

A COMPARATIVE STUDY OF THE EMPHASIS PLACED ON MAJOR
HEALTH STRANDS BY ELEMENTARY CLASSROOM TEACHERS

by

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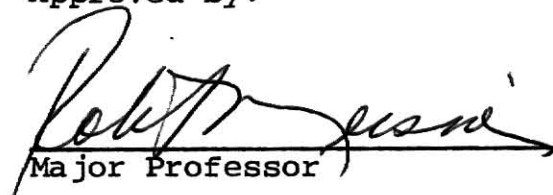
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CHAPTER 1

INTRODUCTION AND BACKGROUND

A sudden emergence of public and professional interest in health education is being fueled by national and international trends converging on the issues of self-help, prevention, and health promotion.

In the keynote address at a National Interagency Council on Smoking and Health conference meeting, January, 1978, HEW Secretary Joseph Califano set forth several new departmental initiatives on smoking and health. ". . . , I will urge the Chief School Offices of the fifty states to develop comprehensive health education programs dealing with the dangers of smoking in every school system in the country. I have made the same request in a letter to each one of the nation's 16,000 school superintendents, and have pledged cooperation and support from HEW and the United States Office of Education" ¹

Concurrently the Superintendent of Schools of USD #259 requested that health education be reviewed in the Wichita Public Schools.

¹Bureau of Health Education, Focal Points, U.S. Dept. of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Atlanta, Ga., April, 1978. Publication No. 2L9118748.

The Curriculum and Pupil Services Divisions cooperatively organized the study. A committee was established to carry out the assignment. This researcher served as one of the co-chairpersons.

The Health Education Review Committee selected as one of its tasks a survey of classroom teachers to ascertain and document what is being taught in health education curriculum as indicated by classroom teacher responses to a mailed questionnaire. (Appendix A contains a copy of a Position Paper on Health Education, USD #259, modified by this committee in January, 1979.)

Statement of the Problem

Alternative health education units are being utilized in the district.

This study will compare the utilization of an adopted textbook in health, specific curriculum guides and the utilization of resource programs and personnel by classroom teachers who have been trained and are implementing the School Health Curriculum Project (SHCP) in their classrooms with teachers who are not implementing SHCP in their classrooms.

The SHCP provides experiential health education activities in units designed for grades two through seven, each unit focusing on a different body system. In 1978-79 SHCP had expanded from a pilot program in 1972 that involved fifty-five fifth grade students to 93 units at six grade

levels in 45 different elementary schools. (Appendix B contains Classroom Implementation Chart.)

The successful inclusion of units from the model curriculum involved the close coordination of principals, classroom teachers, school nurses and a wide variety of community organizations. The curriculum design had been well conceived and field tested before placed within the curriculum at a particular school. In addition, each school who wished to participate indicated their interest on a voluntary basis and preceded their participation by involvement of key personnel in an intensive summer workshop.

At the elementary level, in grades one through six, there was an adopted health text entitled "The Healthful Living Program" published by Laidlaw. Each of the texts were organized spirally and present content and activities in health education around major health themes or strands. These strands included: nutrition; health knowledges, attitudes, decisions, and behavior; mental and social health; growth and development; safety and first-aid; diseases and disorders; environment; health information, products and services; dependency causing substances; and health organization.

Board of Education Policy P6317.00 defined the time allocations for health as well as for other subjects. The policy suggested that the teacher devote 100 minutes of health instruction per week in kindergarten, and 50 minutes

per week in grades 1 through 6. In addition, the same policy allotted 75 minutes per week in kindergarten for physical education of a structured nature; 100 minutes per week in grades 1, 2, and 3; and 125 minutes per week in grades 4, 5, and 6. These allotments were in addition to scheduled non-structured recess periods. The adopted health series was designed partially to address goal #8 listed in the official statement of educational philosophy by the Wichita Public Schools. Goal #8 reads as follows:

"Health

In achieving this goal, areas which include the following will be emphasized:

1. Physical Fitness
2. Mental Health
3. Emotional Maturity
4. Understanding and appreciation of the importance of good health to an effective life
5. Health habits and safety."

The two guides, Human Growth and Development, 1967, and Drugs: Use and Abuse, 1968, were developed and published under the auspices of the Wichita Public Schools Curriculum Division. These were available for use by classroom teachers as resource material.

Significance of the Problem

There is much variation in the way health education is offered in schools, and this variation seems to evolve

largely from policies of individual school districts and community level of interest as well as mandates in state educational codes. Very few districts provide comprehensive health teachings from kindergarten through twelfth grade. Most offerings are sporadic and fragmented with specific offerings at selected grade levels. Classroom implementation by teachers and course selection by students is quite often optional.

A statewide study evaluating the health knowledge of 1742 freshman students enrolled at 22 institutions of higher education in Kansas during the 1976-77 academic year was to determine areas of strength and weaknesses for the purpose of improving the quality of health instruction programs in the state.

When the results of the Fast-Tyson Health Knowledge Test were analyzed by content area, indications were that the subjects were not strong in any content area. The subjects did display moderate strength in the areas of safety/first aid, consumer health and mental health. The content areas found to be the weakest were nutrition/diet, tobacco/alcohol, drugs and diseases.²

The need for better and more consistent health education curriculum planning and development became apparent.

²The Kansas School Health Education Study, Parris R. Watts, HSD, Director Division of Health, Physical Education, Recreation, and Athletics, Emporia State University, Emporia, Kansas, 66801, September, 1977.

"In educational parlance, curriculum development generally refers to the systematic selection of goals, content, teaching methods and materials, and evaluation procedures for a given topic of study. Curriculum planning in schools is typically a committee function, ideally taking into account suggestions and concerns of parents, community representatives, and students as well as faculty and administration."³

Data generated from this study should be useful to Health Educators who are being held more accountable for their expenditures on health education and their consumption of precious curriculum time for health teaching. In the age of competency-based instruction and criterion-referenced testing, the educational system needs more hard data for justification of such decisions.

Recent preliminary survey data indicated that the SHCP is being used by over 4,000 teachers in nearly 1,000 schools, in 34 states in this country.⁴

In May, 1979, the fifth, sixth, and seventh grade levels of the SHCP achieved national validation by the Joint Dissemination Review Panel of the United States Office of Education and the National Institute of Education. The Panel was created to assure that replicable education

³Health Education Planning a Diagnostic Approach, Green, Kreuter, Deeds, Partridge, The Johns Hopkins University, Mayfield Publishing Company, 1980

⁴The School Health Curriculum Project: Its Theory, Practice, and Measurement Experience by Green, Heit, Iverson, Kolbe, Kreuter; Bureau of Health Education, Center for Disease Control, Atlanta, Georgia 30333, 1980. (in print)

interventions have exhibited positive impacts before they are endorsed by the government or disseminated with federal monies. SHCP was the first health education curricula to receive such recognition.

Hypothesis

There is no significant difference in the degree of emphasis placed on the eleven strands (i.e., nutrition; health knowledges, attitudes, decisions, and behavior; mental and social health; growth and development; safety and first-aid; diseases and disorders; environment; health information, products and services; dependency causing substances; and health organization) in the elementary health textbook ("The Healthful Living Program" published by Laidlaw) by classroom teachers who have been trained and are implementing the School Health Curriculum Project in their classrooms and those teachers who are not implementing SHCP in their classrooms.

Definitions of Terms

For the purpose of this study the following definitions will be used:

1. Health Education - any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health.⁵

⁵Health Education Planning A Diagnostic Approach, Green, Kreuter, Deeds, Partridge, The Johns Hopkins University, Mayfield Publishing Company, 1980, page 9.

