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## Improving Teacher Effectiveness In Implementing Comprehensive Health Education

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IMPROVING TEACHER EFFECTIVENESS IN IMPLEMENTING  
COMPREHENSIVE HEALTH EDUCATION

by

Janet L. Kehoe

A Practicum Report

Submitted to the Faculty of the Center for the  
Advancement of Education at Nova University in partial  
fulfillment of the requirements for the degree of Master  
of Science.

The abstract of this report may be placed in a  
National Database System for reference.

November/1989

## Authorship Statement

I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give this testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my work, presented here, will earn similar respect.

Signed Janet L. Kehoe

Improving Teacher Effectiveness in Implementing Comprehensive Health Education.  
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The Center for the Advancement of Education.

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Methods/Teacher Effectiveness/Instructional Improvement/Instructional  
Effectiveness/Instructional Development/Health Education/Elementary Education/

Comprehensive Health Education/Growing Healthy (GH) was not being taught for the required number of hours as was indicated in the pupil progression plan for this community. The objectives of the practicum were to increase the number of trained teachers by 60 percent; thereby increasing the instructional time GH was taught, and to place, and organize all commercial instructional-support materials within the elementary school. The author designed a six-week long training program, conducted an inventory of all GH materials, and color coded all commercial instructional-support materials by phase and grade level.

The researcher received administrative support from the school's administration to provide the necessary training program designed to enhance teacher behavior and improve student achievement as indicated by the effective schools research.

The results noted that instructional time increased due to the effectiveness of the training program and the success of the organization of the commercial instructional-support materials. The author will share with other elementary health educators the color-coded strategy designed and training opportunities for the Growing Healthy curriculum. Appendices include a teacher survey, the Growing Healthy training program for kindergarten through fifth grade, and sample check lists and results.

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## CHAPTER I

### Purpose

The setting for this practicum was an elementary school. There were 30 elementary schools, 12 middle schools, seven high schools, four exceptional student education schools, two alternative schools, and one vocational-technical school in the school district. The school district was located in a major metropolitan county in Southwest Florida. It was one of the five fastest growing counties in the United States. The 1980 census showed a total population of 205,266. The total population projection for 1991 is 306,000. Unemployment has, since 1980, been well below the national average. Occupations were classified as follows: services - 46.3 percent, administration - 16.1 percent, sales - 14.7 percent, managerial - 10.8 percent, professional - 9.6 percent, and technical - 2.3 percent (Donnelley, 1988).

The elementary school was located in a low socio-economic community with a pre-dominantly Black population. In the community, 874 persons were enrolled in schools, nursery through high school. Of persons 16

to 19 years old, 34.7 percent were considered dropouts. Forty-seven and six-tenths percent of persons 25 years or older had a grade school education or less. In 1979, the median household income in the community was \$9,489. Households with incomes less than \$7,500 were 36.7 percent. The average per capita income in the community was \$2,813. The poverty threshold, in 1979, was \$7,412 for a four-person family. Poverty status was determined for 42.5 percent of all persons in the community (Beluschak, 1984).

The school staff consisted of one building administrator, 24 instructional personnel, and 13 non-instructional personnel. The student body had a population of 384. Three ethnic groups were represented in this population: 64 White non-Hispanic, 272 Black non-Hispanic, and 48 Hispanic.

The author was a teacher-on-assignment for health education, kindergarten through twelfth grade. The primary responsibilities of the writer were to provide support materials, inservice training, and work cooperatively with school principals and other school personnel to ensure success in meeting student, school, and district needs in the area of Comprehensive Health



Education. Growing Healthy inservice training was available for the elementary teacher. However, inservice training participation was not mandatory.

Comprehensive Health Education/Growing Healthy was not being taught for the required number of hours as indicated in the pupil progression plan. Four factors contributed to this problem: (1) untrained teachers in the Growing Healthy curriculum; (2) allotted appropriate time for instruction was arbitrary; (3) lack of materials; and (4) poor usage of materials. A written survey was conducted to determine the extent of teacher training and instructional time allotment (See Appendix A:37).

#### Untrained Teachers

The elementary school had 14 classroom teachers. Each teacher was responsible for Comprehensive Health Education/Growing Healthy instruction within their classroom. Seventy-one percent of the instructional staff were not trained in the Growing Healthy curriculum (See Table 1).

The elementary school had a relatively new instructional staff. Ten teachers (72 percent.) had three or fewer years teaching experience at the school.

Two teachers (14 percent) had five to eight years teaching experience and two teachers (14 percent) had 15 or more years teaching experience. The elementary school received a new principal with less than six months experience as a school-site principal in March, 1989. These were contributing factors to the number of untrained teachers and lack of commitment to teaching Comprehensive Health Education.

Table 1

A comparison of trained & untrained teachers by grade level in the Growing Healthy Curriculum

Grade Level	# Trained	# Untrained
Kindergarten	3	0
First	1	2
Second	0	2
Third	0	2
Fourth	0	2
Fifth	0	2

The pupil progression plan required a minimum of 30 instructional hours, per year, for all students in kindergarten through third grade. A minimum of 45 instructional hours, per year, were required for fourth and fifth grade students. The written survey conducted

by the author indicated all grade levels were not meeting the minimum instructional hours required for Comprehensive Health Education (See Figure 1).

The Growing Healthy curriculum for each grade level required specific support materials and teacher-made packets. An in-depth inventory, of the Growing Healthy materials, indicated that these necessary materials for each grade level were grossly inadequate. Existing support materials were housed in old boxes and stored in various locations throughout the school. These materials were yellowed, torn, and water damaged.

The "Florida Comprehensive Health Education and Substance Abuse Prevention Act," Florida Statutes 233.067 (5) (b) required school districts to submit to the Commissioner of Education an exemplary comprehensive health education and substance abuse prevention program for kindergarten through twelfth grade. Program evaluations, by the State Department of Education, included program effectiveness, efficiency, and use of resources. Each district shall be held accountable for comprehensive health education pursuant to the policies and regulations adopted by the Commissioner of Education.

