The methods of instruction differed markedly in the three observed health programs. In the Hobart health program, audiovisuals such as films, filmstrips with records, and several hands-on activities were predominantly used.

The methods of instruction used in the Urbandale kindergarten health program were all small group hands-on

exercises. During the health lesson, a group of four or five students would meet at small tables and complete a series of tasks or games for 15 to 20 minutes.

The methods of instruction at Botham City were two-fold; a text book was used throughout the district and a closed circuit television health education program was broadcast twice weekly.

All of the methods used in the three observed health programs had positive and negative attributes. Hands-on experiences where the instructors got the students involved seemed to be most enjoyable in the three sites. Other notable methods were the use of unanswered questions in the reproductive health films of Hobart, and visitation to community activities or businesses. These methods of learning also seemed to generate considerable student participation and enthusiasm. The use of closed circuit television was very well received by one of the instructors interviewed at Botham City. The potential for closed circuit television as a tool for health education instruction is yet to be explored in the Urbandale or Hobart health programs.

Methods used for inservice education. The methods used for inservice education at the Hobart health education program were not observed; however, one of the instructors said that during the inservice education the teachers reviewed all of the films and filmstrips, and discussed ways to complement the films with discussion.

There were two different types of inservice education meetings observed at the kindergarten program of Urbandale. One was directed to all of the teachers, the school nurses, and the health program staff. This inservice meeting focused on helping teachers identify and help students with developmental deficiencies, and to distinguish these students from students who have cultural/ethnic interactional difficulties. The second type of inservice at Urbandale focused on one student and his family, who had received a home visitation by one of the student nurses. (See vignette "Inservice Education" on p. 252). At this meeting, different educational and social agencies that could be contacted to help the student and his family get needed medical, social, and economic assistance were discussed.

The inservice education provided at the Botham City school district was not observed. Interviews with one of the instructors at Schultz School revealed that the Dairy Council had provided nutrition inservice education to their school instructors. The District Coordinator also mentioned that some inservice education had been broadcast over the closed circuit television health education program.

Additional health education program activities. One of the additional programs receiving inservice education in the Hobart health program was the parent volunteer program to help with the Hobart's dental health initiative program "Swish". "Swish" is a fluoride rinse program offered to elementary students as a preventive dental

health measure. Several parents have helped with the program to prepare and distribute the fluoride rinse to the students.

Another health education program receiving inservice education was the Hobart high school's anti-smoking team. Inservice education was provided to the team in preparation and evaluation of the team's anti-smoking pitch presented to elementary students.

In the Urbandale health education program, student nurses who were involved in the home visitation program received special inservice education. This inservice education focused on preparing the student nurses to take family histories, identify environmental social problems, and serve as resource persons to the family.

There were no observed additional health education programs receiving inservice education at Botham City.

CONTENT OF HEALTH INSTRUCTION

The content of each of the three health education programs also varied considerably. The content of the Hobart health education program was certified by the Michigan Department of Education (MDE), and recognized by the Michigan School Health Association as being a comprehensive health education program. As described in the review of literature chapter, comprehensiveness is defined by the Michigan Department of Education as meeting all of the Essential Objectives for Health Education in Michigan in the ten topic areas of: nutrition, personal health, community health,

consumer health, family health, emotional and mental health, growth and development, disease prevention and control, substance use and abuse, and safety. In the Hobart school district, these ten topic areas and essential objectives are represented in the health education curriculum in five units: Growing Up, My Healthy Community, Foods for Health, My Safety, and Decisions for Growth. All of the instructors in the Hobart district have implemented the health curriculum in their classes, with varying degrees of time spent on each unit.

The Urbandale kindergarten health curriculum does not contain a health content. The content consists of a number of games or exercises the students complete that tests their listening skills, visual discrimination, and manual dexterity. The curriculum has been implemented for its ability to offer small groups of students an opportunity to improve their skills without competition from their peers, and have successful experiences completing the exercises. This success is theorized to help the student improve her/his sense of self-esteem, thus enhancing the chances of the student's choosing positive health behaviors. The students in the observed lessons seemed to enjoy the health lessons, but evidence of improved self-esteem was not observed.