2. School Health Curriculum Project - an innovative approach to help children learn how their bodies function, what affects their bodies, and how to make better health choices throughout life. It has been described as a curriculum, a method, and a training program.⁶

3. Strands - refers to identifiable concepts or themes threaded through the spiral organization of the adopted health textbook.

⁶The School Health Curriculum Project, U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education, Atlanta, Ga., December, 1977. HEW Publication #(CDC) 78-8359.

CHAPTER 2

REVIEW OF LITERATURE

Introduction

Competence in exploring physical and emotional feelings, the ability to access one's own need for seeking assistance, and being knowledgeable about the community's health care facilities are becoming increasingly important in today's complex society. Teaching these life skills is one of the challenges facing public schools.

School Health Programs

School health means different things to different people and varies from one community to another. It can mean only the traditional "band-aids and first-aid", a method of guaranteeing access to health care providers for all children, routine screening procedures as mandated by state law, or a combination of some or all of the above. Today many school health programs include educational activities also.

In the past, school health has been approached on the basis of a supplemental service, but not of practical importance. In general, school health programs have been faced with three major constraints: A tradition of low visibility and low priority, a narrow definition of the appropriate content and jurisdiction for health educators' efforts, and

according to many observers, a shortage of adequately prepared health educators.⁷ Financial constraints on education are increasing, so careful selection of health care resources for schools are becoming increasingly important.

Health education activities must compete with other school "basic" curriculum items for teaching time as well as financial and inservice costs.

Communities are beginning to recognize that differing needs and resources dictate different options for the scope and nature of the health program.

In 1977, recognizing an existing need the Lincoln Public Schools, Lincoln, Nebraska, developed a K-12 Health Education Study. Data for the study was gathered from the community and parents; teachers and students were surveyed about scope suggestions. "Our health education program should provide sequential and progressive learning experiences from grades kindergarten through twelfth in broad content areas To segregate one area of health behavior and develop a separate curriculum is a useless process.

The scope of the Health Education Curriculum should be derived from the health needs of Lincoln, the individual needs of students, the legal requirements of Nebraska, Lancaster County, and Lincoln. Objectives are derived from these needs and a comprehensive course developed.

⁷Bureau of Health Education, Focal Points, U.S. Dept. of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Atlanta, Georgia, July, 1977. Publication No. 2K7221677.

Looking at the actual instruction in health classes, we are beginning to see a balance between the memorization of facts and the acquisition of skills of problem solving. Content should be used as a means to motivate students to think and not only to regurgitate facts."⁸

Five states had legislation requiring comprehensive school health education by which specific content is indicated by specific grades: Florida, Illinois, New York, South Carolina and Virginia. An additional thirteen states had general laws requiring health education but with no specific provisions for what to teach or in what grades. However, some of these states did require instruction on specific health subjects at specific grade levels.⁹ Five states had no requirements for any health education. Nine states required instruction on sexually transmissible diseases. Instruction was included as part of instruction on communicable diseases; community, family or personal health; or sex education.

Instruction on dependency causing substances was most frequently required by state legislation with thirty-six states giving specific mandates or recommendations for inclusion in the curriculum.

⁸Unpublished, Lincoln Public Schools, Lincoln, Nebraska, K-12 Health Education Study - 1977, Issue: Scope and Sequence.

⁹School Health In America, A Survey of State School Health Programs, 2nd. Edition, Castile, Jerrick, U.S.Dept. HEW, Public Health Service, Center for Disease Control, Bureau of Health Education, Atlanta, Georgia 30333.

In New York, North Carolina and Ohio the mandates requiring health education are specific only in the drug-related areas. Nebraska even names specific drugs upon which special instructional emphasis should be placed. Delaware is working with the state drug office to obtain a full-time person to work with drug education.

Major thrusts are currently under way in several states that will lead to improvement of school health programs. The State Department of Education in California developed materials and establishing inservice training programs for teacher education institutions. Wyoming and Idaho were working to develop guidelines and recommendations for a comprehensive health education training at university level.

The 1978 Florida Legislature amended the Comprehensive Health Education Act of 1973 and provided an annual appropriation of one-million dollars as categorical funding for health education.

Maine had a two-million dollars, four-year program funded to implement K-12 Health Education with sixteen sites operating. Each site was to provide training for six more sites.

Some states such as Virginia and South Carolina were mandating separation of certification for health and physical education.

A chart entitled State School Health Education Programs has been included in Appendix C.

School Health Curriculum Project

SHCP comprised health activities for grades two through seven. It had been described as a curriculum, a method and a training program. It focused on the human body and the maintenance of that body in good health. It was designed to involve and motivate students, teachers, principals, school district administrators, school health staff, community resource people, voluntary agencies, and the student's families. It was to enhance other school subjects, such as reading, writing, arithmetic, science, and the creative arts. The project was fully integrated with life and personality development of the children by providing situations in which the children assumed responsibility, make decisions, share knowledge, research ideas, and create activities to illustrate their comprehension and their internalization of concepts and attitudes.¹⁰

The SHCP had approximately an eleven year old history. The concept for the curriculum was initially developed out of the efforts of two public school educators associated with school districts in the state of California. The National Clearinghouse for Smoking and Health took an interest in their efforts and began funding

¹⁰The School Health Curriculum Project, U.S. Dept. of Health, Education and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education, Atlanta, Ga. 30333, December, 1977. HEW Publication No. (CDC) 78-8359.

the further development, listing, and national dissemination of the emerging curriculum. Responsibility for coordination of the development and dissemination of the curriculum was transferred to the Bureau of Health Education of the Center for Disease Control in 1974. Presently, coordination and management of SHCP program development activities reside within the aegis of the National Center for Health Education in San Bruno, California, a private sector non-profit organization under contract to C.D.C.

The model consisted of a curriculum and a teaching plan for the inservice training of teachers in health education. To become a project member, a school team had to be willing to participate in a training workshop.

A school team consisted of at least two grade-level classroom teachers, a building administrator, and one or two other school professional staff members (such as a health education coordinator, school nurse, audiovisual coordinator, curriculum specialist, or school librarian). The members of the team learned the unit by actually performing every activity prescribed in the unit as it was to be taught to the students.

Adams County School District #12 had approximately 20,000 students located in the suburban areas a few miles north of Denver, Colorado. Inservice evaluation was included as part of a study of SHCP during the 1977-78 school year. Experiencing the role of a student was considered an effective way of learning about the program by 88 percent of the

participants. Eighty percent of the teachers felt that they would be able to use or had used the teaching techniques utilized by the project in other classes. Teacher attitudes were generally positive toward the program. Nearly half reported that they have changed some of their own health habits since teaching the unit, and a third attributed change to the program.¹¹

A model unit was a comprehensive nine to twelve week study of a body system. Each unit included an introduction, five phases and the culminating activities. Presently, six curriculum units (Grades 2-7) are available. Each unit's conference theme is a particular body system. While the content of each unit builds upon the structure of content in previous units, no prerequisite requirements were specified.

Although the SHCP was not developed from an explicitly identified theoretical base, the structure of the curriculum, training of teachers, and teaching methodology could be linked to sound teaching and learning theory. The curriculum content and teaching methodology revealed that the SHCP is consonant with several important elements of Piaget's developmental theory as well as the main themes of theoretical positions espoused by John Dewey and Carl Rogers.¹²

¹¹Evaluation of the SHCP (Berkeley Model) in School District No. 12, Adams County, Colorado.

¹²Summary Evaluation Report (SHCP), Green, Heit, Iverson, Kolbe, and Kreuter, 1980.

A number of partial evaluations have been attempted over the past several years. Yet none of these evaluations was able to provide answers to the important questions regarding the effectiveness of the SHCP.