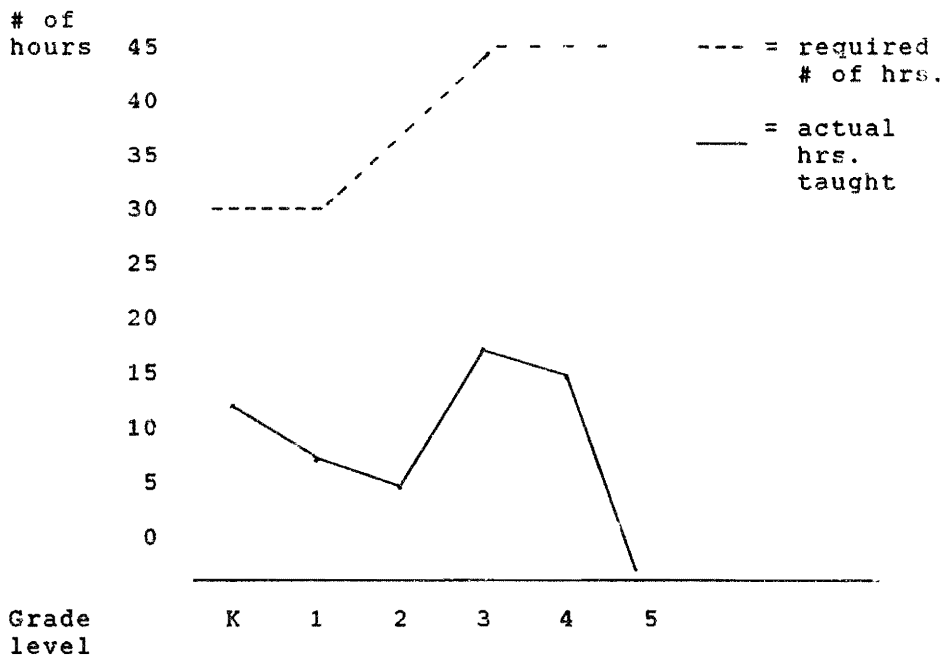


Figure 1

Comparison of Minimum Instructional Hours  
and Actual Instructional Hours  
Being Taught

The four contributing factors, listed previously, had a direct effect on the Growing Healthy instructional hours being taught at the elementary school. Each of these factors was addressed in an attempt to correct the instructional deficiency as indicated below:

1. 60 percent of the elementary school's teachers would participate in a six-week long Growing Healthy training program, in which the teachers

would complete 85 percent of the teacher make and take packets as measured by an itemized check list

2. over a period of nine weeks, the staff would increase instructional time in Comprehensive Health Education/Growing Healthy by 50 percent from school year 1988/89 to school year 1989/90 as indicated by a pre/post teacher survey
3. 100 percent of the required commercial instructional-support materials would be in place at the beginning of the practicum, as verified by an inventory using the curriculum resource list for each grade level
4. 100 percent of the required commercial instructional-support materials would be organized by grade level as indicated by the teacher's guide prior to instructional usage.

## CHAPTER II

### Research and Solution Strategy

#### Review of Literature

In this study, the author focused attention on research involving comprehensive health education and effective schools. The School Health Education Evaluation (SHEE) was the first major effort to evaluate health education in the United States since 1964. In May 1981, the Office of Disease Prevention and Health Promotion (ODPHP) and the Center for Health Promotion and Education, Centers for Disease Control, contracted with Abt Associates, Inc., to evaluate the School Health Curriculum Project (SHCP), now known as Growing Healthy (GH), as compared with three other approaches to school health education. The three comparison programs selected for the study were Health Education Curriculum Guide (HECG), Project Prevention, and Reading, 'Riting, 'Rithmetic, and High Blood Pressure (3 Rs and HBP). The SHEE Report, a three-year study, involved 30,000 students in fourth through seventh grades, in 1,071 classrooms from 20 states.

A student test was developed and designed to measure effects across all grades and programs in health knowledge, attitudes, and practices. For students taught health (688), the test was administered before and after the program. Students not receiving health (383) were tested at the same times. Teacher questionnaires provided information on teacher training and the time allotted for health education. Cost effectiveness of these programs and parent questionnaires were completed and analyzed, but the author of this study did not address the results (Gunn, 1985).

Knowledge scores, attitude scores, and self-reported practices showed increases between pretests and posttests (See Table 2). Knowledge scores increased more in program classrooms than in those classrooms with no health program. Healthier attitudes, self-reported health skills and practices were higher in health program classrooms, with decision-making skills showing the greatest differences. Although attitude and practice differences appeared to be minor, they are the result of brief exposure to health education. Students exposed to a second year of health instruction showed a positive increase in attitudes and practices (See Figure 2). These results suggested that health instruction

continued over a period of several years will lead to lifelong, healthy attitudes and practices.