The content of the Botham City health education program is based on a textbook by Laidlaw, "Being Healthy". The district coordinator said this text was selected on the basis of a variety of criteria, including the fact that it

met the Essential Objectives for Health Education in Michigan, that it was multi-ethnic, copyrighted, stereotypes minimized, and that the reading level was appropriate for the students. Interviews with the instructors showed that many teachers felt the text was inadequate, needed expansion, and was not used. The televised health education programs also provided the students with a health content, but the content of these programs was not observed or available.

MAJOR BARRIERS TO IMPLEMENTATION AND MAJOR INNOVATIONS IN THE THREE HEALTH PROGRAMS

Barriers. In addition to the comparison of the three health education programs on the key factors, each health program is also compared with regard to the program's major barriers and innovations observed in the three sites.

According to interviews with the instructors, the major barriers to the implementation of comprehensive school health education in the Hobart health program was differences in implementation by various instructors. Some elementary health instructors in the Hobart school district do not teach health as extensively as others. Time constraints lead some instructors to feel unsupportive of fitting additional subjects into an already crowded curriculum. However, because the health program is strongly endorsed by the school board and the administration, and because all students must take a health test at the end of the unit that

is graded by the health education coordinator, the health instructors comply and teach health education regardless of their personal objections.

This barrier of not enough time in the day to teach all that is expected by the school administration is also seen as the main barrier in the Botham City Health Education Program. Almost every teacher interviewed at Botham City complained that time was a major barrier to the teaching of health. High priority of reading, math, and science, has forced the teachers to treat health education as a lowered priority. A major difference in the health program of Botham City and Hobart is that in Botham City mandatory health tests are not being collected by the health program coordinator. The large size of the student population also makes it quite difficult to monitor the health education competence gained by the students. The Botham school district has recognized that all ten topic areas of comprehensive school health education cannot be provided in all six grades every year. Therefore, the administration has recommended that each grade level emphasize two or three topic areas each year. The success of this recommendation was not observable.

In the Urbandale kindergarten health program the major barrier observed was the lack of a health content being taught in the health lessons. Although health education is provided in later grade levels, the lack of health content in the kindergarten health program is seen

as a major barrier to implementing comprehensive school health education. At this level, kindergarten comprehensive health education curriculums are available, but they were not being used during the observations of the Urbandale health program.

Innovations. The most important innovation observed at the Hobart health education program was the inclusion of parents, professionals, and the general community in the activities of the health program. The open door policy of the advisory board, media coverage, parent review sessions, parent handbooks, newsletters, and the inclusion of professionals as health education resources all contribute to the Hobart health program's major strength: community integration. This community integration is provided through specific aspects of the organizational structure. The provision of regular advisory board meetings, parent handbooks, and other services has helped the Hobart health program to be implemented and maintained despite threats to the program such as budget cutbacks, opposition to reproductive health from various interest groups, teacher apathy and other problems.

The most important innovation observed at the Urbandale health education program was the utilization of community professionals and resources to provide valuable health education services to the kindergarten students and instructors. Through contacting a nearby nursing college, the health program was able to provide student nurses to

serve as resources for the kindergarten student and her/his family. Both the student nurses as well as the families were able to benefit through the home visitation program. In addition, health education inservice was provided to the kindergarten health instructors through having medical and educational professionals share their expertise. These two examples illustrate that the Urbandale health program has been able to improve services through utilizing the resources available in their community.

The main innovation observed in the Botham School District health education program was the use of closed circuit television for broadcasting health programs for students and health inservice education for teachers. The use of audiovisuals to provide supplemental health education information is seen as an important use of available technology. Because of the large size of the Botham School District, the use of closed circuit television helps to overcome instructional problems such as lack of a uniform program content, the reaching of large numbers of students and teachers, and the maintenance of interest and creativity while teaching comprehensive health education.

ADDITIONAL FACTORS INFLUENCING HEALTH EDUCATION

There were also two additional factors identified as important and distinguishing in the three observed health education programs. The first factor was the presence of inter-district peer support for the health education coordinators within the health education professional

network. In Michigan, the main health education professional network stems out of the organizations of Michigan School Health Association (MSHA). Two of the three district health education coordinators were active members of Michigan School Health Association, and have attended their main fuctions. This organizational tie allows the district coordinators to share their personal frustrations and successes with colleagues throughout the state. Inter-district peer support is seen as an important ingredient for the implementation and maintenance of a comprehensive health education program.

