NOTE TO USERS

Page(s) not included in the original manuscript and are unavailable from the author or university. The manuscript was microfilmed as received.

95

This reproduction is the best copy available.

UMI®

THE CARDIAC CONDITIONS:
THE HEART OF BEING A TEACHER IMPLEMENTING A COMPREHENSIVE SCHOOL HEALTH APPROACH

A Thesis
Submitted to the Faculty of Graduate Studies and Research
In Partial Fulfillment of the Requirements
For the Degree of
Master of Education

University of Regina

Twyla Salm
Regina, Saskatchewan
November, 2000

Copyright 2000: Twyla Salm

National Library of Canada

Bibliothèque nationale du Canada

Acquisitions and Bibliographic Services

Acquisitions et services bibliographiques

395 Wellington Street
Ottawa ON K1A 0N4
Canada

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-60249-4

Canada

ABSTRACT

The purpose of this study is to explore what being a teacher using a Comprehensive School Health (CSH) approach means to four health teachers. The need for CSH stems from the realization that the most serious and threatening health problems are primarily related to personal decisions and lifestyle choices which are almost always developed and/or sustained during the school years (Kolbe, 1993). CSH is currently understood more conceptually than practically. There appears to be little or no symbiosis between CSH theory and practice reported in the literature. This study seeks to give authenticity to CSH praxis by providing specific situations and practical learning experiences that create and refine CSH theory.

In-depth, semi-structured interviews were conducted with each of four participants. Based on the conversations in these interviews, the information was organized into four themes. These themes become part of a metaphor, which compares a heart and cardiac conditions to CSH. The three cardiac themes are: (a) Megaheartopia is a fictitious ailment that is characterized by the participant's caring and hopeful nature, (b) Bradycardia describes how CSH is slower and less efficient than it could be, and (c) Arteriosclerosis discusses the severe blockages that impede the efficiency of the CSH components. The fourth theme provides the basis for a discussion of the "cardiac care unit," the team of individuals who address these conditions.

From the findings of this study, a clear picture emerges of what being a CSH teacher means to these four participants. The participants describe a unique profile of the CSH teacher and illuminate the successes and challenges of the elements of CSH. The findings are discussed under four headings. The first section entitled "Is There A Doctor in the House?"

discusses the need for coordination in CSH. Although there are no official coordinators of CSH, each participant assumes a leadership role, particularly in the area of instruction.

The second section entitled "Coping with a Heart Disease" discusses how the participants cope with obstacles when implementing CSH. Chronic lack of time, money and inadequate and inaccessible resources obstruct optimum functioning of CSH and contribute to the participants' sense of frustration. To cope with their frustrations, participants avoid issues related to developing healthy school policies and extensive parental involvement.

The third section, "Being a Cardiac Team Member," examines the relationships between teachers and health service professionals and also illuminates two levels of teacher initiated community involvement. A variety of power struggles between health service agencies and teachers demonstrate the complexity of the role of the CSH teacher.

Unable to neglect the obvious needs of students in crisis, the participants are forced to stay grounded in the students' daily lives. The final section, "Valuing the Patient" analyzes how teachers maintain their commitment to CSH through strong bonds with their students and by focusing on health instruction. Their commitment to health education is energized by their sense of moral obligation to strive to improve health conditions for their students.

The study concludes with a closing statement that argues the need to improve conditions for primary health interventions and draws attention to systemic concerns.

ACKNOWLEDGEMENTS

It is with heartfelt gratitude that I wish to express my sincere appreciation for the wise counsel, support and perspective that my advisor, Cyril Kesten, offered throughout the writing of this thesis. His good judgement, insight, sense of humor and dedication to this project kept this research alive and exciting. His friendship and mentoring have been invaluable. I would also like to thank my two thesis committee members, Dr. David Friesen and Dr. Nick Forsberg for their thoughtful and encouraging feedback.

Even though the four participants were extraordinarily busy in their own lives, they found time to participant in yet another professional development project. I am very thankful that they were so willing to share their time and experiences so abundantly.

Thank you to my first health education mentor, Dr. Gerry Gray. His confidence in me, his inspirational comments and the many opportunities that he has provided, encouraged me to deepen my understanding of health education and to begin the Master's progam.

I wish to thank my parents who have encouraged me in all my educational pursuits and for providing a loving and supportive environment where I learned to be curious and a life-long learner.

This thesis is lovingly dedicated to my family, Shawn, Logan and Janelle who have so willingly helped me pursue my goals. I am so grateful for Shawn's steadfast encouragement and perseverance; for Logan's ability to put everything into perspective with many thoughtful, well-beyond his years comments and for Janelle who has never known a Mommy that was not going to "classes" and "writing". I hope that in observing me strive to achieve my educational goals and through their many sacrifices, that both of my children will have gained knowledge and skills that will help them set and achieve their own personal goals.

TABLE OF CONTENTS

ABSTRACT i

ACKNOWLEDGEMENTS iii

CHAPTER 1: THE PROBLEM 1
- DEFINITIONS 3
- THE PURPOSE OF THE STUDY 4
- THE RESEARCH PROBLEM 4
- SIGNIFICANCE OF THE STUDY 4
- DELIMITATIONS. LIMITATIONS AND ASSUMPTIONS 5
- ORGANIZATION OF THE THESIS: THE HEART OF THE STUDY 7

CHAPTER 2: REVIEW OF LITERATURE 9
- OVERVIEW 9
- WHY COMPREHENSIVE SCHOOL HEALTH? 12
  - State of the Children 12
  - Call for Schools to Act 14
- DOES SCHOOL HEALTH MAKE A DIFFERENCE? 16
  - School Health Programs 17
  - It is Cost Effective 20
  - It All Adds Up 21
- IMPLEMENTATION 22
  - Including all Dimensions 23
  - Curriculum Issues 23
  - Community and Outreach 24
  - The Teaching Package 26
  - In-Service 26
  - Assessment 27
  - Management System 28
- BARRIERS 30
- THE CANADIAN PERSPECTIVE 32
- CONCLUSIONS 34
- SUMMARY 35

CHAPTER 3: METHOD 37
- METHODOLOGY 37
- CONFIDENTIALITY AND ETHICS APPROVAL 39
- THE QUESTIONS 39
- SELECTION OF PARTICIPANTS 40
- THE PARTICIPANTS 42
  - Rhonda 42
  - Linda 42
  - Tim 43