Table 2

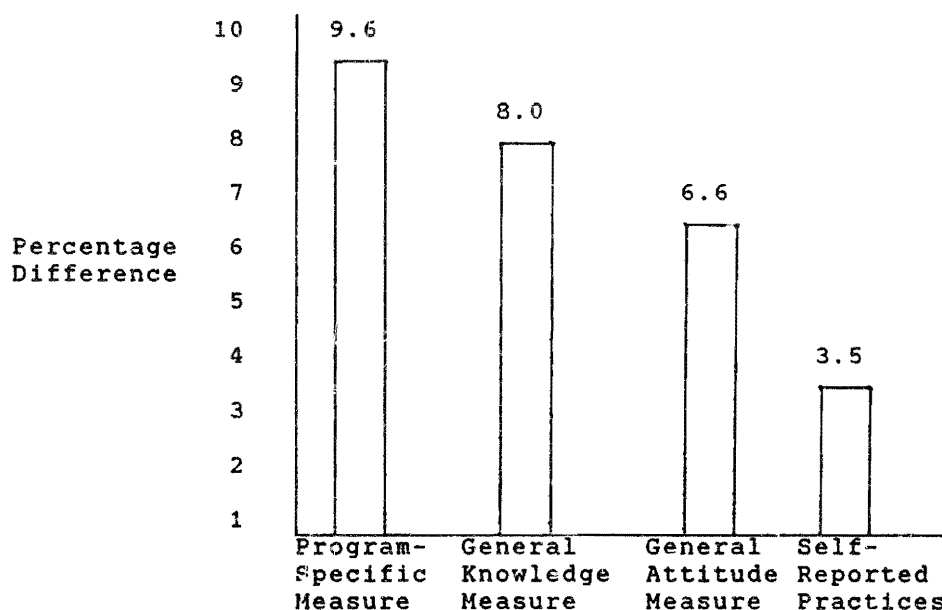
Descriptive Statistics for the Student Inventory Scores  
Total Evaluation Sample

	Students Taught Health Mean Pre/Posttest	Students Not Taught Health Mean Pre/Posttest
Program-specific knowledge	51.1/59.7	50.4/52.3
Overall Knowledge	49.0/57.9	49.3/52.1
Overall Attitudes	71.3/73.5	71.8/72.3
Overall Self-Reported Skills & Practices	63.3/65.0	64.8/63.5

Implementation of school health education was directly related to health curricula resources and teacher training. Insufficient classroom time or instructional-support materials failed to provide a complete program resulting in a reduction of the program taught. Loss of program effectiveness was the result. Program implementation measures were directly related to



the amount of teacher inservice training. Trained teachers implemented more fully a greater percentage of programs compared to partially trained teachers. Teachers with no training implemented programs with less commitment than either of the above groups (See Figure 3).



Note: All differences favor health program classrooms and are statistically significant. The percentage differences for each measure are the observed posttest differences divided by the scale range (Connell, 1985).

Figure 2

Observed Differences Between Groups Taught Health for Two Years Compared to Groups Taught Health for One Year

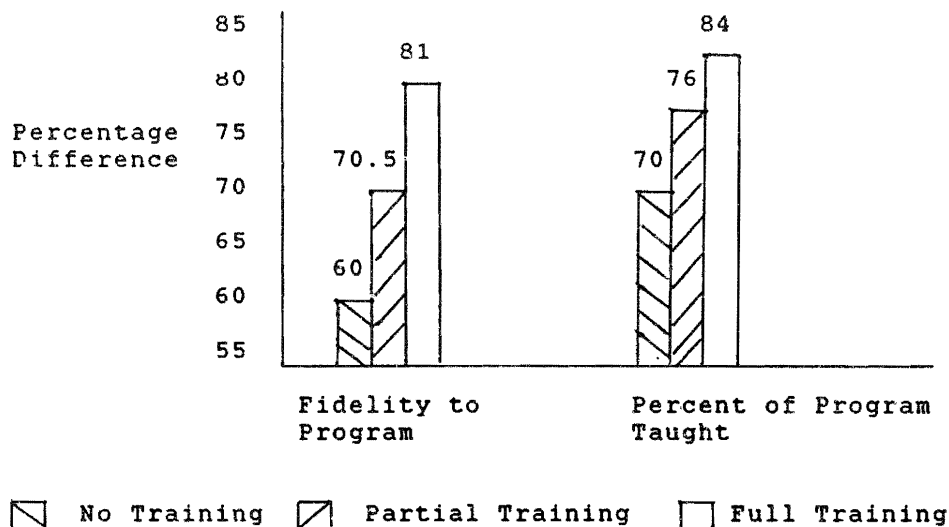


Figure 3

Comparison of Program Implementation for Classrooms  
 Where Teachers Received No Training,  
 Partial Training, or Full Training

Since relatively few elementary school teachers were familiar with the complete range of health instruction methods and objectives, a program of in-service training appeared to be an important factor in persuading teachers that an additional effort to fully implement health instruction would produce additional benefits (Connell, 1985:318).

Individual program effects on student inventory measures were considered successful for each program. However, SHCP had a greater increase in student effects across all domains. The greater the implementation of each program, the more each program was enhanced.

The study shows, in general, that health education works; that it works better when there is more of it; and that it works best when implemented with broad-scale administrative and pedagogic support for teacher training, integrated materials, and continuity across grades (Green, 1985:300).

A 10-year, 1977-1987, longitudinal study of the Growing Healthy curriculum was sponsored by the American Lung Association. This study determined the knowledge level of students, the impact of the curriculum on students' attitudes toward good health practices, and the impact of the curriculum on the smoking, drinking, and drug-use behavior of the students. The study compared three groups of students: (1) students who had received the Growing Healthy curriculum; (2) students who had been taught using a standard health textbook; and (3) students who had received the standard textbook approach from kindergarten through third grade, and then received the Growing Healthy curriculum from fourth through sixth grades. Kindergarten students in two Northeast school districts were administered cognitive and affective tests, and a student survey. These students were followed and retested in the first, second, third, fifth, sixth, seventh, and ninth grades.

### Health Attitudes

During each of the above years, the students were given a 31 item test to measure their attitudes toward maintaining themselves as healthy people and not smoking. The Growing Healthy students had a significantly higher positive attitude than those only receiving the standard textbook approach.