One such study, "Analysis of the Long Range Effects of the SHCP: Grade 5" was conducted by Burks, Olsen, and Redican in Arkansas. The purpose of the study was to analyze the permanence of cognitive and affective changes effected by exposure to the fifth grade unit of the SHCP. Four hundred students were given pre tests (28 affective items and 35 multiple choice cognitive items), exposed to the prototype curriculum and were then given a post-test. Three years later these same students were tested using a modified form of the initial test instrument.

Although there was some regression in the cognitive mean scores at the time of the three year follow-up, the cognitive retention for the total group remained above 80 percent. This is in direct contrast with other research which shows as much as 80 percent loss as short as one year following instruction. The affective scores also remained very high.¹³

Many evaluation studies have been carried out to this point, but all or most have measured only limited areas of the whole project.

¹³International Year of the Child in School Health, Abstracts of the 1979 Research Council Scientific Forum, 53rd. Annual Convention, San Diego, California, October 1979, pg. 31.

A Summary Analysis of Twenty-four SHCP Evaluation Efforts can be found in Appendix D.

Future evaluation efforts in school health education should focus upon measurement of foundation and health-maintenance skills along with measurement of cognitive growth and select behaviors. For this reason, the Bureau of Health Education has contracted with Development and Evaluation Associates to design a comprehensive evaluation plan.

CHAPTER 3

METHOD

Description of Subjects

The Wichita Public Schools (USD #259) serves Wichita, the largest city in Kansas. Over 43,000 pupils are enrolled in pre-kindergarten through grade twelve in seventy-four elementary schools and twenty-five secondary centers. USD #259 serves a multi-racial population which includes 1.43 percent Native Americans, 2.13 percent Hispanics, 2.2 percent Asians, 18.9 percent Blacks, and 73.5 percent Caucasians. With a long history of involvement in multi-agency projects and a long-term commitment to health education, USD #259 has successfully operated over twenty federally funded projects with an enviable record of fiscal and program accountability. Appendix E contains A Numerical Report of Teaching Positions, Elementary Level for the Wichita Public Schools, 1979.

In May, 1979, survey instruments were distributed to 247 Wichita Public Schools elementary classroom teachers.

Sample

A twenty percent sample of classroom teachers (every fifth name) was selected from alpha building rosters, utilizing P-017-015 program in Data Processing. The following groups were excluded from the universe:

- a. Special teachers (music, P.E., etc.),
- b. Special Education classroom teachers,
- c. Nurses, Counselors, speech clinicians,
- d. Principals and other building level administrators.

Distribution

Survey forms were distributed through the school offices by the Wichita Public Schools' mail system under the auspices of the Pupil Services Division. Arrangements were made for return of the responses through the school mail to the Research Department to preserve the anonymity of the respondent. Samples of directions for return, cover letter and survey instrument are in Appendix F.

Responses were received from 134 elementary teachers (81 primary grade level; 53 intermediate grade level) with 111 usable responses for this study.

Research Design and Procedures

The survey instrument was designed by the elementary level participants of the Health Education Review Committee. The committee consisted of representatives from Central Administration, Pupil Services Division, Curriculum Division, Health Services, building level administration, and classroom teachers from both primary and intermediate grade levels.

Four items were selected that committee members felt covered the most appropriate areas. Respondents were asked

to designate the emphasis placed on eleven major health strands as outlined in the adopted health textbook on a four point scale: much, some, little, none.

Items two and four refer to the utilization of specific curriculum guides, programs, and community resources available to classroom teachers for optional use.

Item three, "Which of the School Health Curriculum Project: Wichita Model (SHCP-WM) have you participated in this year?", formed the dicotomy upon which this study was based.

Description of Measures Employed

Data from the four items on the survey instrument were analyzed separately since each item dealt with a specific content and was tested with instruments specific to that content.

The dichotomous groups defined by Item three were designated as follows:

Group I - participants SHCP

Group II - non-participants SHCP

The t-test for dependent means were calculated on the four point scale used to measure the emphasis placed on each strand outlined in the health textbook.

Frequency of utilization was calculated for the specific curriculum guides, programs and community resources listed in Items 3 and 4.

CHAPTER 4

RESEARCH FINDINGS

Respondents

Usable responses for this study were received from 111 classroom teachers of which 24 were participants SHCP (Group I) and 87 were non-participants (Group II). Tabulation of respondents by grade level follows:

Primary

Pre-kindergarten	2
Kindergarten	9
First grade	14
First/Second combination	7
Second grade	12
Second/Third combination	4
Third grade	<u>15</u>
	63

Intermediate

Third/Fourth combination	2
Fourth grade	10
Fourth/Fifth combination	3
Fifth grade	18
Fifth/Sixth combination	1
Sixth grade	<u>14</u>
	48

Hypothesis

There is no significant difference in the degree of emphasis placed on the eleven strands (i.e., nutrition; health knowledges, attitudes, decisions, and behavior; mental and social health; growth and development; safety and first-aid; diseases and disorders; environment; health information, products and services; dependency causing substances; and health organization) in the elementary health textbook ("The Healthful Living Program" published by Laidlaw) by classroom teachers who have been trained and are implementing the School Health Curriculum Project in their classrooms and those teachers who are not implementing SHCP in their classrooms.

Presentation of Data

Table 1 presents a comparison of the mean scores compiled from the 111 responses to item 1 of the survey instrument. Mean scores in Strand I (dependency causing substances) for Group I were found to be significantly higher at the 0.05 level. Strands E (disease and disorder), J (health organization), and use of the teacher's edition of the textbook, for Group I approached significance.

Mean scores for Strands A (health knowledge, attitudes, decisions and behavior), B (mental and social health), C (growth and development), D (safety and first-aid), and F (nutrition) were all slightly higher for Group II,

Table 1

A Comparison of Mean Scores for Participants (Group I)/
Non-Participants (Group II) SHCP-Classroom Teachers

Strand	Group	No. Cases	S.D.	Mean	t
A	I	24	0.659	2.5000	-0.70
	II	84	0.562	2.5952	
B	I	24	0.737	2.2500	-0.60
	II	84	0.668	2.3452	
C	I	23	0.619	2.2609	-0.71
	II	84	0.655	2.3690	
D	I	24	0.690	2.2917	-1.94
	II	85	0.586	2.5647	
E	I	23	0.674	2.0000	1.76
	II	82	0.784	1.6829	
F	I	24	0.654	2.5833	-0.50
	II	86	0.569	2.6512	
G	I	24	0.588	2.2083	0.60
	II	80	0.711	2.1125	
H	I	23	0.864	1.7391	1.57
	II	78	0.845	1.4231	
I	I	20	0.887	1.9500	3.28*
	II	81	0.981	1.1605	
J	I	15	0.799	1.733	1.88
	II	55	1.056	1.1818	
K	I	21	0.784	1.7143	0.55
	II	59	1.054	1.5763	
Teacher's Edition	I	11	0.467	2.7273	1.97
	II	25	0.898	2.1600	

*Significance beyond the 0.05 (1.98 required)

resulting in a negative t-score. Strand D (safety and first-aid) was the only Strand approaching significance for Group II.

Frequency responses concerning access and utilization of the Human Growth and Development and Drug: Use and Abuse Curriculum Guides are listed below:

Human Growth and Development Guide

69.4 percent frequency - access

56.8 percent frequency - utilization

Drugs: Use and Abuse

57.7 percent frequency - access

36.9 percent frequency - utilization

Fifty-three teachers indicated involvement with the National Preventative Dental Demonstration Program (PPDDP), twenty-three indicated involvement in and use of the Health Activities Program (HAPS) and nine indicated use of the Low Income Dental Program.

NPDDP and HAPS utilized classroom activities while the Low Income Dental Program involved students on an individual basis.