The second factor is the quality of relationship between the district health coordinator and the teachers. The observations of the three health education programs can in no way compare the quality of this relationship between any of the three programs. However, certain attitudes towards the coordinators and administration in general were observed. Candid conversations with the teachers in all three of the programs indicated that colleagial cooperative relationships between teachers and the administration (including the district health coordinator) tends to foster the most productive and constructive participation by the teachers and the district coordinator. Comments such as: "the coordinator needs to be a squeaky wheel to get some grease", "the teachers really resent being ordered to teach or do anything", "we are sick of getting it (health) pushed down our throats". All voiced resentment that they are not on a cooperative, mutual goal-oriented relationship with the

district coordinator. In these instances, the district coordinator and the administration were viewed by the teachers with animosity. These attitudes do not improve the teacher's ability to teach health education in a positive and interesting way. Instead, health is seen as just one more subject to cram into an already overloaded curriculum. Eventually, the students are the ones who often receive this message, and instead of fostering interest and participation, health education becomes just another subject for the students to contend with.

The observations of the three health programs identified several rules or practices that did seem to be positively received by the teachers. Some of these were:

- Inclusion of the teachers in the decision-making process regarding the health education program.
- Provision of health education inservice training that provides the teachers with an opportunity to share their experiences and frustrations in the classroom.
- The provision of health education inservice that suggests new ways or methods for health education instruction.
- Maintaining personal relationships between the district coordinator and the teachers.
- Providing financial or time compensation for health education inservice.
- Strong support from the administration and district coordinator to the teachers in the wake of any community disruption regarding the teaching of reproductive health as a content area of comprehensive health education.

These administrative rules were observed in at least one of the three observed health education program, and were

very positively regarded by the health instructors.

SUMMARY

This chapter has compared three main factors: organizational structure, program content, and program methods between the three observed health education programs. It was found that each program had a different organizational structure, and thus a different program emphasis. Hobart's health program emphasized integration of the health program into the community, while the Urbandale health program emphasized integration of school health services into the health program. Botham City's health program emphasized the utilization of closed circuit television to supplement the health education being provided in the health textbook.

The three observed health programs were examined in the light of what particular organizational components fostered their respective program emphasis, and how these components shaped the overall health program's structure.

Differences in implementation by various health instructors, lack of sufficient time in the day to teach all required subjects, and the lack of a health content were identified as the major barriers to the implementation of comprehensive school health education in the three sites. Integration of the health program into the community, utilization of community resources into the health program, and the use of closed circuit television to teach health education were identified as the major innovations of the three sites.

In addition, peer support for the district coordinator, and the quality of relationship between the district coordinator and the teachers were identified as important administrative practices for the improvement of comprehensive school health education.

CHAPTER VII

CONCLUSIONS AND RECOMMENDATIONS

The results and recommendations of this dissertation address several main themes of comprehensive school health education. These themes include the organizational structure, program content, methods of instruction, professional preparation of instructors, selected health education issues, and research methods for health education.

The recommendations generated by this thesis are directed toward school health program administrators, health instructors, college and university administrators, and health educators. The conclusions and recommendations are divided into two sections. The first section includes conclusions and recommendations that are derived directly from the data and findings of this dissertation. The second section includes conclusions and recommendations that go beyond the actual findings of the dissertation, and suggest future directions that health education should pursue.

The conclusions and recommendations based directly on the dissertation findings are discussed below.

ORGANIZATIONAL STRUCTURE

The results of this study reveal essential information regarding the organizational structure of school

health education programs. The findings of the health education survey indicate that there is a lack of a well-developed organizational structure to implement comprehensive school health education in Michigan public schools. Some of the major findings from the survey that point to this conclusion are (1) a majority (70.2%) of the elementary principals responded that there was no building health coordinator to help develop, coordinate, implement, and evaluate the comprehensive school health education program, (2) 35.1% of all principals responded that school health services were not integrated into the overall health program, and (3) a majority (62.7%) of principals from all grade levels responded that their school board had not appointed a school health advisory board made up of parents having children attending the district schools, educators, local clergy, community health professionals, and other interested citizens.