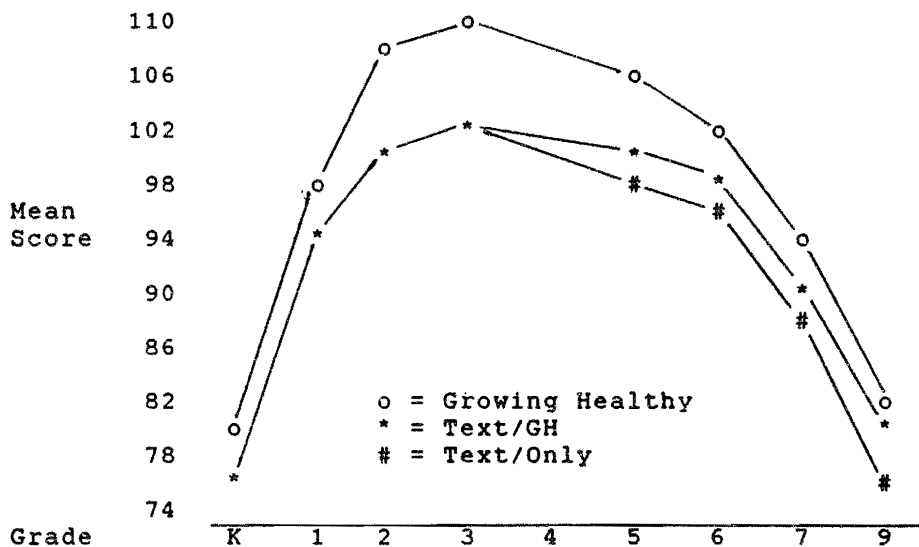


Figure 4

Affective Scores of Students

### Experimentation with Smoking

Data was collected to measure students' responses to experience, exposure, and future expectancy to smoke.

The younger students (Growing Healthy) reported less experimentation, exposure to experimentation, and future expectancy to smoke. Differences in experimentation and exposure to experimentation were no longer evident by the time students reached the ninth grade. However, for reported smoking on a regular basis there were significant differences. Smoking on a regular basis was reported by 24 percent of the Growing Healthy students, whereas 34 percent of the text only students reported smoking on a regular basis.

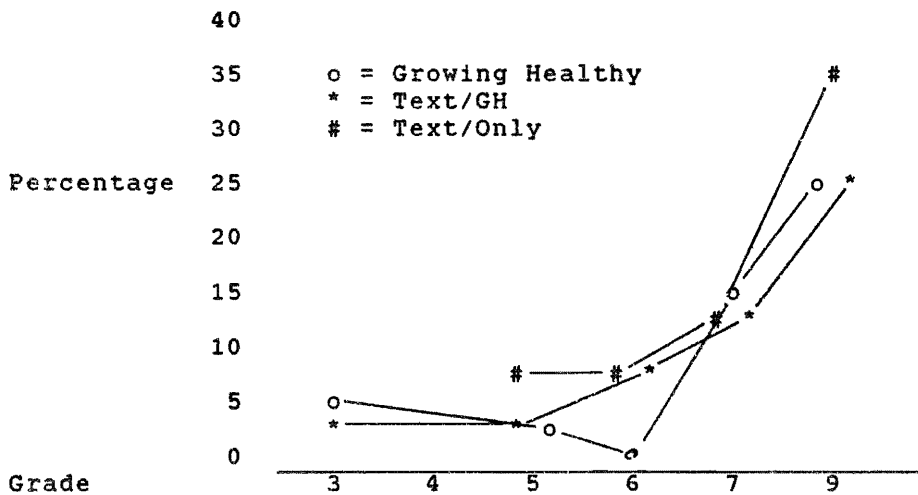


Figure 5

Percentage of Students Reporting Smoking on a Regular Basis

### Drinking Alcohol

Data was collected to measure the students' responses to those who had experimented with, used, or expected to use alcohol in the future. Experimentation with alcohol was much higher for all age groups when compared to experimentation with smoking.

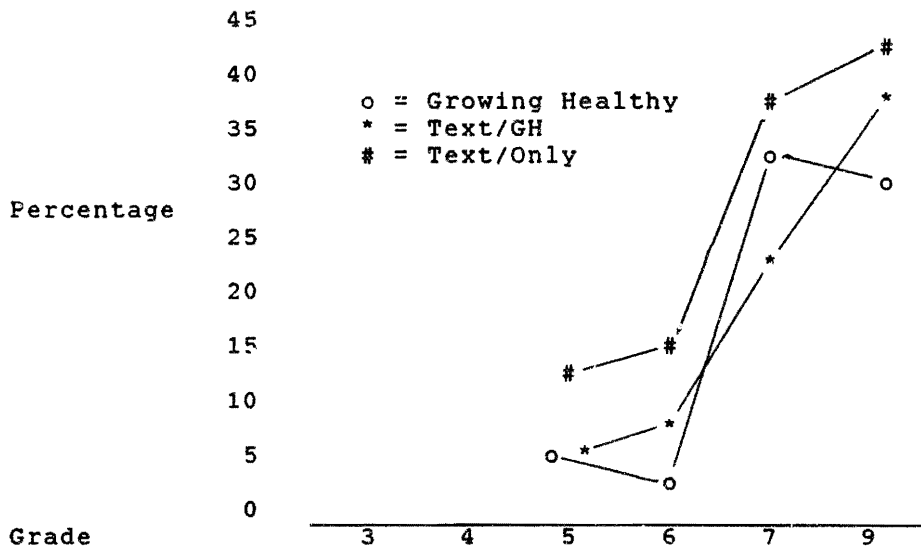


Figure 6

Percentage of Students Reporting Drinking  
on a Regular Basis

### Experimentation with Drugs

A third area of the study was the extent to which the students experimented with or expected to use

marijuana and other dangerous drugs as adults. In all categories, younger students showed little experimentation or little expectancy to use drugs as an adult. The most significant increases were seen between the seventh and ninth grades. Students who received instruction in the Growing Healthy curriculum had significantly lower levels of experimentation and future expectancy to use drugs.