Bev 43
TRUSTWORTHINESS 43
INTERVIEWS 44
ANALYSIS 45

CHAPTER 4: THE FINDINGS 47
MEGAHEARTOPIA 49
Rhonda 50
Linda 53
Tim 55
Bev 55
BRADYCARDIA 58
Rhonda 60
Linda 63
Tim 65
Bev 67
ARTERIOSCLEROSIS 69
Rhonda 70
Instruction 70
Healthy environment 70
Social support (parental involvement) 71
Angina 72
Linda 72
Instruction 72
Healthy environment 73
Social support 73
Angina 74
Tim 75
Instruction 75
Healthy environment 76
Social support 76
Angina 77
Bev 77
Instruction 77
Healthy environment 78
Social support 79
Angina 79
THE CARDIAC SUPPORT TEAM 80
Rhonda 81
Linda 82
Tim 84
Bev 87
CONCLUDING STATEMENTS 89

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS 90
"IS THERE A DOCTOR IN THE HOUSE?" 90
Leaders 90
Followers (But Not by Choice) 92
COPING WITH A HEART CONDITION 94
Healthy Environments 95
Social Support 96
BEING A CARDIAC TEAM MEMBER 98
Community Involvement in the Classroom and School 98
Power Struggles 100
VALUING THE PATIENT 104
RECOMMENDATIONS 105
Teachers 105
School Division and School Administration 106
Government and Universities 107
RECOMMENDATIONS FOR FUTURE RESEARCH 107
CLOSING STATEMENTS 108

REFERENCES 112

APPENDICES 124
APPENDIX A: Ethics Form 125
APPENDIX B: Letter of Consent 127
APPENDIX C: Interview Questions 130

CHAPTER 1: THE PROBLEM

The young people of today face health problems very different from past generations of children who died from diseases such as smallpox and polio. Once vaccines were discovered, immunization was the key to significantly reducing the number of mortalities. Few people now suffer the ravages of communicable diseases; but children continue to die as a result of modern maladies, namely motor vehicle accidents (alcohol and other drugs are a major factor in injury and death), unintentional injuries, homicide and suicide, all of which are potentially preventable, "social" issues (Black, 1997; Kann et al., 1998; Statistical Report, 1999). The vaccine for these contemporary health issues has been largely developed, yet the dissemination of the vaccine is far more complex than an injection with a syringe filled with a concoction of antigens. Today, children need to develop knowledge, attitudes, behaviours and social support that will act as the immunization against needless deaths or suffering (Mason, 1989).

The concept of school health has evolved dramatically from the 1940s, when health was defined as the absence of disease, to current ideas that health embodies a much more holistic perspective. Currently in North America, inclusive approaches to school health promotion are referred to as Comprehensive School Health (CSH). CSH is "a broad spectrum of programs, policies, activities and services that take place in schools and their surrounding communities" (Canadian Association for School Health [CASH], 1991). As McCall (1999) describes it, "the approach is designed to affect not only individual health behaviours, but also to improve the environments where young people live and learn" (p. 4). Specifically, CASH (1991) focuses on an integrated approach to CSH, using specific strategies within four categories of means: instruction, health services, social support and

physical environment. It emphasizes the need for collaboration between schools, students, families and communities and the importance of leadership from elected officials, adequate funding, effective administrative support and appropriate policy.

While there is certainly research that provides supportive evidence for school health (Anderson & Thorsen, 1997; Kolbe, 1985; Metropolitan Life, 1988; Report of the 1990 Joint Committee on Health Education Terminology, 1991; Seffrin, 1990) there still is a tremendous amount of work that needs to be done to fully understand CSH. It is currently understood more conceptually than practically (Anderson et al., 1999). Current literature outlines definitions, frameworks and strategies but there are few nationally documented studies of CSH in practice (Allensworth, 1994). Very little is known about how teachers actualize the CSH ideals and how this actualization affects the way they teach and understand CSH programs.

Even though there is significant evidence of a rich body of academic discourse contemplating the promises and perils of CSH, it is critical to note that CSH is more than an institutional construct. Teachers must connect personally with the philosophy that drives CSH in order to interact intensely and effectively with the students and the activities. Exploration of the lived experience of teachers who are teaching health education from a CSH perspective has not been reported in the literature, particularly Canadian literature, and thus very little is known about CSH as a lived reality.

Because CSH theory is currently not informed by practice, there appears to be little or no reciprocity or symbiosis between theory and practice. This neglected negotiated reality of CSH is what intrigues me. I am confident that the basic premise and the general philosophy of CSH are well grounded and must guide the intentions and interventions in schools and

communities in the 21st century. However, the potential for this theory will only be optimized when feedback from the practice provides the necessary link as praxis.

DEFINITIONS

- *Comprehensive School Health (CSH).* CSH is an approach which includes a broad spectrum of activities and services which take place in schools and their surrounding communities in order to enable children and youth to enhance their health, to develop to their fullest potential, and to establish productive and satisfying relationships in their present and future lives. It incorporates the following strategies, instruction, services, support and environment (CASH, 1991).
- *Comprehensive School Health Education (Instruction).* CSH education is health education that is a planned, sequential prekindergarten to Grade 12 curriculum that addresses the physical, mental, emotional and social dimensions of health and is designed to motivate students to promote health and not merely prevent disease (National Professional School Health Education Organization [NPSHEO], 1984).
- *Catalyst Teacher.* This is a teacher who has met the requirements outlined by Saskatchewan Education for a Catalyst Teacher and has been selected and is currently participating in this program. The Saskatchewan Education selected practicing, Middle Level health teachers from a variety of regions in the province to participate in this 2-year program which enables them to be seconded up to 10 days per year for curriculum in-service. Each year the teachers are trained in a 2-day workshop which "certifies" them to conduct Middle Level Health Curriculum implementation workshops, which also describe CSH.

PURPOSE OF THE STUDY

The purpose of this qualitative study is to explore what being a teacher using Comprehensive School Health (CSH) has meant to four health teachers. In doing this study, a profile can be created and knowledge gained about the role of CSH in schools where there is a Catalyst Health Teacher who is intimately involved with the implementation of the curriculum endorsing CSH. Primarily, the study will explore what it means to be engaged in the role of the CSH teacher.

This study presents the teacher's role in CSH, however, this role is only a small portion of a much larger picture in terms of understanding the roles of other key members in CSH.