The observations of the three health education programs also generated several conclusions regarding the organizational structure of school health education. The observations of the kindergarten health program at Urbandale showed how the integration of school health services and community resources into the health program can be used to provide additional information on selected students through a home visitation program. Inservice education sessions with the teacher, student nurse, school nurse, and the health project staff provided valuable information and

insight into the home environment of students who demonstrated poor achievement in the classroom.

The publication of parent handbooks, and the participation of parents on the advisory board and as volunteers for the Hobart health program illustrated how parent involvement can serve to improve and maintain a comprehensive school health education program. In addition, the health program at Hobart was able to sustain considerable opposition by a vocal minority to the reproductive health component because of a sound organizational structure.

The observations of the Botham City health program indicated how outside resources can be used to supplement the health program content. The Dairy Council provided curricular materials as well as inservice education to instructors to supplement the nutrition education of the health program.

Based on these findings regarding the organizational structure of the health program, the following recommendations are made:

1. A sound organizational structure of comprehensive school health education programs should be established before the implementation of the program. This structure should include:

   a. Appointment of a qualified health education coordinator.

   b. A health education advisory board made up of parents having children attending the district schools, local clergy, community health professionals, students, teachers, administrators, school nurses, and other professional staff.

   c. Integration of school health services into the overall health program.

d. Community health agencies and community health professionals as resource providers to the school health program.

e. A needs assessment of the status of the comprehensive school health education program already being taught in the school district and local community.

f. An assessment of the current health needs and concerns of the local community.

2. A continuous evaluation mechanism should be ongoing during the planning and implementation of the program.

3. Health instructors, school health services personnel, and school district administrators should be involved in the planning and implementation of the health education program.

4. Health program administrators should improve their skills in implementing educational change programs.

HEALTH PROGRAM CONTENT

The results of this dissertation indicate that comprehensive school health education is fragmented, and inconsistent or non-existent in Michigan public schools. The major findings of the statewide health education survey indicated that community health and consumer health were the least frequently taught health areas in all grade levels. In addition, 36.5% of the elementary principals responded that teachers within the same grade level did not follow the same health curriculum.

The observations of the three health education programs also indicated several findings pertaining to the content provided in the health education programs. The Botham City health program recognized that the teachers in their

school district did not have enough time to teach all ten topic areas contained in the Essential Objectives for Health Education in Michigan. The school district responded to this curricular overload by recommending that only certain health topics be taught at each grade level, and that all ten topic areas be covered at least once by the time the student reaches the end of 6th grade.

This adaptation of the Essential Objectives by the Botham City School District indicates that the standards developed by the Michigan Department of Education for providing a comprehensive school health education program may need to be modified by school districts that are already experiencing an overcrowded curriculum.

In the kindergarten health education portion of the Urbandale program, none of the content areas of comprehensive school health education were provided. Instead, the curriculum focused on academic readiness skills and improving the students' sense of self-esteem.

The content of the health program provided in the Hobart School District contained all topic areas listed in the Essential Objectives for Health Education in Michigan. In addition, several health education issues and topics were discussed, such as anti-health messages in the media, sex-role stereotypes, and the presence of a double standard for boys and girls to have opportunities for personal choice and decision-making.

Based on the findings relevant to the program content

in comprehensive school health education, the following recommendations are made:

1. The content provided in the health education programs should be based on the Essential Objectives for Health Education in Michigan.

2. The content of the health program being provided should be relevant to the students' personal experiences.

3. The content of health instruction should be presented in terms of the students' personal responsibility, choice, and decision-making.

4. The content of health instruction should be reassessed to include cultural differences present in the Michigan student population. Each of the ten topic areas of comprehensive school health education should discuss cultural patterns and differences within each topic area. For example, the nutritional diet of Hispanic Americans may be quite different from that of native Americans, yet be equally nutritious.

5. Within each school district, teachers within the same grade level should teach from the same health curriculum.

6. The content of health instruction should discuss anti-health messages in the media, in stores, and in advertising. These anti-health messages need to be identified as gimmicks used to sell material products.

7. Sex-role stereotypes should be eliminated from all health instruction content areas, and be identified as undesirable aspects of teacher attitudes in health education professional preparation courses.