Table 2 depicts the frequency of utilization of auxiliary school personnel and community resources available for use with the health education curriculum.

Table 2

Utilization of Auxiliary School Personnel and Community
Resources in Health Education Curriculum

No. Responses indicating use	Resource	Relative frequency percent
<u>Auxiliary School Personnel</u>		
104	Nurse	93.7
49	Counselor	44.1
29	Psychologist	26.1
27	Social Worker	24.3
23	Paraprofessionals	20.7
<u>Community Resources</u>		
73	Wichita Dairy Council	65.8
56	Wichita Police Department	50.5
43	Wichita Fire Department	38.7
34	Parent	30.6
32	American Red Cross	28.8
29	Hospitals	26.1
29	Tel Med Tapes	26.1
27	Personnel Contacts	24.3
25	Health Related Personnel	22.5
20	Health Associations	18.0
20	Wichita Council on Drug Abuse	18.0
14	Wichita Department of Health and Environmental Services	12.6
14	Halstead Health Museum	12.6
14	Sedgwick Co. Extention Services	12.6
13	Wichita Water/Pollution Department	11.7
13	Kansas Gas and Electric Company	11.7
9	Wichita Wheat Council	8.1
3	Insurance Companies	2.7

CHAPTER 5

SUMMARY

Discussion

A significant difference in the major emphasis placed on major health concepts by teachers implementing SHCP and those not involved in classroom implementation was found only in the area of dependency causing substances. Instruction on drugs, alcohol and tobacco is the most frequently mandated by state legislation. Reviewing the former evaluations of SHCP elicits no known evaluative studies in this particular area. This may be an issue worthy of future research.

High School Seniors in an appeal for early education about drugs said, "Teach us the good and bad about drugs, but teach us the truth. Teach the cost in dollars, that it is high priced and a necessity when addicted, and leads to becoming thieves and prostitutes. Teach us how social problems relate to narcotics addiction."¹⁴

The slightly higher mean scores in the areas of safety/first-aid and food/nutrition are consistent with past research. In an attempt to deal with health subject matter

¹⁴Ruth V. Byler, Gertrude M. Lewis, and Ruth J. Totman, Teach Us What We Want To Know (Mental Health Materials Center, Inc., New York, New York 10016).

in a more meaningful way the School Health Education Study (SHES)¹⁵ presented a conceptual approach to curriculum design. Accident prevention and food and nutrition were among the five areas SHES found taught most consistently and repetitively by elementary classroom teachers. The Kansas School Health Education also found that safety/and first-aid was an area in which freshmen college students had shown moderate knowledge. However, nutrition and diet was one of the weaker areas.

Frequency of utilization of the Wichita Dairy Council, the Wichita Police and Fire Departments is consistent also with the higher mean scores in these areas.

Conclusions

1. A significant difference was found on the emphasis placed in the health education area of dependency causing substances for those teachers implementing SHCP in the classroom.

2. The mean scores for teachers not implementing SHCP were slightly higher in the areas of health knowledge, attitudes, decisions, and behavior; mental and social health; growth and development; safety and first-aid; and nutrition. However, safety and first-aid was the only area of emphasis that approached significance.

¹⁵School Health Education Study, Summary Report of a Nationwide Study of Health Instruction in the Public Schools, Elena M. Sliepcevich, Director, 1961-63, Samuel Bronfman Foundation, New York City.

3. Responses indicated that teachers utilized the school nurse as a health education resource in the classroom twice as frequently as other auxiliary school personnel. The Wichita Dairy Council and the Wichita Police and Fire Departments were the most frequently utilized community resources.

Implications

At present, most teachers seem to include in their classroom teaching, areas of health education with which they are most comfortable and as time allows. The SHCP not only includes resources for teaching drug education, but through its training program offers the opportunity for teachers to become more knowledgeable and comfortable with the material.

Two intervening variables may have influenced the responses of the teachers in regard to the emphasis placed on major strands from the adopted textbook. Teachers implementing SHCP develop lesson plans from a prescribed model curriculum which does not include the adopted text and may not have identified with these particular strands which were so closely related to that text.

Also several responses indicated displeasure with this particular Health textbook. Listed below are comments from two of the survey instruments.

"Very poor book."

"The current texts are not worth the paper

they're printed on. There are few facts, poor content, poor illustrations. Fifth graders need to see and need to be able to relate to their changing bodies. It's too soon to start with public health and theories. They need concrete information."

Several teachers indicated also that while use of the textbook itself was low, health education was being incorporated into the curriculum through an interdisciplinary approach.

The unequal size of the groups may also have resulted in skewed scores. Further study with an equal number of responses randomly selected from Group II (non-participants SHCP) might demonstrate more differences. Further testing in this area seems to be indicated.

The highest mean scores for both groups appeared in the nutritional area. Inexpensive and free resource material was readily available for classroom use by teachers from both groups. The Wichita Dairy Council has made available free classrooms materials for kindergarten, second, and fifth grade teachers willing to attend short and easily accessible inservice training sessions for suggested use of these materials. Frequency of utilization of the Wichita Dairy Council listed as a community resource was consistent with the higher mean scores for this listed strand.

Recommendations

Since existing research generally supports the value of quality inservice training for teachers, further testing of the data generated by this study with more equal group sizes seems to be indicated.

Revisions of the fifth and sixth grade curricula of SHCP contain updated material for drug education. With the emphasis placed on drug education by the state legislative bodies, further research to explore the significant difference for teachers implementing SHCP, could be of value to health educators involved in curricula planning.

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APPENDIX A
MODIFIED POSITION PAPER

A Position Paper
on
Health Education
USD 259
Wichita, Kansas

Recognizing the fact that many fine aspects of health education are already occurring at all levels of our school system, and that good health is a valuable asset in life, it becomes imperative that a coordinated and comprehensive health education program be implemented in USD 259. The school is a setting in which individuals spend many hours during their formative years--more if we include early childhood programs, college education, and continuing education for adults. If our pupils are to function as health-educated adults, then the total health of the pupil during his maturing years is of priority concern.

It is of primary importance that we eliminate the traditional crisis approach to health education and redirect our health goals toward a preventive--and constructive--approach to health through health education for every pupil. This preventive focus, therefore, is the goal towards which the rationale of this position paper will be directed.

Health has been defined as the absence of pathological disorders and a perceived sense of well-being. Thus, the health needs of human beings are multidimensional. They include emotional, mental, and social as well as physiological needs. If people are to approach optimum health, they must be aware of and attempt to fulfill each dimension. All learning experiences in the health education program should be based on this principle.

For the purposes of this paper, health education is defined as a learning process utilizing physiological, psychological, and social dimensions related to activities which increase the abilities of people to make informed decisions affecting their personal, family, and community well-being. This process, based on scientific principles, facilitates desirable behavioral change.

A comprehensive school health education curriculum includes all the health experiences in the total school curriculum which affect the learning and behavior of pupils. These experiences can be gained in both school and community settings as the pupil interacts with his peers, school personnel, parents, and community members.

Education for and about health should not be synonymous with the mere acquisition of information. It is rather concerned with behavior, and is a composite of what one knows, senses, values, and practices. An individual who has been educated in health is one who possesses attitudes and exhibits behaviors that will last a lifetime and will lead to a positive life style according to personal choice. Its primary purpose is to help people find and maintain patterns of living that will prevent disease and further optimum health, thus improving the length and quality of life.