THE RESEARCH PROBLEM

The research question on which this study is based is: **What does it mean to be a teacher who is attempting to implement a Comprehensive School Health approach?**

The subproblems focus on learning what teachers perceive their role in CSH to be and what they perceive themselves as capable of doing and changing. There is also a need to focus on understanding how the teachers perceive each of the four main elements of CSH (instruction, healthy environments, social supports and health services) and how these perceptions reflect both obstacles and advantages in implementing CSH.

SIGNIFICANCE OF THE STUDY

Anderson et al. (1999) have suggested that more research needs to be done to understand the intricacies of the various components of CSH (school policies, relationships with the community, the role of health services, cost effectiveness and professional

development). At the same time, they have stated that CSH is more of a concept than a reality. This is evidenced through the fact that the voice of teachers is virtually nonexistent in the literature. In Saskatchewan, Catalyst Teachers are a CSH reality and, if given a voice, could contribute to the "realness" of CSH. Currently, the renewed Middle Level Health Curriculum has been implemented too recently for general classroom teachers to provide appropriate data for this study. The individuals best suited to explore and get an adequate reading of the CSH pulse are the Catalyst Teachers who are also classroom teachers. Catalyst Teachers are at the heart of school health in Saskatchewan and it is timely to study this population.

This study will deepen the understanding of how the ideals of CSH are actualized. Through the narrative stories of the participants, the realities of being a CSH teacher will be illuminated. Also, this knowledge will contribute to a greater understanding of the actual challenges and successes of CSH in a provincial setting. Most importantly, it will give authenticity and "life" to CSH praxis by providing a context, specific situations and learning experiences that, in practice, create and refine CSH theory. Understanding the teacher's perspective may serve to improve our ability to overcome some of the obstacles related to CSH and perhaps enhance society's understanding and appreciation of the CSH approach.

DELIMITATIONS, LIMITATIONS AND ASSUMPTIONS

This study has certain delimitations, limitations and assumptions, which do not allow for further generalization of this study beyond the four participants. This research presents the experiences and stories of four Catalyst Health Teachers in different school divisions in urban and rural Saskatchewan. Each teacher has been a part of the Catalyst Teacher program

since its inception in 1997. Limiting the number of participants in this way, and recognizing that these teachers have had special in-service training in CSH and unique experiences as Catalyst Health Teachers, preclude an examination of others' experiences, which may be very different from these four.

While none of the participants were more than slight acquaintances, I had conversed and been in catalyst groups with them in the past. Additionally, they know that in all likelihood our professional paths could cross again because of our common interest in health education and the small network that exists in Saskatchewan. This may have affected the interviews in that the participants may have spoken more freely with someone with whom they had an established and trusting relationship. On the other hand, they may have been more comfortable with a complete stranger or someone they were not likely to ever meet again.

The first interview was in person and was about 2 hours in length and the second interview, over the telephone, was about 45 minutes. Because the second interview was not in person, there could have been nonverbal cues which were not reflected in the transcript.

All the teachers are considered "ambassadors" for health education and have participated in workshops organized by Saskatchewan Education, which endorses CSH and has included this approach as a part of the health curriculum. Since provincial education personnel are often considered to be educational "gurus" there may have been a particular skew in some of their comments. The teachers' responses may have also been affected as they knew that I am deeply committed to CSH and also teach in this area of study.

While the interviews took place in a variety of settings and were all conducted in the spring of 2000, it is possible that different results may have been obtained at other times or places.

ORGANIZATION OF THE THESIS: THE HEART OF THE STUDY

Central to the human system is the heart, the epicenter for life and the long-established symbol of love. In coming to know health education in another way through this project, the images of the heart frequently emerged and the analogy of "the Cardiac Care Unit" and Comprehensive School Health being at the "heart" of health education began to take form. Similar to the heart's four chambers, CSH is divided into four components: instruction, health services, social support and the healthy environment. Like the heart, CSH is the center of a vastly complicated and interdependent system. However, the heart is just a piece of smooth muscle tissue until it is energized by an intangible and mysterious electrical catalyst that "kick starts," controls, and regulates this vital element of existence. Comprehensive School Health is a framework - merely smooth muscle tissue - until it is given the depth and meaning through the rhythm that is created when Catalyst Teachers initiate and maintain the beat in health education. While CSH teachers may not be the only or the most pivotal person in kick starting CSH, the role of these teachers is critical because they have their finger on the pulse of the school. They are in a position to identify the kinds of strategies that are needed to gain the trust and develop relationships with students and families. Additionally, they are at the center of health instruction, one of the four main components of CSH.

This study will review the literature relevant to CSH programs and approaches in Chapter 2, describe the methodology and explain how the data were collected and analyzed in Chapter 3, and present the research findings under four themes in Chapter 4. The study concludes with Chapter 5, which includes a summary and the discussion of the findings, conclusions, recommendations, and suggestions for future research.

CHAPTER 2: REVIEW OF THE LITERATURE

OVERVIEW

> Schools do have an important role in promoting the health of Canadian children, but ultimately, success in this complex task requires the creation of partnerships involving schools, communities and young people working together. (Anderson et al., 1999, p. 1)

The little red schoolhouse in a contemporary setting has become more than a place of instruction and educative lessons. By default, when obvious needs of students require attention, teachers' roles have expanded to include the roles of crisis managers, fight mediators, grief counselors, advocates, social workers and liaisons to a variety of bureaucracies (Tyson, 1999). During the last few decades there has been a distinct and intentional division between public health services and education which has compounded the effect of two "helping systems" working simultaneously but, oftentimes, oblivious to one another. This division has only recently begun to be mended. The guiding principle of CSH, and other similar school health movements, is that schools and communities can be more efficient and effective in promoting health when they coordinate their staff, costs, resources and creativity. The underlying premise suggests that taking care of students' needs is not the sole responsibility of schools. If health agencies, community members, families and schools can develop approaches to work together, it would lower the barriers that often exist which impede student learning and academic progress. At the same time, it might be emphasized that there is wide-spread agreement that schools should accept responsibility for providing health education for children (Johnson & Deshpande, 2000). According to the Gallup Organization (1994), over 80% of parents and administrators thought that health education was of equal or greater importance than other subjects. An overwhelming 86% of students

reported that schools should spend more time on health education than on subjects such as English. Math and Science (Lawton. 1999).