METHODS OF INSTRUCTION

There were several different types of methods of instruction observed in the three health education programs. One method of teaching health that appeared to be effective in all three observed programs was the use of hands-on

experiences for teaching different health topics. The teachers as well as the students seemed to participate more actively and to enjoy hands-on health exercises more than any other observed methods of instruction.

Each of the three health programs also used different methods of health instruction. The Hobart health program used audiovisuals for most of its health instruction. One of the films showed students asking questions about reproductive health. These questions were not answered in the film. Following the film, the teacher asked the class to recall the questions and to try to give the appropriate answer. This technique generated considerable discussion about reproductive health topics that might not have occurred otherwise.

Another method of instruction used at the Hobart health program was the separation of genders for the discussion and film From Girl to Woman (for females) and From Boy to Man (for males). This separation of the genders may have given the students a message that reproductive health should not be discussed openly, or that it is embarrassing, or that it should only be discussed with members of the same sex. Separation of the genders for certain reproductive health topics is seen by the researcher as a method of instruction that may give the students undesirable perceptions about reproductive health education.

The methods of instruction used to teach the kindergarten health program at Urbandale consisted of small group

interactions with four or five students and the teacher aide. Teaching small groups of students helped the teacher to give each student more individualized attention than would be possible in a larger group.

The Botham City schools supplemented their textbook method of instruction with a health education television program shown twice weekly. This method of instruction was well received by the teacher whom I interviewed, and was an effective way of teaching health to a large number of students.

Based on the findings relevant to the methods of instruction observed in the three health programs, the following recommendations are made:

1. The methods of health instruction should include more hands-on experiences.
2. Kindergarten health instruction should include as much small group interaction as is possible.
3. The instructional method of using films with unanswered questions is recommended as an effective tool for stimulating discussion.
4. Closed circuit televised health programs is recommended as an effective method of teaching health to a large population of students.
5. Using a film showing an actual childbirth that also discusses personal responsibility and decision-making is recommended as an effective method of teaching about human childbirth.
6. The inclusion of outside resources is recommended as an effective method of teaching health and involving the community in the health education program.

PROFESSIONAL PREPARATION OF INSTRUCTORS

There were two main results from the health education survey that indicated that instructors of health have had little or no professional preparation in general health education. First, only 19.5% of the elementary principals responded that health teachers had at least four semester hours of professional preparation in general health education. Second, 84.8% of the elementary principals responded that health education inservice is not being received by the teachers on a yearly schedule. These two findings point to the conclusion that health instructors in Michigan public schools have had little or no preservice (college) or inservice training in general health education.

Based on these findings, the following recommendation is made:

> Colleges and universities that provide elementary teacher education should require at least four semester hours of general health education for elementary teacher certification.

SELECTED HEALTH EDUCATION ISSUES

Several health education issues and concerns were observed and/or generated during the observations of the three health education programs. In the observation of the Hobart health program, a major issue regarding lack of public confidence in comprehensive health education was evident in the health education advisory board meeting. During the meeting, there was considerable debate about the appropriateness of three reproductive health films. Although

the advisory board recommended the films be included in the 6th grade curriculum, the discussion indicated that the general public lacks confidence in and knowledge of the need for comprehensive school health education.

Also observed in the Hobart health program were discussions about anti-health messages in the media.

The observations of the health program at Botham City indicated that there was a substantial difference of opinion between the elementary health education instructors and the administrators of the school district. These differences of opinion were about such issues as health education content, methods of instruction, time allotment for health instruction, inservice education, and parent involvement.

The main issue evident in the observations of the Urbandale health program was the possible misidentification of students as being developmentally deficient, when in fact their deficiencies might have been due to differences in cultural patterns of communication and behavior. The remedial efforts for these misidentified students may serve further to exacerbate the problem.

Based on these health issues and concerns observed in the three health programs, the following recommendations are made:

1. Health education professionals should disseminate research findings and professional perspectives to the general public via the media, local forums, and community and school meetings. These perspectives should be in lay persons' terms so that

the general public can be reassured of the essential nature of comprehensive school health education.

2. Health educators should work together with other health professionals, such as physicians and nurses, to increase current knowledge and share perspectives on health issues and concerns.

3. Health educators should take a more active role than simply being available to local school districts. Local school boards should be encouraged to conduct a health education needs assessment and to implement a comprehensive school health education program.

