

## Part Two:

# Meeting the Challenges of Health Education Curriculum Development

In 1994, the Public Education Network (PEN) entered into a cooperative agreement with the Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC/DASH) to integrate comprehensive school health programs (CSHP) into a larger, systemic school reform effort at the local and national levels. Under this agreement, PEN worked with and provided funds to six local education funds (LEFs) to implement local projects that would establish, enhance, and/or institutionalize school health programs within their districts—and in the case of one LEF, throughout the state. This case study documents the experiences of these LEFs and their partners in the second year of the implementation of this project, which focused on activities reforming the health education curriculum reform.

PEN was able to explore and delineate the issues surrounding comprehensive services through its first federal grant from the CDC. Through the Comprehensive School Health Initiative (CSHI), PEN, along with its partner LEFs, aims to link school health and school reform by approaching the issue of school and adolescent health, including HIV prevention, with public engagement as a major component. This report looks at the challenges LEFs faced as they engaged a wide array of entities in examining health education curriculum and reform efforts to make it more comprehensive, age-appropriate and developmental.

### Introduction

A basic tenet in the comprehensive school health program (CSHP) philosophy is that healthy students learn more effectively. Former Surgeon General Jocelyn Elders, MD advanced this view when she stated that “you can’t educate a child who isn’t healthy and you can’t keep a child healthy who isn’t educated.” (The Comprehensive School Health Challenge, 1994).

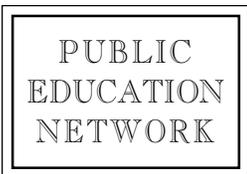
Since 1995, PEN has partnered with six local education funds to bring to fruition this concept of placing CSHPs within the larger context of school reform. As of this writing, however, the Washington, DC site pulled out of the initiative. The LEFs featured in this report include: Academic Distinction Fund (Baton Rouge, LA); Lincoln Public Schools Foundation (Lincoln, NE); Public Education Fund (Providence, RI); Mary Lyon Education Fund (Shelburne Falls, MA); and The Education Alliance (West Virginia).

In its 2<sup>nd</sup> year of implementation, the CSHI afforded PEN an opportunity to examine school health curriculum advances in a variety of situations. Each of the five LEF sites was unique in its size, structure, composition, and relationships and its approach to the process. Yet, they were similar in their commitment to improving and extending services to students through a CSHP approach and using new and innovative strategies to achieve their objectives.

Each of the LEF sites has viewed the classroom as an appropriate environment in which to advance the knowledge that students must possess in order to lead healthy lives. The five LEFs also recognize that a reform effort that is system wide can also maximize the “classroom” benefits of comprehensive school health education.

Reform efforts at the various CSHI sites resulted in the:

1. Reexamination and updating of the health education curriculum
2. Redefinition of teaching roles and responsibilities
3. Development and delivery of teacher in-service education
4. Advocacy of health education issues with teachers and other educators



## Challenges of Health Education Reform

Each of the sites addressed the issue of health education reform differently, but one thing was common among all: confronting a uniform set of challenges that typically accompany any reform effort.

### *1) Acquiring stakeholders to support and advance health education change*

In the project's planning phase (January – April 1996), each site created a Community Planning Committee (CPC) comprised of school and community representatives to engage in an extensive planning process designed to advance comprehensive school health. The planning process brought agreement on

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the objectives and strategies that would be employed during the implementation stage. Advancing health education change, however, meant reaching beyond the initial CPC and involving a new and expanded base of stakeholders, including

teachers, administrators, and other education decision-makers. Also, the sites found they had to enlist a broader pool of school and community supporters and convince them of the value added of the project. Site directors stated that the key to creating stakeholders was through direct participation in the work of CSHI. Those who became involved in the project planning and delivery, and more specifically in teaching health education in the classroom, were very likely to become CSHI's most outspoken advocates.

### *2) Defining the "core" curriculum*

Proponents of curricular reform in schools have not

always agreed on what constitutes the "core" curriculum. On the one hand you have traditionalists and "back to basics" advocates who say that schools should concentrate solely on academic curriculum. Others have viewed school curriculum as an opportunity to address a broader range of social and cultural issues, including health needs. Each site faced the challenge of building a strong case for the expansion of health education in the curriculum. In some instances they had to make their case at the state and district level where health education curriculum content was being debated. In other situations, the challenge came in the form of changing individual teacher understanding, attitudes and behavior.

The **Lincoln Public Schools Foundation** has chosen the strategy of curriculum infusion to ensure that appropriate health education concepts were placed before all students in the classroom environment. This plan recognizes and builds upon the work that teachers are already doing in the CSHI emphasis areas and encourages them to work interactively and with other curriculum areas in a holistic program of health education. This work has been accomplished through collaboration with the Comprehensive Health Education Teams and the Lincoln-Lancaster County Health Department. Because there are a number of excellent curricula currently in place, the site refrained from creating new ones and instead chose to work with educators to design activities and resources, which could interface with existing materials and ongoing activities. *Teacher Idea Booklets* containing suggested activities and adaptable classroom projects were developed for each of the eight emphasis areas.

### *3) Defining health education*

The sites supported a health education curriculum that was comprehensive in scope, directed at all students and woven throughout the entire education experience. A common view among all sites is that various topics should be arranged or sequenced to address the developmental needs and interests of children and adolescents in the classroom. Such placement ensures that health education subjects are introduced at the appropriate level and taught in a manner in which each curricular experience builds upon the knowledge the students have acquired in previous experiences.