The notion of CSH rests on the idea of shared responsibility and cooperation. The Canadian Association for School Health (CASH. 1991) focuses on an integrated approach to CSH using specific strategies within four categories of means: instruction. health services. social support. and physical environment. They emphasize the need for collaboration between schools. students. families and communities and the importance of leadership from elected officials. adequate funding. effective administrative support and appropriate policy. In an expanded concept of a CSH approach. reflecting an American perspective offered by Allensworth and Kolbe (1987). there are eight elements which are not particularly unique to most schools but are developed in this model in a coordinated fashion to reflect high quality. continuity and adaptability (Marx. 1999). The eight components are as follows:

1. ***Healthy environment.*** Is reflected in policies. programs and safety measures.
2. ***Health instruction.*** Uses classroom instruction to develop the knowledge. attitudes and skills to avoid health-risking behaviours.
3. ***Physical education.*** Teaches life-long activity.
4. ***Health services.*** Focuses on prevention and early diagnosis. as well as management of acute and chronic conditions.
5. ***Counseling.*** Offers intervention. services and referrals for emotional. behavioral and social needs of children.
6. ***Food services.*** Provides nutritious and affordable meals and promotes healthy options.
7. ***Staff health promotion.*** Promotes activities to improve the health of school staff. This also promotes healthy role models for children.

8. ***Family and community involvement.*** Creates partnerships to share and make the most of health resources and expertise.

It is not uncommon for schools to have some or all of these elements. Many teachers have needed to call upon nurses, social workers, or counselors to deal with individual student's needs. The difference between this piecemeal approach and CSH is much less duplication of services, missed class time, students "falling through the cracks," or students receiving inadequate or inappropriate services (Wooley, Eberst, Bradly, 2000). In many CSH schools, administrators, staff, students and family members, community members, and health agencies meet as a team (Marx & Northrop, 2000). Other schools designate a health coordinator with authority and release time to formalize and expand collaborative efforts and coordinate the eight components (Wooley et al., 2000).

The guidelines for Comprehensive School Health Programs, developed by the American School Health Association, include all eight of these components and provide direction for practice and outcomes for local school districts to develop strategies for assessing their needs and planning and implementing a local CSH program (American Cancer Society, 1992). Most recently in the United States, the term *Comprehensive* School Health has been replaced with *Coordinated* School Health. The term *coordinated* further specifies the focus of an approach that seeks to link the resources in the school with families and community agencies to address the array of health needs of children (Wooley et al., 2000). The momentum for this approach has been growing as schools recognize this strategy as an effective way to address complex health and education issues. Marx, Wooley, and Northrop (1998) state, "When schools do not deal with children's health by design, they deal

with it by default . . . . Until schools address students' health as directly as they do math, reading and science, they will not produce employable and productive graduates" (p. 2).

Even though the health-promoting strategies used within a Comprehensive School Health approach are varied, the fundamental goals remain common. The goals of such comprehensive approaches are to:

- promote health and wellness
- prevent specific disease, disorders and injury
- intervene by assisting children and youth who are in need or at risk
- help support those who are already experiencing poor health (CASH, 1991).

These broad goals of CSH suggest an acknowledgment that many children are in need, at risk, or in poor health. With that, the rationale for a CSH program must begin with understanding the children.

WHY COMPREHENSIVE SCHOOL HEALTH?

State of the Children

The most serious and threatening health problems are related primarily to personal decisions and lifestyle choices which are almost always developed and/or sustained during the school years (Kolbe, 1993; Seffrin 1990). Unrecognized by most Canadians, the health of Canada's children in many areas has not improved during the 1990s and, accordingly, Canada has received the lowest ranking in the industrialized world for child health support. Overall mortality and hospitalization rates have fallen somewhat but those children in poorer situations have suffered disproportionately during this time (Chance, 1994). Kazemipur and Halli (2000) surveyed 19 of the major cities in Canada. Both Regina and Saskatoon have a

significantly higher poverty rate than the national city average. Reflective of other North American situations, Saskatchewan adolescents are engaging in many high-risk health activities. To illustrate this point Schissel and Eisler (1999) provide copious amounts of data generated from a survey of 2500 Saskatchewan adolescents. For example, they report that 58% of sexually active females "always" or "sometimes" had unprotected sex, 39% of females and 34% of males smoked cigarettes every day, 19% of males drank beer more than once a week, and 31% of females had "sometimes" or "often" thought seriously about suicide.

The National (U.S.) Commission on the Role of the School and the Community in Improving Adolescent Health (1990) states, "Never before has one generation of American teenagers been less healthy, less cared for, or less prepared for life than their parents were at their same age." As a response to this rather startling situation, practically all national and state organizations related to health, education and social services support the notion related to the development and implementation of Comprehensive School Health education as one approach to reducing many preventable problems (CASH, 1991; Detert, Bradly, & Schindler, 1996).

Despite the fact that there is considerable support for the ideals of CSH, a plethora of health issues (O'Rourke, 1996), and the recognition that school is the only stable influence in some children's lives (Dryfoos, 1990), there is not exactly a boisterous campaign raging locally or nationally to improve health education. Awareness and recognition of the need for quality health education is improving however, as 40% of school boards across Canada support CSH (McCall, 1999).

Call for Schools to Act

"Inextricably intertwined" is a commonly cited expression that describes the cohesive relationship between health and academic achievement (McGinnis 1981; National Commission on the Role of the School, 1990; Novello, DeGraw & Kleinman, 1992). While Brown, Grubb, Wicker and O'Tuel (1985) found that health problems are related to classroom problems, it is a well-documented position that students have difficulty learning when they are not in good health (O'Rourke, 1996) and that healthy children are able to acquire knowledge more readily (McGinnis, 1981). Furthermore, it stands to reason that "no curriculum is brilliant enough to compensate for a hungry stomach or a distracted mind" (American Cancer Society, 1995). It is recognized that there are a multitude of factors - ranging from personal to societal variables - that impact academic achievement but regardless, Symons, Cinelli, and James (1997) conclude there is a strong relationship between student health and education outcomes. The prospect that CSH approaches may improve academic success appears to be a significant motivator for implementing CSH in American schools.

Marx and Northrop (2000) state that teachers are under a significant amount of pressure to improve their students' standardized scores thus addressing some of the students' basic health needs may improve test scores. When health needs are met, children are more likely to be in school and engaged with learning (Wooley et al., 2000). Simply, the health of students is a prerequisite for effective learning and since health and learning are symbiotically related, the state of one of these factors significantly affects the other.