4. Health education administrators should involve more health education instructors in their efforts to establish realistic health education program criteria.

RESEARCH METHODS FOR HEALTH EDUCATION

One of the more unusual aspects of this dissertation has been the utilization of two different methods to assess the status of comprehensive school health education and program criteria in Michigan public schools. By using both a quantitative method to obtain a general overview and program criteria frequency count, and a qualitative research method to obtain an inside analysis of different functions of three health programs, the study goes beyond the limitations of using either of these two methods alone.

The qualitative research method has the distinct advantage of being able to illustrate what the participants of a health education program see, do, and confront in their day-to-day activities. The qualitative research in this dissertation tells the story from the participant's point of view, and "brings to life" the implementation of

educational programs and policies enacted at higher levels of educational administration.

Particularly when evaluating educational policies, there needs to be more information beyond frequency count data. There also needs to be qualitative information on how the educational program or policy implementation is working and the various adaptations needed or used in certain settings or circumstances.

As could be seen in the narrative vignettes describing the health programs, qualitative research methods can present new information and findings that would not be possible by using quantitative research methods alone. Both the qualitative and quantitative research methods used in this dissertation were necessary to give a balance of perspective that includes a broad overview of health education status throughout Michigan, and a detailed focus of the inside structures and functions of a health education program.

Based on these findings and conclusions, the following recommendations are made:

1. Qualitative research methods as well as quantitative research methods should be included whenever evaluating public educational policies.

2. More qualitative research studies should be conducted on individual components of comprehensive school health education. Some of these components should include investigation of:

    a. The effectiveness of different methods of health education inservice to health instructors.

b. The effectiveness of various methods of instruction used to teach health education to students.

c. The role personal responsibility and behavioral choice and decision-making plays in health education presently being taught in Michigan public schools.

d. The importance and necessity of certain health education organizational structure components such as integration of health services, advisory board, outside resources, district and building health coordinators, health curriculum planning committees, parental involvement, participation of health professionals, participation of students, etc.

The following section of conclusions and recommendations are not based directly on the dissertation findings. Instead, these conclusions and recommendations have been developed in response to what was found to be absent from the observed health education programs. These suggestions and conclusions reflect a general educational phenomenon that seems to occur in a variety of subjects where controversial or value-laden issues are omitted from the academic curriculum.

Because this omission happens in such a wide variety of academic subjects, it suggests that schools have organizational structures in place to measure and respond to outside political pressure by deleting controversial topics from the curriculum.

This omission of controversial topics may serve to protect the schools from political conflict, however, the students are forced to pay the price by being less informed

of critical health issues affecting their lives.

This conclusion also suggests that school administrators should examine the consequences of omitting these controversial issues, and seek creative ways to endure outside political conflicts yet provide the students with a realistic understanding of the various issues.

Some of these issues include the ethics and rights of abortion, toxic waste contamination and responsibility, the threat of nuclear war, conservation of dwindling natural resources, and the causes and remedies of world hunger and poverty.

Based on these considerations, the following recommendations are made:

1. The content of health instruction should stress the interdependent nature of life. Students must learn that their health and well-being necessarily affects the health and well-being of others, and vice-versa.

2. The content of health instruction should include more emphasis on current health issues affecting peoples' lives, such as toxic waste pollution and responsibility, the threat of nuclear war, the reasons and remedies for world hunger and poverty, and the diminishing of natural resources.

3. The content of health instruction should include information regarding why the public has been deliberately uninformed or misinformed about health-threatening circumstances or pollutants affecting their lives.

4. Health educators should take a more active role to combat health-threatening issues and circumstances that affect human lives, such as toxic waste contamination, the threat of nuclear war, anti-health messages in the media, conservation of dwindling resources, and the reasons and possible solutions to world hunger and poverty.

SUMMARY

In order for our future society to understand and make knowledgeable choices about the multitude of health issues and concerns facing our lives, comprehensive school health education must be included in the educational curriculums of Michigan public schools. However, as this dissertation has pointed out, comprehensive school health education is either non-existent, or inconsistent throughout Michigan public schools.