A coordinated health education program is vital for the following reasons:

- "Health" is one of the cardinal principles of education and is included in USD 259's statement of educational philosophy.
- A school district has a responsibility to those it serves to introduce and reinforce, through an educational continuum, certain basic health knowledges.
- Schools need to exhibit responsibility in what they present or include in their educational program.
- A pupil's health is directly related, and basic, to all other facets of learning and living.
- Health knowledge leads to changes in attitudes, decisions, and behavior.
- It is important that pupils obtain the necessary tools for coping with today's complex way of life.
- Well-planned health education leads to improved social interaction, greater responsibility to society (preserving the environment), and a higher level of personal decision-making.
- It will provide sequential direction to teachers/staff.

A comprehensive school health education program is one that will provide health knowledge. With this knowledge pupils will develop a growing awareness of healthful living that will enable them to form positive health attitudes. Pupils who have the opportunity to form positive health attitudes are better equipped for the kind of decision-making that will help them to have a health expectancy comparable to their life expectancy.

All persons enrolled in USD educational programs should have access to a continuing health education program designed to meet the needs of all ages from pre-kindergarten into adult education.

A comprehensive health education program will introduce basic concepts which can be enriched and broadened to meet the needs of all persons involved. It should be sequential, developmental, and provide education for the total person. In order to promote wellness and health maintenance, it should include the following:

- Consumer education (health services and agencies, health insurance, products, quackery and charlatanism)
- Diseases and disorders (communicable and chronic diseases--prevention and treatment, malfunction of body and mental systems)
- Environment (school, home, neighborhood, pollution, pesticides, radiation, balance in nature)
- Food and nutrition (food groups, diet, meaning of nutrition, weight control)
- Health careers (professional and paraprofessional health personnel)
- Human life cycle (genetics, birth, growth, family life, and death)
- Physical-emotional-social health (feelings, relationships with others, stress, individuality and physical fitness)
- Safety and first aid (accidents, meaning of safety, dealing with emergencies, causes of unsafe behavior)
- Substance use and abuse (safe and unsafe products and foods, drugs, alcohol, tobacco, and medications)

The alphabetical listing is deliberate because no one content area is considered more important than another. Items listed in parenthesis are samples and not meant to be all-inclusive.

APPENDIX B
IMPLEMENTATION SUMMARY

IMPLEMENTATION SUMMARY •
SCHOOL HEALTH EDUCATION CURRICULUM PROJECT

SCHOOLS	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80
ADAMS							LU	LU
ALLEN							HE	
ARKANSAS AVENUE						HE LU	LU	LU DI
BENTON							K-3	DI K-3
BLACK			HE	HE	DI	DI	DI	DI
BOOTH			HE	HE	HE	LU	LU	LU DI
BRYANT			HE	HE	HE	HE	HE	HE EYE DI EAR
BUCKNER			LU			DI	LU	LU
CALDWELL								
CARTER								DI
CESSNA				HE	HE	EYE DI HE	DI HE	EYE DI
CHISHOLM			HE	HE				
CHISHOLM TRAIL				HE	HE DI	HE DI EYE LU	HE DI EYE LU	HE DI EYE LU
CLARK	LU	LU	LU	LU	LU	LU		
CLEVELAND								DI
CLOUD								
COLLEGE HILL								
COLVIN						LU	LU	LU
DODGE						LU	LU	LU
EARHART								

* Table for interpretation of Code on page 5.

Page 2

IMPLEMENTATION SUMMARY *
SCHOOL HEALTH EDUCATION CURRICULUM PROJECT

SCHOOLS	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80
EMERSON							HE	
ENTERPRISE				HE				
FABRIQUE			LU	LU	LU	LU	LU	LU EYE
FIELD						HE	HE	HE EYE
FRANKLIN				HE	HE	HE LU	HE LU	HE LU DI
FUNSTON				HE	HE	HE LU	HE LU	HE
GARDINER						EYE		
GARRISON								
GREIFFENSTEIN				LU		DI	DI	DI
GRIFFITH								
HARRIS				HE	HE	HE	HE	
HARRY STREET								
HORACE MANN							HE	HE
HYDE						HE	HE LU	HE LU
INGALLS		HE	HE LU	HE LU DI	HE LU DI	HE LU DI EYE	HE LU DI EYE	HE LU DI EYE EAR
IRVING								
JEFFERSON								
KELLOGG							HE	HE
KELLY							EAR LU	EAR LU EYE

* Table for interpretation of Code on page 5.

IMPLEMENTATION SUMMARY *
SCHOOL HEALTH EDUCATION CURRICULUM PROJECT

SCHOOLS	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80
KENSLE			HE	HE LU	HE LU DI	HE LU DI	HE LU DI	HE LU DI EYE
KISTLER							HE LU	HE LU
KNIGHT				HE LU	HE LU DI	HE LU DI	HE LU DI	LU DI
LAKE APTON				LU	LU			
LAWRENCE								EYE
LINCOLN								
LYNWOOD								
LONGFELLOW							LU	LU
L'OUVERPURE								
MCCOLLON				LU	LU DI	LU DI EYE	LU DI EYE	LU DI EYE EAR
MCCORMICK								
MCLEAN						LU	LU DI HE	LU DI HE
MICHENER								
MINNEHA					DI HE	DI HE LU	DI HE LU	LU EAR
MUELLER			LU HE	LU HE	LU HE	LU HE	LU HE	LU HE EAR
O.K.								DI
PARK								
PAYNE					EYE	EYE LU	EYE LU HE	EYE LU HE

* Table for interpretation of Code on page 5.

Page 4

IMPLEMENTATION SUMMARY *
SCHOOL HEALTH EDUCATION CURRICULUM PROJECT

SCHOOLS	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80
PETERSON				HE	HE	HE	HE DI LU	HE DI LU
PLEASANT VALLEY								DI
PRICE								EYE
RIVERSIDE						EYE	EYE LU	LU EAR
RIVERVIEW							HE	HE
SEITZER						HE	HE LU	HE
SIM			HE	HE LU	HE LU DI	HE LU DI EYE	HE LU DI EAR	
SOUTH HILLSIDE			LU	LU HE	LU HE DI	LU HE DI	LU HE DI	LU HE DI
SOWERS								
STANLEY						HE DI	HE DI LU	HE DI LU
STEARMAN				HE	HE	HE	HE DI	HE DI
SUNNYSIDE								
WASHINGTON								
WELLS								
WHITE				LU	LU	LU	LU	
WILSON							LU HE	LU HE DI
WOODLAND							EYE	
WOODLAWN						DI EYE	DI EYE	DI EYE EAR

* Table for interpretation of Code on page 5.

Page 5

IMPLEMENTATION SUMMARY *
SCHOOL HEALTH EDUCATION CURRICULUM PROJECT

JR. HIGH SCHOOLS	1972-73	1973-74	1974-75	1975-76	1976-77	1977-78	1978-79	1979-80
ALLISON				BR	BR	BR	BR	BR
BROOKS				BR				
COLEMAN								
CURTIS								
HADLEY				BR	BR	BR	BR	BR
HAMILTON								
HORACE MANN - (Middle School) See Page 2								
JARDINE								
MARSHALL								
MAYBERRY								
MEAD								
MUNGER				BR	BR	BR	BR	BR
PLEASANT VALLEY				BR	BR	BR	BR	BR
ROBINSON								
ROOSEVELT								
TRUESDELL								
WILBUR				BR	BR	BR	BR	BR

* CODE TABLE

EAR	-	EAR UNIT	-	GRADE 2
EYE	-	EYE UNIT	-	GRADE 3
DI	-	DIGESTIVE UNIT	-	GRADE 4
LU	-	LUNG UNIT	-	GRADE 5
HE	-	HEART UNIT	-	GRADE 6
BR	-	BRAIN UNIT	-	GRADE 7
K-3	-	PILOT PROGRAM	-	KINDERGARTEN - GRADE 3