From Kolbe's (1985) perspective, not only is academic performance, cognition and concentration affected by a CSH program, but problem-solving skills and peer sociability are

also enhanced when children are healthy. This type of fundamental knowledge and skill, which is related to CSH, is essential for growth and development throughout the life cycle and contributes to general life satisfaction (DeFriese, Crossland, MacPhail-Wilcox, 1990). The U.S. Public Health Service (1999) reports that students use fewer drugs, are less likely to binge drink, become pregnant and leave school when support services such as nurses and counselors are involved with quality health instruction in the schools.

Effective health education could and does take place in other venues, but Kirby (1990) states that schools are the one public institution with the greatest opportunity to improve the health of students.

> Next to the family, schools are the most significant influence in young people's lives and as such, provide unique and exciting opportunities for educators and their community partners to help young people enjoy the important possibilities in their lives. (Anderson et al. 1999, p. 22)

The role of the school in health education should not be underestimated. Given a choice among media, teachers, friends, parents and medical professionals about their preferred source of information regarding sex, Saskatchewan students show an overwhelming preference for teachers. Similarly, the students show an even greater preference for information about birth control to be addressed by teachers (40%), twice as high as media (19%) and medical professionals (21%) and about six times more preferred than parents (6.6%) (Schissel & Eisler, 1999).

Anderson and Thorsen (1997) suggest that schools must provide teachers who are pedagogically prepared (at least theoretically) to facilitate students in collaboration with their peers to engage in a systematic exploration of health issues. CSH teachers avoid prescriptive guidelines and emphasize skill building that affects attitudes and behavior for a lifetime

(Marx & Northrop, 1995). Here is where a planned, sequential, purposeful CSH curriculum, in combination with a broader CSH program, will be more effective than addressing individual topics outside a school health framework (Kolbe 1993).

DOES SCHOOL HEALTH MAKE A DIFFERENCE?

School health education does make a positive difference (Anderson & Thorsen, 1997; Kolbe, 1985; Metropolitan Life, 1988; Report of the 1990 Joint Committee on Health Education Terminology, 1991; Seffrin 1990). Kolbe (1985) states that at least 15 metaevaluations have synthesized the results from hundreds of health education interventions. One of the generalizations concedes that school-based health education programs consistently improved health knowledge, attitude and skills but inconsistently improved health behaviours. Other studies show that a behavioural impact may occur, especially in school-based interventions which are meticulously planned and implemented (Connell, Turner & Mason, 1985; Mason, 1989). Seffrin (1990) contends that schools are clearly effective in reducing the incidence of students engaging in many risk-taking behaviours and also in supporting students to maintain a high level of wellness.

School Health Programs

The U.S. Public Health Service (1999) reviewed more than 50 programs that addressed some aspect of student physical, emotional, or social health through school-based programs. Such programs have led to improved school attendance, graduation rates, and standardized test scores, as well as lifestyles that contribute to good health. One of these programs called ACHIEVE, located in Florida, involves teachers and support staff, as well as school psychologists, in an effort to provide training in problem solving, social skills and

anger management, effective teaching, curriculum-based assessment, parent training, organizational planning and development and evaluation. The evaluation showed a 75% reduction in referrals for special-education assessment and a decline from 6% to 2% of students placed in special education.

Programs that use a comprehensive approach to target specific health-risking behaviors such as poor nutrition (Luepker et al., 1996), physical inactivity (Kelder, Perry & Klepp, 1993), smoking (Perry, Kelder, Murray & Klepp, 1992), unprotected sexual behavior (Kirby, 1992), and alcohol-and-drug abuse (Botvin et al., 1990) have shown significant behaviour benefits in programs using a CSH approach. Another well-documented program which uses the CSH approach, and is successful in behaviour changes, is a program called The Adolescent Trial for Cardiovascular Health (CATCH). It uses a variety of interventions related to healthy eating, physical activity, and nontobacco promotion to reduce the risk of cardiovascular disease in children (Perry et al. 1990). The results show not only an improvement in the students' school lunches but also that this behaviour carries over into their home-eating choices. Physical activity also increases in these students.

"Raising Healthy Children," a CSH-based program, was developed in Seattle, Washington, and provides parenting education for parents of students in Grades 1 though 6. The U.S. Public Health Service (1999) reports that for the students who participated in the program for several years there was an improved academic achievement and lower rates of delinquency, pregnancy, tobacco use, and illegal substance use.

Roper (1991) reported on the Teenage Health Teaching Modules Curriculum - a large-scale, controlled study involving almost 5000 students. In the self-reported study, a reduction in drug use, alcohol consumption, and cigarette smoking was achieved in schools

using a Comprehensive School Health education curriculum. While there are changes to behaviour and attitudes, the most outstanding results relate to student health knowledge (Gold et al., 1991).

As summarized by Connell, Turner, and Mason (1985), similar results were found regarding a large-scale study that evaluated four CSH curricula that included over 30,000 students. In classrooms where "The School Health Curriculum Project," "Project Prevention," "3 Rs and High Blood Pressure," or the "Health Education Curriculum Guide" were implemented, students had a marked increase in health knowledge and statistically significant increases in positive attitudes and in their self-reported health practices. Students reported that attitudes and behaviours benefit most when there was a second exposure to the program. This may support the theory that CSH needs to be coordinated and evolve over many grades and should begin in an elementary school setting.

The "Health Curriculum Project" involved elementary children in a preventative smoking program. Students participating in this program had a more positive health attitude, experimented less with cigarettes, and had a lower future expectancy to engage in cigarette smoking (Andrews & Hearne, 1984). Another program that shows CSH has an impact on improving school health was developed in Calgary with the "Learning Through Health Partnerships" (1997). Results from this extensive evaluation of 24 Calgary schools found that health curriculum had been strengthened, self-reported student health knowledge and behaviour had improved, the environment was enhanced though health displays, posters and newsletters, there was increased parental involvement in the school, especially regarding communication with health issues, and many outside agencies became active in the school.

One of the most recently completed formative evaluations of a CSH program is the "Mariner Project" in South Carolina (Valois & Hoyle, 2000). The main focus of this study was to determine the extent to which a CSH infrastructure could be developed in a two to three year period. In the "Mariner Project" staff, families and interagency teams work together in program development and implementation as they strived to share leadership, responsibility, and interagency commitment to develop health-promoting schools. Findings from the seven schools involved with this project show that two of the schools (primarily the administrators) did not "buy into" the project and CSH was essentially not even attempted. In the other five schools, the performance score, which is a rigorous set of scores based on specific criteria, was in the "above average" and "approaching excellence" range.