This dissertation has described five main themes of school health education that comprise a comprehensive school health education program: organizational structure, program content, methods of instruction, behavioral choice and decision-making, and selected health education issues. Each of these five factors has been identified as necessary but not sufficient components of a comprehensive school health education program. These five themes or constructs were also identified as having an interdependent nested spiral relationship, with more focused and specific constructs at the center, and more broad and global constructs on the fringes. The spiral nesting effect of the five factors has allowed the articulation of a conceptual scale of health education program quality. The more a health program reflects each of these five factors, the better the program quality seems to be.

A statewide health education survey of public school principals and a participant observation study of three health education programs has provided only a small part of the total picture of comprehensive school health education ongoing in Michigan. The total picture of comprehensive school health education is beyond the scope of this study. However, this dissertation does provide valid information, and recommends a framework upon which future research in health education can be based.

APPENDIX

SCHOOL HEALTH EDUCATION RESOURCES COORDINATION

a project of

MICHIGAN SCHOOL HEALTH ASSOCIATION
MICHIGAN HEALTH COUNCIL

April 2, 1981

Dear Principal,

Your school is being asked to participate in a survey to assess the status of health education in Michigan schools. The Michigan School Health Association and the Michigan Health Council through a grant from the W.K. Kellogg Foundation is surveying all public schools in Michigan to determine the status of their school health education program.

Enclosed is a survey to assess the current school health education program of your building. Please fill out the survey and return it no later than April 24, 1981 to:

MSHA Survey
Suite 340, Nisbet Building
1407 S. Harrison Road
East Lansing, MI 48823
Phone (517)3378413

The results of this survey will be used to identify existing health education programs and to identify schools which desire assistance for developing or expanding their health education program. With the exception of this assistance referral, all answers to the survey will be held in strictest confidence by the Michigan School Health Association.

The statewide statistics resulting from this survey will be shared with the Michigan Department of Education, the Michigan Department of Public Health, and any other interested school health groups. If you desire a copy of the final report, please check the Final Report Box on page 4 of the survey.

Your prompt attention and personal assessment of your school is extremely important to the success of this survey.

Thank you in advance for your cooperation.

Sincerely,

Martha DuShaw

Martha DuShaw
Project Director

SCHOOL HEALTH EDUCATION RESOURCES COORDINATION

a project of

MICHIGAN SCHOOL HEALTH ASSOCIATION
MICHIGAN HEALTH COUNCIL

April 2, 1981

Dear Superintendent,

This is to inform you that all school building principals in your district are being asked to participate in a survey to assess the status of health education in Michigan schools. The Michigan School Health Association and the Michigan Health Council through a grant from the W.K. Kellogg Foundation is surveying all public schools in Michigan to determine the status of their school health education program.

The results of this survey will be used to identify existing health education programs and to identify schools which desire assistance for developing or expanding their health education program. With the exception of this assistance referral, all answers to the survey will be held in strictest confidence by the Michigan School Health Association.

The statewide statistics resulting from this survey will be shared with the Michigan Department of Education, the Michigan Department of Public Health, and any other interested school health groups. If you desire a copy of the final report, please write to:

MSHA SURVEY
Suite 340, Nisbet Building
1407 S. Harrison Road
East Lansing, MI 48823
Phone (517)337-8413

Thank you for your attention.

Sincerely,

Martha DuShaw
Project Director

(B-)