APPENDIX C
STATE SCHOOL HEALTH PROGRAMS

STATE SCHOOL HEALTH EDUCATION PROGRAMS

State	Health Education	Drugs, Tobacco Alcohol	Venereal Disease	Nutrition	Mental Health	Environmental Health	Family Life/ Sex Education	Personal Health
Alabama		M	Semester of health education required for graduation.					
Alaska	G		Same as Kansas.					
Arizona		O		O	O	O	O	
Arkansas		M	M		M	M		
California	G	M	M	O	O	O	O	M
Colorado	G	M						
Connecticut		M						
Delaware	G	M	O	O	O	O	O	O
District of Columbia		M	M	M	M	M	M	M
Florida	C	M	M	M	M	M	O	M
Georgia		M	O	O	O	O	O	O
Hawaii	G	M	M	M	O	M	M	M
Idaho		M	O	O	O	O	O	O
Illinois	C	M		M	M	M		
Indiana		M						M
Iowa		M	M					
Kansas	Health education is not required; however, one unit of physical education is required for							
Kentucky	G-E	M		O	O	O	O	
Louisiana		M-S	O	O	O	O		O
Maine	G	Subject offerings are option of local school district.						
Maryland	G	M					M	
Massachusetts				M	M	M		
Michigan	G	M	O	M	M		M	O
Minnesota		M	O	O	O	O	O	O
Mississippi	In grades 1-12; health instruction is required, but no specific requirements.							
Missouri		O		O	O	O	O	O
Montana	G							
Nebraska	G							
Nevada	One half unit of health education is required for graduation.							
New Hampshire		M	M	M				
New Jersey	G	M-S	O	O	O	O	O	O
New Mexico	**	O	O	O	O	O	O	O
New York	C-E	M		O	O	O		
North Carolina	G-E	M	O	O	O		O	O
North Dakota		M						M
Ohio		M	M					
Oklahoma	Although no separate program exists, health education content is taught in conjunction with other							
Oregon		M						
Pennsylvania		M						
Rhode Island		M	One hundred minutes of instruction in health and physical education per week is					
South Carolina	*C	M	O	O	O	O	O	O
South Dakota	No formal program at state level.							
Tennessee		M	M	M		M		
Texas	G	M						
Utah		M	O	M	M	M	O	M
Vermont		M						
Virginia	C	M		M	M	M		M
Washington		M						
West Virginia	Instruction in physical and mental health is required at the junior high and high school levels							
Wisconsin	G	O			O			O
Wyoming	Health education is taught according to local education mandates.							

M = Mandated O = Optional/Permissive S = Secondary School Level E = Elementary School Level
 Unless otherwise noted, programs refer to both elementary and secondary levels.

** - See section 6c of New Mexico state data sheet.
 G = general; local option for selection of content and when offered.
 C = Comprehensive; specified content areas for each grade level.

STATE SCHOOL HEALTH EDUCATION PROGRAMS

Anatomy Physiology	Safety	First Aid	CPR	Diseases	Community Health	Dental Health and Oral Hygiene	Health Careers	Consumer Health	Growth and Development
			M						
O	O	O		O	O				O
O	M	M	M	M	M	M	O	O	O
M	O	O		M	O	O	O	O	
M	M	M		M	M	M	O	M	M
M	M			M	M	M	M	M	M
O	O	O		O	O	O	O	O	O
O	M	O		M	M	M	M	M	M
O	O	O		O	O	O	O	O	O
M	M			M	M	M	M	M	M
	M								
graduation of which one half unit may be health education.									
O	O			O	O				
O	O	O		O	O	O	O	O	
M					M	M		M	
O	M	O		M	O	M		O	O
O	O	O		O	O	O	O	O	O
	O	O		O	O			O	
O	O	O		O	O	O	O	O	O
O	O	O		O	O	O	O	O	O
	M	O		O		O		O	
O	O	O		O	O	O	O	O	O
M				M					
subject areas.									
	M-E								
required for all students, K-12.									
O	O	O		O	O	O	O	O	O
M	M	O		M	O	O	O	M	M
	M	M		M				M	M
O	O								

APPENDIX D

A SUMMARY ANALYSIS OF TWENTY-FOUR
SHCP EVALUATION EFFORTS

TABLE ONE: A Summary Analysis of Twenty-four SHCP Evaluation Efforts

Investigators/Study/ Year	Grade Unit	Dependent Variables	Sampling	Instrumentation	Results
American Lung Association of Southeastern Michigan, "School Health Curriculum Project Summary Evaluation Report," 1977	4	(a) Knowledge (b) Student Enthusiasm	603 Students in 7 districts in Michigan	(a) Student Cognitive achievement test (b) Student Enthusiasm assessment instrument	Descriptive (No pretest for comparison)
	5	(a) Knowledge (b) Student Enthusiasm	364 Students in 6 districts in Michigan	(a) Student Cognitive achievement test (b) Student Enthusiasm assessment instrument	Descriptive (No pretest for comparison)
Becklund, Larry W. "Respiratory Knowledge Test for the Intermediate Grades," (Master's Thesis), 1970	5	(a) Knowledge	30 Students in Champaign, IL and 60 students in Los Altos, California	(a) Respiratory Knowledge test (r=.56)	Descriptive (No pretest for comparison)
Bell, Donald A. "A Comparative Study of Two Strategies for Seventh Grade Health Education" (Master's Thesis), 1976	7	(a) Knowledge	250 Students in North Reading, Massachusetts	(a) Knowledge test	Increased knowledge (p < .01)

TABLE ONE: A Summary Analysis of Twenty-four SHCP Evaluation Efforts (Con't)

Investigators/Study/ Year	Grade Unit	Dependent Variables	Sampling	Instrumentation	Results
Carmanica, Feiler, & Olsen. "Evaluation of the Effects of Performance Based Teacher Education on the Health Knowledge and Attitudes of Fifth Grade Students," 1973	5	(a) Knowledge (b) Attitudes (c) Self-reported behaviors	280 Students from three districts in Arkansas	(a) Revision of Becklund's knowledge test (r=.65) (b) Revision of Univ. of Illinois Anti-Smoking Attitude Instrument (b&c) Teen-Age Self-Test Items	(a) Increased knowledge (p<.025) (b) Changed attitudes (p<.025)
Feiler, Ellen G. "Assessment of the Cognitive Effects of the School Health Education Curriculum Project on Selected Fifth Grade Students," (Master's Thesis), 1973	5	(a) Knowledge (b) Self-reported behavior	240 Fifth-grade students from three districts in Arkansas (2 experimental and 1 control group from each district)	(a&b) Revision of Becklund's knowledge test (r=.65)	(a) Increased knowledge (p<.025) (same data reported in study d)
The Health Education Council (of Great Britain) "An Evaluation of One Unit of the American Elementary School Health Curriculum Project," February 1976	5	(a) Knowledge (b) Attitudes (c) Self-reported behaviors	55 Students at Sheffield, England school	(a) Knowledge test (b&c) Modified Teenage Self-test	Descriptive study (increased knowledge and changed attitude pre-to post test)

TABLE ONE: A Summary Analysis of Twenty-Four SHCP Evaluation Efforts (Con't)