Another aspect of defining health education relates to the handling of sensitive topics in what can often become a politically charged environment. Successful CSHI sites dealt with these issues by creating a position with respect to the issues in advance and then moved proactively to work for the inclusion of that position within the health education curriculum.



Effective public outreach and engagement also produced a more receptive and cooperative community when controversial subjects were being addressed. Other approaches, with less emphasis on communications and engagement were destined to generate or extend the controversy that often accompanies controversial subjects when they are addressed by the school or school district.

The **Public Education Fund** (PEF) in Providence, RI, collaborated extensively with the RI Department of Education in a number of efforts aimed at advancing health education in the classroom. That collaboration resulted in the publication of Comprehensive Health Instruction Outcomes, which articulated what students should know and be able to do after being engaged in health education in the classroom. This document has built upon Rhode Island's recently adopted health education standards and is part of the state's strategy for creating and mobilizing a state-wide infrastructure for comprehensive school health. In addition, the LEF developed the Guide to Comprehensive School Health, a "tool kit" for CSHI school site staff members to use in integrating the concepts of the project in their respective roles.

#### ***4) Professional development and training***

A critical challenge is the preparation of teachers. Proponents of professional development argue that such experiences are necessary to: 1) generate interest and enthusiasm, 2) introduce new health education standards, content and information; 3) and offer strategies, techniques and tools that result in more effective teaching. The inadequately prepared teacher is frequently a major obstacle to advancing health education.

The **Academic Distinction Fund** in Baton Rouge, LA was able to measure considerable progress in the integration of a health education curriculum at the elementary school level. A portion of the credit for this success can be attributed to teacher training activities. Some 30 teachers participated in a 3-day workshop by the Southwestern University Comprehensive School Health Center. This training addressed national health standards and curriculum strategies that could be utilized at both the elementary and secondary levels to present the health education curriculum.

Sites have learned that quality staff development and training experiences are more likely to result from effective planning and sound implementation by leaders and the presentation of knowledge, skills and concepts by first-rate trainers.

The **Education Alliance**, working with the West Virginia Departments of Education and Health and

schools across the state, discovered that CSHI curricular reform initiatives could be most effectively addressed through working with Local School Improvement Councils (LSICs) and through efforts to help schools achieve the "West Virginia Healthy School" distinction. PEN and Education Alliance cooperated in the development of a grants program whereby up to 10 grants of \$1,000 each were available to teachers and other educators committed to advancing the Working on Wellness goals in their respective schools. A number of these grants addressed curricular development and reform efforts,



as well as in-service and staff development experiences for staff. As the only statewide CSHI project, the Education Alliance places considerable emphasis on providing technical assistance and support to schools wishing to implement a comprehensive school health program. LEFs were able to face this challenge head on largely through the nature of the relationships established within the individuals comprising their respective community planning committees. As these committees met, other resources were identified and oftentimes shared through joint activities. The identification of other funding sources also became a more feasible task as information was shared among committee members.

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#### ***5) Competition with other education-focused issues***

What's hot? What's not? At every level of American education, leaders and decision-makers are engaged in creating agendas and setting priorities. Some of these issues are home grown, emanating from local needs and concerns. They can also grow out of a crisis or the need to immediately address a

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particular problem or issue. Finally, issues can represent aspects of a federal or state agenda usually being advanced by leaders and politicians or influenced by forces outside the educational community.

Each site has been challenged to compete with other projects and other priorities for attention, commitment and resources. While many educators and community members would agree that comprehensive school health is a concept whose time has come, it still struggles for consideration on various decision maker agendas and for the human and fiscal resources needed to make the concept a reality.

**6) Human and fiscal issues**

Change has its price. Organizing curriculum development teams, providing in-service education for teachers, publishing new curriculum guides are but a few examples of where human and fiscal resources need to be spent if the concepts of the CSHI are to be fully implemented in the schools. Working with relatively small implementation grants (\$20,000 a year for 3 years), the CSHI projects have accomplished much with modest resources. In some cases, sites have been successful at leveraging people and money from their

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school district, LEF and state departments of education and health, or private sources to ensure that their work move forward. Several sites discovered that connecting their efforts to related programs allowed them to advance the CSHI objectives through collaborative relationships.

A significant advance in health education standards in the Mohawk Trail School District came with the completion and approval of a comprehensive pre-K-12 health curriculum. With the **Mary Lyon Education Fund** in Shelburne Falls, MA working with the Massachusetts Health Reform Curriculum Framework, the health education coordinator and committee developed a health curriculum with content and classroom activities that reflected local needs assessment, goals and objectives. After revisions and community discussions, the curriculum was adopted for use in a nine town rural school district. Additional financial support for this initiative was obtained from the state departments of education and public health. To support curricular change, the CSHI also established an annual Healthy Children, Healthy Communities conference that pro-

vides educators with staff development opportunities to earn state mandated professional development points toward recertification under the Massachusetts State Education Reform Act.

**Conclusion**

Clearly, the work of ensuring health education curriculum in our public schools is oftentimes difficult and arduous. But with proper planning, teamwork and public engagement that includes teachers, administrators, students, parents and other community members, enough energy, support and resources can be mustered to ensure that this work comes to a productive end. Having a health education curriculum that is comprehensive, age-appropriate and developmental is merely a step in creating an environment where childrens' and adolescents' health and well-being needs are addressed. This curriculum becomes a reflection of a school community's priorities as manifested through its policies, programs and overall support. Once these pieces are in place, no challenge can pose as a permanent barrier. As the development of a health education curriculum is connected to a larger school reform effort, other aspects and components of comprehensive school health programs become much more feasible and manageable to implement.



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