Tyson (1999) reports that there are at least 900 school-based health centers in the United States and several of these examples of successful school- based programs were showcased at the American School Health Association's annual conference (Wooley et al., 2000). It appears there are many CSH programs functioning in the schools that are not necessarily researched in a systematic and standardized way, but have been deemed valuable in an anecdotal way from those who are involved. Marx (1999) describes programs in Louisiana where there is a CSH program with an on-site (part-time) pediatrician, parents who attend literacy classes, and a counselor who offers group sessions to teen mothers. In a Rhode Island school, a multidisciplinary team of administrators, parents, nurses, psychologists and counselors meets regularly to problem solve on common issues. In Harvey, Illinois, the school district and the health district coordinate a concerted effort to meet the health needs of a low-income student body using their school nurse, a social worker, and a health educator.

Cortese (1993) suggests that the Michigan Model for CSH has been deemed very successful and frequently serves as a model for other programs. Hardy (1999) describes a successful CSH program at Marrington Middle School in South Carolina where a small teacher-initiated program expanded to a 3-year, community-type project with a grant of $450,000 which involved six other schools in the area. Even though Comprehensive Health Programs can cost a considerable amount of money, they are a bargain in comparison to the cost of secondary and tertiary health care.

It is Cost Effective

The moral issues related to health education alone warrant the costs that may be incurred for CSH (Cameron, 1991), but CSH is also financially feasible and economical (Kirby, 1990; O'Rourke, 1985) not only for schools but also for the nation. In addition to the fact that the economic state of the country rests on a healthy productive workforce (Marx & Northrop, 1995), prevention efforts are cost effective (Anderson & Thorsen, 1997; Kolbe, 1985).

While rising medical costs are the most obvious concern, there are many other costs related to decreased health. These include lost wages, reduced productivity, increased absenteeism, high job turnover, and disability payments. The costs related to health care may be reduced through health education, in general, and school health education, in particular (O'Rourke, 1985). Dr. Seffrin (1994), chief staff officer for the American Cancer Society, says that "If everything we already know about primary and secondary cancer prevention were only taught and applied universally, we could reduce cancer deaths by 50% to 60%" (p. 398).

This is true for cancer and for each of the 11 leading causes of death in the U.S. population a measure of prevention now exists. Seven of the 10 causes of death in the U.S. could be significantly reduced if people at risk were to address just five behaviours: diet, smoking, lack of exercise, alcohol abuse, and use of antihypertensive medication. Estimates indicate that 400,000 lives and 20 billion dollar could be saved each year if individuals made particular changes in lifestyle decisions related to smoking, alcohol and exercise (O'Rourke, 1985). To strengthen the cost-effective argument, Resnicow, Cherry and Cross (1993) call for rigorous studies to be conducted to support these estimates with quantifiable data. Even given a modest reduction in risky behaviour it would be significantly cost effective (Lavin, Shapiro & Weile, 1992). O'Rourke (1985) speculates that if school health education programs were only 2% successful in decreasing smoking, STDs, teen pregnancy, and child-and-drug abuse there could be 480 billion dollars saved. Rothman et al. (cited in Anderson et al., 1999) reviewed exemplary CSH programs and claimed that the potential costs of secondary and tertiary treatment programs were 13.8 times the cost of the CSH program. As Tyson (1999) reports, many schools already have foundational parts of the eight components in the model of a comprehensive program but do not have them well coordinated. In these circumstances, coordinating and delegating tasks may incur slight, if any, costs and the payoff may be great.

It All Adds Up

There appears to be considerable consistency consuming what a successful comprehensive program must entail, even within a very broad range of locations and programs. The "Harvard School Health Education Project" initiated a national policy analysis

related to school health promotion. The project reviewed a variety of publications including government documents, commercial books, and reports produced independently by private and professional organizations. There were 25 reports, which addressed children's health and education in a comprehensive way, rather than focusing on a single categorical concern. Five themes emerged from the reports, even though the sources were very diverse (Lavin et al., 1992).

1. Education and health are interrelated.
2. The biggest threats to health are "social morbidities" or preventable behaviours which are often established during youth.
3. A more comprehensive, integrated approach is required.
4. Health promotion and education efforts should be centered in and around schools.
5. Prevention efforts are cost effective and social and economic costs of inaction are too high and still escalating.

This report summarizes what health educators have known, studied, and debated for a long time. With a sound theoretical base, a more global understanding, and the collaboration of many partners, the emphasis of CSH literature as of late has been not "Why?" but "How?"

IMPLEMENTATION

In an attempt to standardize and create an overview of CSH, the National Professional School Health Education Organization (NPSHEO, 1984) developed 10 standards of performance which function as criteria for successful CSH education. Complementing these standards, Davis, Gonser, Kirkpatrick, Lavery, and Owen (1985) studied four CSH programs and deduced a list similar to the NPSHEO elements and supplemented the criteria to address

entire CSH programs including health services, environment, and community. Others such as DeGraw (1994), English (1994), and Lavin (1993) also suggest that fundamental parameters and innovative practices are needed to ensure successful programs, many of which are in agreement with the NPSHEO standards, but some of which are more detailed or emphasize specific factors. This variety of recommended or essential components will be described under the following seven headings: Including All Dimensions, Curriculum Issues, Community and Outreach, The Teaching Package, In-service, Assessment and Management.

Including All Dimensions

NPSHEO (1984) recommends that health instruction should motivate health maintenance and promote wellness while integrating all dimensions of health within a range of topics. They recommend that a comprehensive program should include the following areas: community health, consumer health, environmental health, family life, growth and development, nutrition, personal health, prevention and control of disease, safety and accident prevention and substance abuse. Even though most professionals teach within the suggested 10 commonly accepted topic areas, it is important to focus on priority health issues and to apply multiple theories and models when developing interventions to promote health (Allensworth, 1994).