Investigators/Study/ Year	Grade Unit	Dependent Variables	Sampling	Instrumentation	Results
The Health Education Council (of Great Britain) "An Evaluation of One Unit of the American Elementary School Health Curriculum Project-- Evaluation Report No. 2," August 1976	5	(a) Knowledge (b) Attitudes (c) Self-reported behaviors	93 students at a Sheffield, England School	(a) Knowledge test (b&c) Modified Teenage Self-test	Descriptive study (increased knowledge and changed attitudes pre- to post test)
Heit, Kaplan & Iammarino "Long-term Effects of Selected Units of the School Health Curriculum Project on Students' Cigarette Smoking Attitudes and Behavior," (Doctoral Dissertation) 1978	5, 6 7	(a) Attitudes (b) Self-reported behaviors	395 Ohio students who received one or more units of the SHCP were compared with 562 who received traditional health instruction and 160 who received no health instruction	(a&b) Supplemented Teenage Self-Test	Changed knowledge and attitudes ($p < .05$)
Insel, Schmida, Alexander, & Poninski "Shifts in Attitudes Towards Smoking Among Pre-Teenagers," 1964	6	(a) Attitudes	8 groups of 265 California students comprising 4 experimental and 4 matched control groups	(a) Student essays about cigarette smoking	Changed attitudes (rho coefficients used)

TABLE ONE: A Summary Analysis of Twenty-four SHCP Evaluation Efforts (Con't)

Investigators/Study/ Year	Grade Unit	Dependent Variables	Sampling	Instrumentation	Results
Lorton, Paul "Evaluation of the Effects of Health Edu- cation Units on the Smoking Attitudes & Behavior of Fifth, Sixth and Seventh Grade Students," 1970	5,6 7	(a) Knowledge (b) Attitudes (c) Locus of control (d) Self- reported behaviors	All students in the 5th, 6th, & 7th grades in San Ramon Valley California School Dis- trict and all those in a neighboring district from 1966 through 1969	(a) Health Knowl- edge Survey (b&d) Health Edu- cation Project Questionnaire (c) Attitude Toward Self- Questionnaire	Increased knowledge changed attitudes among 5th and 6th graders ($p < .05$)
Maida, Anthony "An Empirical Evalua- tion of the Elementary School Health Educa- tion Project." (undated)	5	(a) Attitudes (b) Self- reported behaviors	67 students in Darien, Connecticut	(a&b) Health Smoking Inventory ($r = .95$)	Descriptive students (changed attitudes pretest to post test)
Milne, Colmen, & Stone "A Study of Impact of the Elementary School Health Education Curriculum on Knowledge Attitude & Behavior of Teenage Students, 1974.	5,6 7	(a) Attitudes (b) Self- reported behaviors	815 9th grade students from districts in Washington, West Virginia California, and New York served as an experimental group, 208 served as lo- cal controls, and 760 served as a national control group	(a&b) Teenage Self-test	Changed attitudes and self- reported behaviors ($p < .05$)

TABLE ONE: A Summary Analysis of Twenty-four SHCP Evaluation Efforts (Con't)

Investigators/Study/ Year	Grade Unit	Dependent Variables	Sampling	Instrumentation	Results
Ojanlatva, Ansa "Standardization of a Fifth Grade Smoking Inventory," (Master's Thesis), 1975	5	(a) Attitudes (b) Self- reported behaviors	790 fifth grade stu- dents from 25 districts in New York, Arkansas, Kansas, New Jersey, Penn. and Iowa	(a&b) Revised Univ. of Illinois Anti-Smoking Attitude in- strument	Descriptive study (no pretest for comparison)
Olsen, Stone, & Saunders "Inservice Training for Element- ary School Health Education," 1975	5,6	(a) Success or failure of maintain- ing the SHCP	Two situa- tions (1 success, one failure)	Not applicable	Certain activity seemed asso- ciated with implementing success and failure
Redican, Wilson, Olsen, & Stone. "Cigarette Smoking Attitudes of Lower Socio-economic Sixth Grade Students," (Doctoral Dissertation) 1976	6	(a) Attitudes	141 Black, lower SES stu- dents from East Coast and Mid-west Schools	Teenage Self- test	Changed attitude ($p < .01$)
Redican, Olsen & Olsen, "Effects of a Prototype Health Education Curriculum on Health Knowledge of Lower Socioeconomic Sixth Grade Students," 1978	6	(a) Knowledge	141 Black, lower SES stu- dents from East Coast and Midwest schools (same popula- tion as o)	(a) Cook's Cardio- vascular Health Knowl- edge Test ($r = .86$)	Increased knowledge ($p < .01$)

TABLE ONE: A Summary Analysis of Twenty-four SHCP Evaluation Efforts (Con't)

Investigators/Study/ Year	Grade Unit	Dependent Variables	Sampling	Instrumentation	Results
Redican, Olsen, & Stone "Health Education: A Positive Force in in- creasing the Reading Skills of Low Socio- economic Elementary Students." (undated)	6	(a) Reading Comprehension (b) Vocabulary Skills	64 Midwest Students	(a&b) Iowa Test of Basic Skills (Form 5, Level II	Increased vocabulary skills ($p < .01$)
Regional Educational Service of Appalachian Maryland. "A Progress Assessment of the School Health Education Project of Appalachian, Maryland	5	(a) Knowledge (b) Attitudes	1400 students in Appalach- ian Maryland	(a) Revision of Becklund's Knowledge Test (b) Revision of Univ. of IL Anti-Smoking	No change report at an accept- able level of signifi- cance
Regional Educational Service of Appalachian Maryland. "A Progress Assessment of the School Health Education Project of Appalachian Maryland," 1976.	6	(a) Knowledge	974 Appalach- ian Maryland students	(a) Knowledge In- strument developed by Olsen at the Univ. of Illinois	Descriptive Study (knowl- edge in- crease pre- to post test)
Regional Educational Service of Appalachian Maryland. "A Progress Assessment of the School Health Education Project of Appalachian Maryland," 1977.	7	(a) Knowledge	734 students in Appalach- ian Maryland	(a) Knowledge In- strument developed by Olsen at the Univ. of Illinois	Descriptive study (knowledge increase pre- to post test)

TABLE ONE: A Summary Analysis of Twenty-four SHCP Evaluation Efforts (Con't)

Investigators/Study/ Year	Grade Unit	Dependent Variables	Sampling	Instrumentation	Results
Secarea, Rebecca "An Evaluation Instru- ment for Appraising the Health Knowledge of Seventh Grade Students Participating in a Special School Health Education Project," (Master's Thesis), 1974	7	(a) Knowledge	700 students Washington, California and West Virginia	(a) Brain and Ner- vous System Knowledge Test ($r=.54$)	Descriptive study (no pretest for comparison)
Stone, Elaine "The Effects of a Prototype Health Educa- tion Curriculum Model on Locus of Control, Perceived Vulnerability and Health Attitudes of Fifth Graders," 1976	5	(a) Locus of control (b) Perceived vulner- ability to illnesses & accidents (c) Attitudes toward health concepts (d) Attitudes toward self-esteem (e) Knowledge and atti- tudes about smoking	635 students from Albuquerque, New Mexico	(a) Nowicki- Strickland In- ternal-External Locus of Con- trol Scale for Children (b) Gochman Per- ceived Vulner- ability (c&d) Semantic Differential Health Con- cept & Self- esteem Scale (developed by the investi- gator) (e) Two subtests of the Teen- age Self-test	Knowledge and atti- tude changes ($p < .05$)

TABLE ONE: A Summary Analysis of Twenty-four SHCP Evaluation Efforts (Con't)

Investigators/Study/ Year	Grade Unit	Dependent Variables	Sampling	Instrumentation	Results
White, Albaneppe, Anderson, & Caplan. "Effective Cardio- vascular Health Educa- tion in the Young: An Elusive Goal," 1978	6	(a) Knowledge	577 6th grad- ers and 358 7th graders were compared with 1782 other Iowa students	Iowa Cardio- vascular Test	Increased knowledge ($p < .01$)
Wichita Public Schools "A Report of the School Health Education Curriculum Project, Wichita Model," 1975	5, 6 7	(a) Knowledge (b) Attitudes	718 students in Wichita, Kansas	(a) Knowledge tests (b) Attitude tests	Increased knowledge and changed attitudes among 6th graders Changed attitudes among 7th graders ($p < .05$)