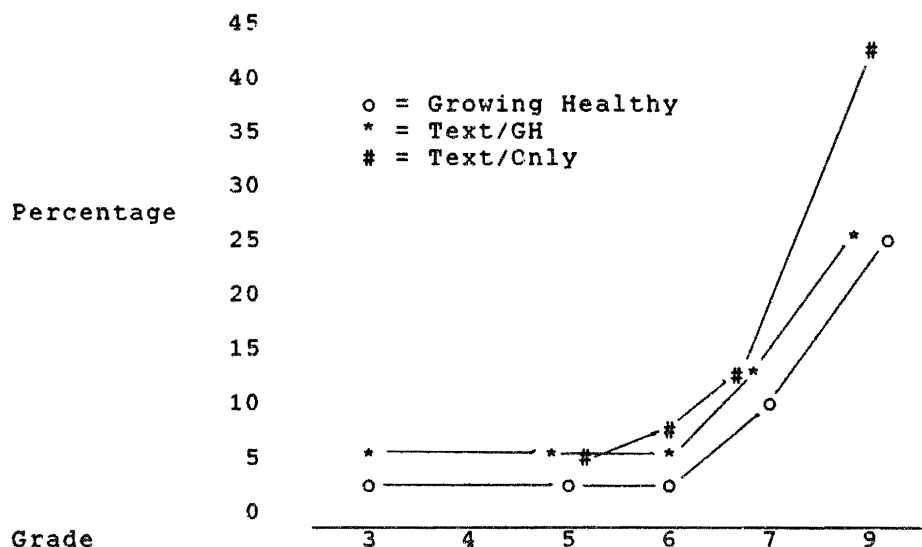


Figure 7

**Percentage of Students Who Reported Having Tried Drugs**

This 10-year longitudinal study indicated that schools, particularly at the elementary level, that provided a

comprehensive health program (GH) with continuity across grade levels had a positive impact on students' knowledge about health, and personal attitudes toward a healthy lifestyle (Andrews, 1987).

Dolly and Katz (1987) conducted a study to evaluate the correlation between instructional practices (traditional vs. nontraditional) and improvement in knowledge, attitudes, and behavior toward good nutrition. One hundred-twenty teachers and 3,600 students in second through fifth grades participated in the study. A week long program had trained the teachers in a variety of teaching techniques related to good nutritional practices.

Two instruments were used to collect data from the students. The Nutrition Assessment Inventory (NAI) consisted of multiple-choice questions and was commercially prepared. Two experts in nutrition and two researchers with a background in reading reviewed and revised the instrument. Twenty-five nutrition-related activities made up the student questionnaire.

Traditional and nontraditional instructional activities were identified by experts in the fields of instructional development and nutrition. Students' mean scores on knowledge, behavior, and attitude were



compared in relation to the type of instruction received. Four teaching styles were identified: (1) nontraditional activities, five or more; (2) non-traditional activities, three or less; (3) traditional activities, five or more; and (4) traditional activities, three or less. Routine lectures, use of bulletin boards, and classroom discussions on nutrition were considered traditional activities. Cooking foods in class, visiting farmers' markets, grocery stores, cafeterias and restaurants to see food preparation were considered nontraditional activities. Results indicated that students who were taught with fewer traditional activities had higher mean scores. No significant differences were found between the high and low nontraditional frequency groups on the NAI. The findings of the study indicated that teachers who used fewer traditional activities had students with the greatest gains. The reasons for the results obtained were not clear. It was felt that teachers who used fewer traditional activities may have used more familiar activities resulting in quality instruction. Teachers who used a variety of methods may have been more concerned with variety, than the type of instruction.

Doll stated "If the curriculum is to improve, teachers must be committed to the significance of self-improvement." (1989:286). Teacher reeducation may be accomplished in three ways: (1) inservice education (formal, mandated); (2) staff development (teacher guided); and (3) workshops (planning and work sessions).

Kolacki stated

Elementary classroom teachers lack preparation in health education...A sequential education curriculum is essential at the elementary level if students are to make intelligent decisions concerning their physical, mental, emotional, and social well-being (1981:32).

Kolacki's suggested guidelines for inservice health education for elementary classroom teachers included philosophy, planning, organizing, and conducting an inservice course. The elementary classroom teacher not only conveys knowledge, but plays an important role in shaping students' attitudes and behavior. Outcome objectives should determine program content. Kolacki's objectives included the following:

1. Increased knowledge of health education topics.
2. Increased skills in encouraging decision-making by students.
3. Ability to discriminate between fact and fiction.

4. Increased understanding of the stresses and problems elementary students face.
5. Ability to strengthen students' skills in evaluating influences of ads, news, television, reports, etc.
6. Ability to evaluate own competence as health education teacher (1981:32-33).

Scheduling and inservice course location needs to be easily accessible for teachers. One day a week during the school day, professional days, weekends, mini-courses, and summer institutes can provide needed time for adequate inservice. School facilities can provide meeting places. The coordinator of health education should act as the director. The director should make all necessary arrangements for meeting rooms, audiovisual equipment, printed material, program items, publicity, speakers, consultants, and evaluation. Primary and intermediate teachers should be offered separate sessions. Teachers must be informed if they are to provide a variety of learning experiences which will enhance students' knowledge, decision-making skills, and behaviors toward a healthy lifestyle.

#### Schools

need to involve students in a variety of ways of thinking, to introduce students to concepts and not just facts, to provide situations that provoke and evoke curiosity, to develop in students concern for one's own performance in work and the satisfaction of

meeting one's own standards, to cultivate appreciation of others through cooperative endeavors, and to be concerned about the traits of mind and character fostered in schools (Goodlad, 1984:244).