Curriculum Issues

A well-planned, sequential curriculum (Davis et al., 1985) that provides a state-wide (or provincial-wide) framework of standards (English, 1994) and develops specific program goals and objectives is critical. There must be opportunities to develop and demonstrate knowledge, attitudes and practices that are interwoven within the context of personal life.

family and community (NPSHEO, 1984). Cameron (1991) reports that most provinces have a sequential curricula but only from Grades 1 to 9. Quebec is the only province that has a complete program spanning the elementary and secondary years. Saskatchewan curriculum addresses health issues and continues the CSH philosophy in the secondary level through Wellness 10 and Life Transitions 20/30. Teaching generic skills, such as decision making, refusal skills, and problem solving helps students learn skills that relate to a variety of health issues (Allensworth, 1994) and opportunities to develop and demonstrate appropriate knowledge, attitudes and practices (NPSHEO, 1984).

Community and Outreach

A congruency noted in the literature reflects an emphatic need for outreach programs that link schools to their families and the communities (Killip, Lovick, Goldman, & Allensworth, 1987). Health education is energerized by community and family involvement, especially since students are significantly influenced by the attitudes and behaviours of their parents (DeGraw, 1994; Lavin, 1993). Outreach activities assist families and community members to support, understand and reinforce CSH goals (Allensworth, 1994). Conversely, family and community members can contribute valuable information, resources, and expertise to the school health curriculum (Davis et al., 1985). DeGraw (1994) calls for the reconceptualized notion of health, which is a community-based system that is highly student focused and needs driven. Establishing a CSH program with such an emphasis would also address the need of CSH to be more culturally sensitive and prevention oriented.

There are a variety of models which integrate schools and communities and, depending on the needs of the particular community, an appropriate model or combination of

models are utilized (Killip et al., 1987). There appears to be some overlap in the literature related to "community schools" and "coordinated school health programs." Community schools focus on creating partnerships that open the school doors to the community and on addressing both child and family needs from early in the morning to late at night. The school building is a safe, comfortable and central meeting place at any time of day for all community members (Dryfoos, 2000). It seems that CSH and Community School Models have some distinct similarities and the research supporting Community School philosophies and initiatives with parents and community partnerships would also support CSH ideals.

While most parents (82%) and community members favour health education (Gallup Organization, 1994; Lavin, 1993), they can potentially serve as advocates or critics (Lavin, 1993). Epstein (1987) reports that effective schools are characterized by a significant parent involvement. However, few schools effectively encourage parental, familial, and community involvement, even though parents are ultimately responsible for the student's health care (Brown et al., 1985; English, 1994; Tyson, 1999). DeGraw (1994) suggests that the school should be the focal point in which a variety of resources are available. Social service agencies, nonprofit organizations, community health centers, hospitals, local practitioners and health departments can all contribute to form school health services.

Community involvement also contributes to understanding health in a larger social context and to establishing a caring, nurturing school that has increased expectations for student success (Allensworth, 1994). Community involvement is vital in not only understanding national health concerns but in dealing with local and community issues (Davis et al., 1985).

The Teaching Package

Time, money, and resources, continue to play a significant role in successful programs. Davis et al. (1985) isolate the need for age-appropriate, "rich" teaching and learning resources that accommodate students with a variety of learning styles, as a distinct element for successful programs. Lavin (1993) concludes that financial resources for school health education have been meager, even though funding for specific health crises is often provided. In relation to time, Connell et al. (1985) state that 40 to 50 hours/year of classroom health instruction is required to affect changes in behaviour. Cameron (1991) reports that while the time allotted to health education varies from province to province, health is afforded less time than most other subjects. The time allotment for health in Saskatchewan ranges from 80-100 minutes per week depending on the grade.

In-Service

Perhaps part of the problem related to the lack of time scheduled for health education may be linked to teacher preparation and confidence. Hausman and Ruzek (1995) studied a teacher-development project that attempted to reduce elementary school teachers concerns regarding feelings of preparedness and comfort in teaching a Comprehensive School Health education curricula. Because there was a widespread view that health is not taught, teachers were involved in professional development opportunities and provided with materials and resources. Findings from the evaluation suggest teacher-development efforts can have significant classroom effects with training and on-going reinforcement. Not only does in-service assist teachers to gain confidence and plan and prepare better, but it also provides an on-going update of relevant knowledge and teaching skills (NPSHEO, 1984). In-service also

provides time for curriculum input (Davis et al., 1985) and for designing work site health-promotion activities for the teachers and staff in the school (Allegrante, 1998). Ross, Luepker, Nelson, Savedra and Hubbard (1991) found in-service training is often neglected even though it has been shown to be a critical factor in program effectiveness.

Despite the fact that teachers with a variety of backgrounds and at varying career stages seek and value good professional development in health education (Macrina, Creswell, Forouzesh, & Stone, 1986), lack of teacher training in health education continues to present a major obstacle to program implementation and effectiveness (Lavin, 1993). English (1994) recommends that colleges and universities upgrade their preservice programs, provide separate courses for elementary and secondary preservice teachers, and satisfactorily complete a personal health course prior to becoming a health educator. Mutter, Ashworth, and Cameron (1990) identify the need for more university-based programs that would provide teachers who are trained in CSH education. They state that Health and Welfare Canada, in conjunction with other national organizations, has created a national advisory committee to assist in this process. The purpose of this group is to promote enhanced quality in preservice teacher-education health programs and to elevate the priority assigned to these programs.

Assessment

Some argue that implementing assessments which measure how well students meet statewide/provincial goals would enhance the public perception of health education (English, 1994; NPSHEO, 1984). Lavin (1993) notes that health would assume greater respect if it were included in national achievement tests but admits, due to the nature of health outcomes,

especially in the attitude and behavioral domain, assessment would be difficult. Davis et al. (1985) emphasize that assessment should not only be considered for students, but also for the CSH program as a whole. Feedback from students, teachers, school districts, parents and community members would also contribute to identifying whether objectives have been met (NPSHEO, 1984). Grunbaum, Gingiss, Orpinas, Batey and Parcel (1995) offer a needs-assessment method that can be used to set priorities and guide policy and program decisions. This is would be of particular benefit as resources are often declining and demands on schools are increasing. Additionally, periodic but intense assessment of the school learning environment is vital because students are being exposed to conditions that may motivate or reinforce factors that contribute to their overall health or lack thereof (Davis et al., 1985; NPSHEO 1984).

Management System

As all systems, a complex program such as CSH needs some type of management or leadership to coordinate all the components (Davis et al., 1985; Kolbe, 1993; NPSHEO, 1984; Seffrin, 1990). Conducting these programs with some coordinated orchestration is vital (Kane, 1993; Stone, 1990), yet Cameron (1991) reports that this issue is poorly addressed in Canadian curricula and, at best, is only superficially considered. Gibson-Laemel (1987) suggests that individual teachers should take the initiative to develop an advisory committee but others can also look to the curriculum for guidance.