APPENDIX E

NUMERICAL REPORT OF TEACHING POSITIONS

WICHITA PUBLIC SCHOOLS
DIVISION OF PERSONNEL SERVICES

Numerical Report of Teaching Positions
as Reported to the State

1979

Elementary School Level

Regular Educational Program	Number of Positions
Preschool	21.5
Kindergarten	81.1
First Grade	132.7
Combination 1-2	32.0
Second Grade	114.7
Combination 2-3	19.0
Third Grade	115.6
Combination 3-4	19.0
Fourth Grade	111.7
Combination 4-5	25.0
Fifth Grade	101.7
Combination 5-6	22.0
Sixth Grade	103.0
Physical Education	51.5
Art	1.0
Science	1.0
Relief	1.0
	<hr/> 953.5
Special Education--Regular	131.5
Grand Total	1085.0

APPENDIX F
ELEMENTARY LEVEL SURVEY

Wichita Public Schools
DIVISION OF PUPIL SERVICES
640 North Emporia
Wichita, Kansas 67214

May 10, 1979

TO: Principals or Secretaries
FROM: Pupil Services Division

Please distribute one cover letter and one survey form to each teacher named on the cover letters.

The survey forms, completed by the named teachers, may be returned directly or through your office to:

Carolyn Plavcan
Research Assistant
640 N. Emporia

(Use School Mail)

Thanks.

Wichita Public Schools
CURRICULUM SERVICES DIVISION
PUPIL SERVICES DIVISION
640 North Emporia
Wichita, Kansas 67214

Teacher's Name

School

Dear Teacher:

A Comprehensive Health Education Review Committee has had a number of meetings this year to examine where we are and where we ought to be in the Wichita Public Schools as related to an organized sequence of health education instruction.

The Committee is desirous of obtaining your responses and ideas relating to the topic as described in the attached survey form.

Your name has been randomly selected and we would like for you to reply. Since we selected only one teacher out of every five in the district, your individual response is genuinely needed to reflect the ideas of all teachers.

The responses you give are to be your own and completely anonymous -- no names are wanted. Therefore, you can be candid. There will be no follow-up inasmuch as we will not know who has and has not responded.

Please return your completed survey without the cover letter no later than May 23, 1979.

Forward either directly or through your school office to:

Carolyn Plavcan, Research Assistant
640 North Emporia
Wichita, Kansas 67214

Committee Co-chairman: Dr. Lawrence A. Bechtold, Director
Curriculum Services Division

Dr. Donald E. Younglund, Director
Pupil Services Division

ELEMENTARY LEVEL SURVEY: HEALTH EDUCATION IN THE SCHOOLS

Please identify your grade level_____.

1. These are the topics in the elementary health textbooks, K-6. To what degree do you emphasize each?

	MUCH	SOME	LITTLE	NONE
A. Health knowledge, attitudes, decisions and behavior _____				
B. Mental and social health _____				
C. Growth and development _____				
D. Safety and first aid _____				
E. Disease and disorder _____				
F. Nutrition _____				
G. Environment _____				
H. Health information, products and services _____				
I. Dependency causing substances _____				
J. Health organization (grades 3-6) _____				
K. Health and the future (grades 2-6) _____				
TEACHER'S EDITION _____				

COMMENTS:

2. Do you have access to either of these guides?

Human Growth and Development _____ Drugs _____

Do you utilize these guides in planning classroom activities?

Human Growth and Development _____ Drugs _____

COMMENTS:

3. Which of the School Health Curriculum Project: Wichita Model Programs have you participated in this year?

a. Ear _____ d. Lung _____

- b. Eye _____ e. Heart _____
 c. Digestive _____ f. None of the above _____

COMMENTS:

4. Please indicate which of the following you utilize in classroom health programs? (The following are partial listings and no priorities are intended by either including/omitting possibilities.)

A. Projects/Programs:

- _____ National Preventive Dentistry Project
 _____ Low Income Dental Care (Community Health Department)
 _____ Health Activities Project
 _____ Other _____
 _____ (identify) _____

B. Auxiliary School Personnel:

- _____ Counselor
 _____ Psychologist
 _____ Social Worker
 _____ Nurse
 _____ Paraprofessionals
 _____ Other _____
 _____ (identify) _____

C. Community Resources/Materials: (Includes printed matter/field trips)

- | | |
|---|---|
| _____ American Red Cross | _____ Tele Med Tapes |
| _____ KG&E | _____ Halstead Health Museum |
| _____ Hospitals | _____ Sedgwick County Extension Service |
| _____ Wichita Fire Department | _____ Parent |
| _____ Wichita Police Department | _____ Insurance Companies |
| _____ Wichita Water/Pollution Department | _____ Personal Contacts |
| _____ Wichita Department of Health and Environmental Services | _____ Health Related Personnel |
| _____ Wichita Dairy Council | _____ Health Associations (Cancer, Heart, Lung) |
| _____ Wichita Wheat Council | _____ Other _____ |
| _____ Wichita Council on Drug Abuse | _____ (identify) _____ |

A COMPARATIVE STUDY OF THE EMPHASIS PLACED ON MAJOR
HEALTH STRANDS BY ELEMENTARY CLASSROOM TEACHERS

by

EDYTH J. BANKS

R. N. B. A., Ottawa University, 1977

AN ABSTRACT OF A MASTER'S THESIS

submitted in partial fulfillment of the

requirements for the degree

MASTER OF SCIENCE

College of Education

Department of Adult and Occupational Education

KANSAS STATE UNIVERSITY
Manhattan, Kansas

1980

A COMPARATIVE STUDY OF THE EMPHASIS PLACED ON MAJOR HEALTH STRANDS BY ELEMENTARY CLASSROOM TEACHERS

PURPOSE: The purpose of this study was to compare the utilization of an adopted textbook in health, specific curriculum guides and the utilization of resource programs and personnel by elementary classroom teachers who have been trained and are implementing the School Health Curriculum Project (SHCP) in their classrooms with teachers who are not implementing SHCP in their classrooms.

SIGNIFICANCE: There is much variation in the way health education is offered in schools. Very few districts provide comprehensive health teachings K-12. In this age of competency-based instruction and criterion-referenced testing, the educational systems need hard data for justification of its decision making processes. Data from this study should prove useful to Health Educators who are being held more accountable for expenditures on health education resource materials and consumption of precious curriculum time for health teaching.

PROCEDURES: In May 1979, survey instruments were distributed to 247 randomly selected Wichita Public Schools elementary classroom teachers. Useable responses were received from 111 teachers. Participation/non-participation in SHCP formed the dicotomy upon which the comparisons were based. The t-test for dependent means were calculated on the four point scale used to measure the emphasis placed on each strand outlined in the health textbook. Frequency of utilization was calculated for the specific curriculum guides, programs, and community programs and personnel.

FINDINGS: A significant difference in the emphasis placed on major health concepts by teachers implementing SHCP and those not involved in classroom implementation was found only in the area of dependency causing substances. Slightly higher mean scores were found in the areas of safety/first-aid and food/nutrition. The frequency of utilization of the Wichita Dairy Council and the Wichita Police and Fire Departments is consistent with these findings.

CONCLUSION: A significant difference was found on the emphasis placed in the health education area of dependency causing substances for those teachers implementing SHCP in the classrooms. Responses indicated that teachers utilized the school nurse as a health education resource in the classroom twice as frequently as other auxiliary personnel. The Wichita Dairy Council and the Wichita Police and Fire Departments were the most frequently utilized community resources.