Goodlad's research indicated that the major emphasis of schooling had been concentrated on basic skills (cognitive information). Goodlad concluded that schools must be concerned with both cognitive and affective education. Krathwohl, as quoted by Doll (1989:141), defined the affective domain as follows:

1. Receiving, or showing interest in, giving attention to, and indicating awareness of an object
2. Responding, which includes both giving willing response and replying with a feeling of satisfaction
3. Valuing, or accepting a value, preferring it, and becoming committed to it
4. Organizing values by conceptualizing, clarifying, and systematizing them in one's thinking
5. Characterizing values by internalizing them so that eventually they become a philosophy of life.

As indicated by the SHEE Report and the 10-year longitudinal study, the Growing Healthy curriculum utilizes the cognitive and affective domains.

Effective schools research has identified specific characteristics which provide optimum learning opportunities and student achievement. Student achievement is directly related to student and teacher

behavior. Planning, organizing, and developing appropriate lessons requires the effective teacher to be knowledgeable of subject materials, including preparation and arrangement of the materials. Effective teachers manage student conduct, communicate effectively, and provide student evaluation and feedback. The characteristics of an effective teacher increases student time-on-task (involvement), subject content covered (coverage), and mastery of subject content (success) (Squires, 1984).

#### Solution Strategy

Administrative support was requested from the elementary school principal. In order for the teacher and school to provide a complete health education program (GH) for students, the author designed a training program. The training program utilized the GH curriculum, curriculum guidelines and make and take packets specifically designed for the GH curriculum. The training program would enable the classroom teacher to plan, organize and develop lessons including preparation and arrangement of materials. Teacher behavior was an integral part of student achievement, as indicated by effective schools research.

The author has concluded from the research (SHEE and 10-year longitudinal study) proper training of teachers was essential if schools were to have a positive impact on students' knowledge and behavior toward a healthier lifestyle. Kolacki's guidelines for inservice were modified to meet the individual needs of the school and district. The teacher training program was offered one night a week for six weeks for a total of 18 hours. (See Appendices B:38, C:39, D:40, E:41, F:42, and G:43). The program was offered at a centrally-located high school with the cooperation of the Adult and Community Schools. The author asked the cooperation of the adult and community education director, coordinator of the community school, and GH trainers to initiate the teacher training program. The author provided printed materials, program items and evaluation forms.

Classroom teachers were asked to assist in the inventory of GH materials. Upon acquisition of commercial instructional-support materials, the author color coded and organized the materials by phase and grade level to coordinate with the teacher's curriculum manual. Each grade level had individual phase boxes as defined by the GH curriculum. Phase boxes were

clearly marked and included a laminated list of materials necessary to successfully teach the phase.

## CHAPTER III

### Methodology

Following, in order of occurrences, are the tasks the author followed in implementing the practicum. The author contacted the elementary principal to obtain administrative support for assistance in securing a complete inventory of GH materials. The elementary principal instructed classroom teachers to send all GH materials to room 17. Curriculum resource lists for each grade level were obtained by the health contact person and an inventory was completed for kindergarten through fifth grade. A detailed list of all missing GH materials by grade level was recorded and sent to the practicum manager. Purchase orders for all missing materials were sent to appropriate vendors.

The Director of Adult and Community Schools was contacted by the author to obtain permission to use adult and community facilities for the GH training program. Approval was granted and a centrally-located high school was chosen for the GH training site. GH trainer positions were advertised by the local school board for five days, as required by law. Applicants'



resumes were reviewed by the author and the Coordinator of Comprehensive Health Education. The author and the Coordinator of Comprehensive Health Education determined that three GH trainers were necessary. A ratio of 15 trainees to one trainer was required to monetarily support the training program. One trainer was hired for each of the following grade levels kindergarten/first grade, second/third grade, and fourth/fifth grade. The training program was discussed and initial planning took place.

Kindergarten and first grade commercial instructional-support materials were color coded by phases and placed in phase boxes. Colored stickers were placed on each item to correspond with the phase color of the curriculum. This provided more efficient usage of the instructional-support materials in correlation to the curriculum. Each curriculum was divided into five phases: Introduction - yellow, Phase I - orange, Phase II - red, Phase III - purple, Phase IV - blue, and Phase V - green. Each phase box contained a laminated resource list for inventory purposes. Second and third grade commercial instructional-support materials were color coded by phases and placed in phase boxes as described previously.

The author and the GH trainers meet and finalized the training program. Each grade-level curriculum was discussed by phases. Appropriate filmstrips, guest speakers, and make and take worksheets were studied and completed for each curriculum phase (See Appendices B:38, C:39, D:40, E:41, F:42, G:43). The author contacted the coordinator of the community school where the training program was held. Three classrooms, a 16mm movie projector, a filmstrip projector, and a laminating machine were reserved for the GH training program.

Fourth and fifth grade commercial instructional-support materials were color coded and placed in phase boxes as described previously. Two faculty meetings were held during the third week of the practicum. The first faculty meeting was for all instructional staff. The necessity of being trained in GH was explained based on the SHEE Report and the 10-year longitudinal study. The second faculty meeting was for all instructional staff not trained in the GH curriculum. The training program was explained by the GH trainers. The training program would help the classroom teacher to plan, organize, and develop lessons, including preparation and arrangement of materials.

The six-week GH training program was initiated the fifth week of the practicum. The training sessions were held once a week for three hours (See Appendix B:38, C:39, D:40, E:41, F:42, G:43). Each GH trainer maintained an attendance roster and weekly project check list (See Appendix H:44). A post-teacher survey was conducted at the end of a nine-week period. The post-teacher survey was compared to the 1988/89 pre-teacher survey to determine the increase in instructional time. Instructional time, for all grade levels, increased by 53 percent or higher.