SCHOOL HEALTH EDUCATION RESOURCES COORDINATION

SCHOOL HEALTH EDUCATION SURVEY

PRINCIPAL

PHONE GRADE LEVELS DATE

PLEASE CHECK APPROPRIATE ANSWERS AS THEY RELATE TO YOUR BUILDING

		Yes	No	N/A
1.	Is health education taught as an identified (separate) subject?	___	___	___
2.	Is health education integrated into other subjects?	___	___	___
3.	In grades 1-6, do the teachers have at least 4 semester hours of professional preparation in general health education, i.e. personal health/community health, and school health problems?	___	___	___
4.	If the answer to question 3 is "no", what percent of teachers do have at least 4 semester hours of professional preparation in general health education? _____%			
5.	In grades 7-9, are the health education teachers certificated teachers holding majors or minors in health education?	___	___	___
6.	If the answer to question 5 is "no", what percent of teachers do have a major or minor in health education? _____%			
7.	Has a person been appointed as the building health coordinator to help develop, coordinate, implement, and evaluate the comprehensive school health education program?	___	___	___
8.	If the answer to question 7 is "yes", does that person (the building health coordinator) have a major or minor in health education?	___	___	___
9.	Do the school health service personnel (i.e. school nurse, public health nurse, school health workers, school psychologist) help plan and implement the program?	___	___	___
10.	Do you, as principal, provide instructional leadership by working with staff in planning, organizing, implementing and evaluating the health education program in your building?	___	___	___
11.	Do the teachers offer study options, extra credit and/or choice for students on projects?	___	___	___
12.	Do teachers receive health education inservice training on a yearly schedule?	___	___	___
13.	Have curriculum guides for grades K-9, that include the 10 areas, as defined by the "Minimal Performance Objectives for Health Education in Michigan", been developed by the teachers?	___	___	___

	Yes	No	N/A
14. Has the local school board approved curriculum guides and policies for implementing a comprehensive health education program?	___	___	___
15. Are the state guidelines relative to drug education, sex education and comprehensive health education being followed?	___	___	___

16. How many minutes of health instruction are provided per week, and per year in your school building? Please fill in the chart below.

GRADE	1	2	3	4	5	6	7	8	9
MINUTES PER WEEK									
WEEKS PER YEAR									

	Yes	No	N/A
17. Do all teachers within a grade level follow the same curriculum?	___	___	___
18. Is the teacher-student ratio in health education classes consistent with school districts contract policy?	___	___	___
19. Does your school district have a health curriculum planning committee to provide leadership in the development and implementation of the comprehensive health education program?	___	___	___
20. Are the health education knowledge tests suited to the grade level where they are administered?	___	___	___
21. Does your school district have a plan/policy for first-aid and emergency care?	___	___	___
22. Are students involved in planning health instructional activities?	___	___	___
23. Has the school board appointed a school health advisory board made up of parents having children attending the district's schools, educators (e.g. administrators, teachers, professional staff), local clergy, community health professionals, and other interested citizens?	___	___	___
24. Are current health education periodicals and health reference material available for classroom use?	___	___	___
25. Is the school health services component integrated into the total comprehensive health program?	___	___	___
26. Do community resource persons participate in the health education program?	___	___	___

* 27. Please check the appropriate boxes in the following graph where the 10 topical health education areas are taught in your school (for further clarification as to what is included in each area, refer to the "Minimal Performance Objectives for Health Education in Michigan document).

GRADE	1	2	3	4	5	6	7	8	9
Disease Prevention and Control									
Personal Health									
Nutrition									
Growth and Development									
Family Health									
Emotional and Mental Health									
Substance Use and Abuse									
Consumer Health									
Safety									
Community Health									

*Your school building has been identified as containing grades 9-12. Please answer questions 5, 16, 27, 28 and 29 of part I, and question 1 of part II as they apply to your school building. Thank you.

	Yes	No	N/A
28. Does the "minimum Performance Objectives for Health Education In Michigan" serve as a guide for your school district's health curriculum?	___	___	___
29. Are pre-tests and post-tests given in all 10 areas (as defined by the "Minimal Performance Objectives for Health Education In Michigan") of the health education curriculum?	___	___	___

The results of this survey will be used to determine the statewide status of school health education in Michigan. Individual school buildings will not be identified, with the exception of assistance referral (Question #3 Part II), all answers will be held in strictest confidence by the Michigan School Health Association.

PART II

Please answer the following open ended questions as they pertain to your school building. Be as specific as possible, and attach additional pages as required.

1. Do you consider the "Minimal Performance Objectives for Health Education In Michigan" applicable to your school district? If not, why?

2. What do you believe are the major improvements which could be made within your school district to enhance the development of a comprehensive school health education program? (ie. needs assessment, inservice training, curriculum development, integration with community professionals, healthful school environment, etc.)

3. Do you believe your school district would like assistance from the State of Michigan Department of Education in expanding or developing a comprehensive school health education program? If so, in what areas? (see above)

If you would like a copy of the MSHA Survey Final Report, please check the box below. Thankyou.

☐ FINAL REPORT BOX

Return all surveys to:

MSHA SURVEY
Suite 340, Nisbet Building
1407 S. Harrison Road
East Lansing, MI 48823
Phone (517)337-3413.

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