## CHAPTER IV

### Results

The author's first objective was to train 60 percent of the elementary school's teachers in the GH curriculum. The success of the training program was to be determined by each teacher completing 85 percent of the make and take packets. A pre-training survey was conducted to determine the number of elementary teachers previously trained (See Appendix A:37). Twenty-nine percent of the instructional staff had received training in the GH curriculum. Teachers participated in the six-week long GH training program. Each of the teachers completed 100 percent of the make and take packets (See Appendix I:45). Therefore, 50 percent of the instructional staff was trained. The first objective was not met. Voluntary participation was the single-most detriment to the success of the training program. Stipends were not available for participating teachers. Inservice points were awarded for teacher certification renewal. However, educators enrolled in the beginning teacher program were not eligible for inservice points.

The second objective was to increase by 50 percent the instructional time allotted to GH. A post-teacher survey (See Appendix A:37) was conducted at the end of a nine-week period. The post-teacher survey was compared to the 1988/89 pre-teacher survey to determine the increase in instructional time. Instructional hours were increased at all grade levels by 53 percent or higher (See Figure 8).

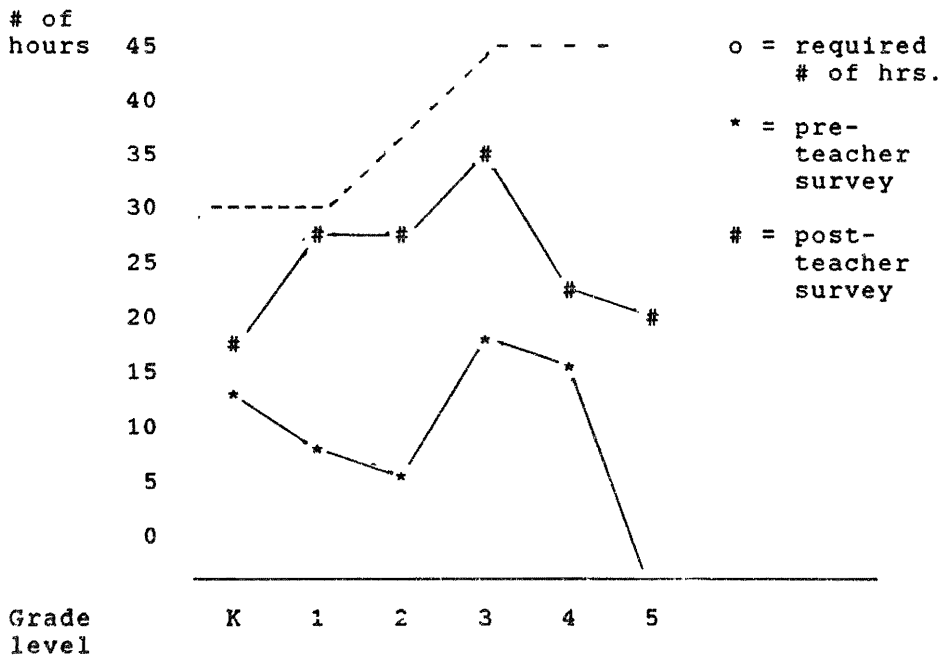


Figure 8

Comparison of Minimum Instructional Hours  
and Instructional Hours Being Taught  
Pre/Post Teacher Survey

The third and fourth objectives were to place and color code all commercial instructional-support materials by phases as verified by the curriculum resource lists and teacher's manuals for each grade level. One-hundred percent of all commercial instructional-support materials were in place and color coded. Curriculum resource lists for each grade-level phase were used to verify that the commercial instructional-support materials were properly color coded and inventoried.

## CHAPTER V

### Recommendations

The Growing Healthy curriculum described in the practicum was a county-wide adopted program. The successful implementation of the training program and organization of the commercial instructional-support materials could have county-wide implications.

The 10-year longitudinal study, sponsored by the American Lung Association, indicated that students' attitudes toward a healthy lifestyle could be positively impacted by a comprehensive health program which provided continuity across all grade levels. The SHEE Report, a three-year study, proved that implementation of school health education was directly related to health curricula resources and teacher training. Insufficient classroom time or instructional-support materials failed to provide a complete program resulting in a reduction of the program taught. Loss of program effectiveness was the result.

The District Teacher Education Center could include this training program in the summer institute. A stipend could then be paid to all participating

teachers, as an incentive to be trained in the GH curriculum. Trained teachers, in the Growing Healthy curriculum could provide needed training for elementary teachers. These training programs could be used to enhance growth schools. Training programs could be school-based, regional, or county-wide. Training sessions could be held during professional days, evenings, weekends, or pre/post school days. The success of the Growing Healthy training program and the organization of commercial instructional-support materials would be shared with all elementary health contacts at district-wide quarterly meetings.



## REFERENCE LIST

- Andrews, Richard L. "Summary Analyses, Growing Healthy: A Longitudinal Study, Kindergarten - Grade 9." University of Washington, 1987.
- Beluschak, Robert. Neighborhood Statistics For Unincorporated Lee County, Florida. Information Services Department Division of General Services, Vol. 3. Lee County, FL, 1984.
- Connell, David B., Ralph R. Turner, and Elaine F. Mason. "Summary of Findings of the School Health Education Evaluation: Health Promotion Effectiveness, Implementation, and Costs." Journal of School Health. October, 1985, pp. 316-321.
- Doll, Ronald C. Curriculum Improvement, Decision Making and Process. Boston: Allyn and Bacon, 1989.
- Dolly, John P., and D. Patricia Katz. "The Relationship of Instructional Practices to Student Learning in Rural Schools." Research in Rural Education. Fall, 1987, pp. 35-37.
- Donnelley Marketing Information Services. "American Profile." July 27, 1988.
- Goodlad, John I. A Place Called School. New York: McGraw-Hill Book Co., 1984.
- Green, Lawrence W., et al. "Thoughts from the School Health Education Evaluation Advisory Panel." Journal of School Health. October, 1985, p. 300.
- Gunn, Walter J., Donald C. Iverson, and Martha Katz. "Design of the School Health Education Evaluation." Journal of School Health. October, 1985, pp. 301-304.
- Kolacki, Eugene C. "How To Plan Inservice Health Education For Elementary Classroom Teachers." Health Education. March/April, 1981, pp. 32-34.

Squires, David A., William G. Huitt, and John K. Segars.  
Effective Schools and Classrooms: A Research-Based  
Perspective. Alexandria, Virginia: Association for  
Supervision and Curriculum Development, 1984.

## APPENDICES

**APPENDIX A**  
**Growing Healthy Survey**

## APPENDIX A

## Growing Healthy Survey

This survey is anonymous.

Your assistance in completing this survey will enable us to provide the necessary training for a successful teaching experience.

Grade Level Taught \_\_\_\_\_

Time Allocated Per Day For Health Education \_\_\_\_\_

Number of Days Per Week Health is Taught \_\_\_\_\_

Total Number of Weeks Health Is Taught \_\_\_\_\_

Please List The Five (5) Priority Units.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Have you been trained in the Growing Healthy curriculum within the last five years? YES or NO. If yes, please indicate the grade level. \_\_\_\_\_

How important is health education on a scale 1 to 5? 1 being lowest, 5 being highest.

Please circle the appropriate number. 1 2 3 4 5

Please explain your answer.

APPENDIX B

Growing Healthy Training Program

Kindergarten

## APPENDIX B

## Growing Healthy Training Program

## Kindergarten

<u>Week</u>	<u>Make &amp; Take</u>	<u>Media &amp; Activity Presentation</u>
1	Introduction Phase I	"Growing Healthy" video Discuss Five Preventive Health Education Specifics
2	Introduction Phase I	F.S. "How Are You Feeling Today?" Demonstrate Touch Cans Discuss the use of manual
3	Phase I Phase II	Guest Speaker: OB/GYN Physician - Topic related to kids, sex, and AIDS.
4	Phase II Phase III	F.S. "A Tale of Two Teeth"
5	Phase III Phase IV	Kindergarten Manual: Page 260, Activity #4
6	Phase IV Phase V	Safety Film from AAA: "Otto the Auto - Buckle Up"

APPENDIX C

Growing Healthy Training Program

First Grade



## APPENDIX C

## Growing Healthy Training Program

## First Grade

<u>Week</u>	<u>Make &amp; Take</u>	<u>Media &amp; Activity Presentation</u>
1	Introduction Phase I	"Growing Healthy" video
2	Introduction Phase I	"Better Safe Than Sorry" video Discuss the use of manual
3	Phase I Phase II	Guest Speaker: OB/GYN Physician - Topic related to kids, sex, and AIDS
4	Phase II Phase III	F.S. "Our Senses Work Together"
5	Phase III Phase IV	First Grade Manual: Page 235, Activity #1
6	Phase IV Phase V	Safety Film from AAA: "Otto the Auto - Buckle Up"

APPENDIX D  
Growing Healthy Program  
Second Grade

## APPENDIX D

## Growing Healthy Training Program

## Second Grade

<u>Week</u>	<u>Make &amp; Take</u>	<u>Media &amp; Activity Presentation</u>
1		"Growing Healthy" video Read and discuss Introductory Phase
2	Introduction	
3	Phase I	Guest Speaker: OB/GYN Physician - Topic related to kids, sex, and AIDS  Read and discuss Phase II
4	Phase II Phase III	Read and discuss Phase III
5	Phase IV	Read and discuss Phase IV and V
6	Phase V	Discuss Personal Safety

APPENDIX E  
Growing Healthy Training Program  
Third Grade

APPENDIX E  
Growing Healthy Training Program  
Third Grade

<u>Week</u>	<u>Make &amp; Take</u>	<u>Media &amp; Activity Presentation</u>
1		"Growing Healthy" video Read and discuss Introductory Phase
2	Introduction Phase I	Read and discuss Phase I and II
3	Phase II Phase III	Read and discuss Phase III
4	Phase IV	Read and discuss Phase IV
5	Phase V	Read and discuss Phase V
6		Make tests to be used with all Phases

**APPENDIX F**  
**Growing Healthy Training Program**  
**Fourth Grade**

APPENDIX F  
 Growing Healthy Training Program  
 Fourth Grade

<u>Week</u>	<u>Make &amp; Take</u>	<u>Media &amp; Activity Presentation</u>
1		"Growing Healthy" video Review lifestyle goals, grade level objectives, and county health continuum Review AIDS curriculum, personal safety lessons
2	Introduction Phase I	Review vocabulary terms, lesson plans, material lists, and learning activities
3	Phase II	Review vocabulary terms, lesson plans, material lists, and learning activities
4		Review vocabulary terms, lesson plans, material lists, and learning activities
5	Phase IV	Review Starting Early
6	Phase V	Review vocabulary terms, lesson plans, material lists, and learning activities

**APPENDIX G**  
**Growing Healthy Training Program**  
**Fifth Grade**



APPENDIX G  
 Growing Healthy Training Program  
 Fifth Grade

<u>Week</u>	<u>Make &amp; Take</u>	<u>Media &amp; Activity Presentation</u>
1		"Growing Healthy" video Review lifestyle goals, grade level objectives, and county health continuum Review AIDS curriculum, personal safety lessons, human growth and development
2	Introduction Phase I	Review vocabulary terms, lesson plans, material lists, learning activities, and teacher references for Introductory and Phase I
3	Phase II I	Review vocabulary terms, lesson plans, material lists, learning activities, and teacher references
4	Phase III	Review vocabulary terms, lesson plans, material lists, learning activities, and teacher references Review station cards, lung dissection, relaxation technique
5	Phase IV	Review vocabulary terms, lesson plans, material lists, learning activities, and teacher references Review health tips
6	Phase V	Review vocabulary terms, lesson plans, material lists, "Stages of Life", and station cards

**APPENDIX H**  
**Make & Take Check List**



**APPENDIX I**

**Completed Make & Take Project Check List**