The Saskatchewan Middle Level Health Curriculum (1998) suggests and provides guidelines for the membership and function of a local liaison committee. Liaison committees demonstrate how local community members, teachers, administrators and students can

embody a management system for CSH. At this time, there are several schools in the province at various stages of development with a CSH liaison committee. Other successful liaison committees have been created, such as in "Project Prevention" (Davis et al. 1985) in Dalles, Oregon, but regardless of where the health promotion idea is initiated, the school is deemed the central and most logical liaison for the community (Pentz, 1986). Some contend that program management may be accomplished by a variety of means such as a multidisciplinary team, a committee or/and advisory board (Davis & Allensworth, 1994), whereas Resnicow and Allensworth (1996) specify that while many goals of CSH can be achieved through committees, a health coordinator position is necessary: in this way, one individual is responsible for ensuring effective and accountable leadership.

Regardless of the structure of the management system, the leadership responsibilities remain similar. A health coordinator must not only provide coordination and liaison services but also have fiscal planning skills, deal in direct health intervention related to policy, program, and in-service, offer accountability, evaluation and quality control (Davis & Allensworth, 1994; Resnicow & Allensworth, 1996). Seffrin (1990) concludes that one of the keys to overcoming some of the barriers for successful implementation is to ensure that an adequate and efficient management system is in place because it is essential that individuals be informed and work as partners.

It appears that the previously mentioned essential elements which contribute to a successful CSH program seem to be congruent with the predominant trends in education. The trends for education, according to Sullivan and Bogden (1993), are to:

- set goals
- employ management through outcomes

- strengthen teacher skills by in-service
- promote innovative schools: experience new strategies
- establish interagency collaboration.

Sullivan and Bogden (1993) state there is a current national movement to reform the ways schools operate. They suggest that school health educators should capitalize on this situation and look at this as an unprecedented opportunity to implement effective health education programs.

Given the congruency between education trends and the common essential elements of CSH, why is CSH not a widely accepted reality (Black, 1997)? Unfortunately, CSH is not a reality in many schools because, in many cases, the obstacles have been too overwhelming.

BARRIERS

Given that primary prevention in the form of a Comprehensive School Health has been widely accepted as the action needed to combat current health and social issues, it is astonishing that there are so many barriers to implement programs successfully. When programs are categorically funded for a specific health issue, such as AIDS or smoking prevention, there appears to be "external pressure" to become diverted from the primary goals of comprehensiveness. Frequently, a particular program extends for a short time period, with limited impact. The issue-specific, "crisis-of-the-day" programs result in fragmented, inefficient and unintegrated programs (English, 1994; Jackson, 1994; Oetter, 1987). If health education is based on the concept of *synergy* - that the whole is greater than the parts (Kolbe, 1986) - individually funded projects for specific health concerns will distract from the goals related to comprehensive health, rather than reinforce the concept (English, 1994). Only

recently have American federal agencies initiated funding partnerships that stimulate local collaboration by requiring communities and schools to work cooperatively and share resources. In Canada such well-defined funding for collaboration does not seen to be quite so apparent (Osorio, Marx & Bauer, 2000).

Additionally, while funding and resources may be available at times, and great strides relating to theory have been made at the national level, very little has filtered down to the local school level. Part of the difficulty is that many of the resources are from Health and not from Education. As a result, the need for dollars (Auter, 1993) and people for planning, implementing, and evaluating health programs within schools is still great (Cortese, 1993). The local level is an area with an enormous amount of potential impact, yet Butler's (1993) study revealed that the most influential barrier for CSH was weak local administrative commitment. This may be related to what Oetter (1987) calls a general ambivalence to the necessity and importance of health education. Yet, a Gallup Poll (1992) suggests that 92% of administrators believed health was as useful as other subjects.

Contributing to the somewhat negative attitude hovering around the area of health education may be the lack of qualified teachers who feel confident and prepared to address health education (Butler, 1993; Cortese, 1993). Mutter et al. (1990) note that only three Canadian universities offer specialized teacher training in health education, while others include school health education in the physical education elective. A study of preservice teachers, conducted in Ontario, concludes that beginning teachers neither feel prepared to teach most topics in health education nor to plan, implement, and evaluate programs or work collaboratively with concerned partners to promote health in schools (Anderson & Thorsen, 1997). However, according to Wood (1996), preservice teachers acknowledge a sense of

professional responsibility to protect and promote students' health and regard CSH as an important part of preservice training. Prospective teachers, regardless of their subject area expertise, comprehend the link between students' health and their capacity for learning. The "Wisconsin Elementary Health Education Pilot Project" studied the impact that experienced elementary teachers, professionally trained in health education, had on delivery of CSH education. The project concluded that professionally prepared elementary teachers have a positive impact on the delivery of CSH at the elementary level (Detert, Bradly, & Schindler, 1996).

Insufficient time, money, lack of parental support, lack of the credibility of health as an academic subject, and concerns about teaching controversial topics, complete the list of the major obstacles in Butler's (1993) study of barriers. The recommendations for change center around improved quality and quantity of in-service programs, and especially target administrators. Also, there is a recommendation to market CSH programs to increase administrative support. Clearly, a stable foundational CSH program must be firmly in place to provide bedrock for the shifting foci or "hot topics" that erupt from time to time to disturb the integrity of a program intended to be comprehensive and focused on the child in a holistic way (Oetter, 1987). Establishing that foundation is not a whimsical task. Evaluations of established programs find that developing and implementing CSH requires considerable commitment (Anderson et al., 1999) and a significant amount of time and energy.

THE CANADIAN PERSPECTIVE

Most provinces now mandate some aspects of health education in the elementary and junior high; this is reflected in separate health curricula guidelines (Mutter et al., 1990).

McCall (1999) reports that 10 out of the 12 ministries support CSH and 40% of school boards support CSH. While this may seem woefully minuscule, he remarks that Canada has made excellent progress in adopting the CSH approach; in 1990 only 3% of health and educational leaders had even heard of CSH (CASH, 1991). Cameron (1991) echoes this sentiment as her examination of Canadian provincial and territorial health curriculum concludes that CSH was far from a reality in Canada.

While quality was a concern, quantity was as well. At least 50 hours of health instruction per year is needed to make an impact (Connell et al., 1985), yet Canadian students receive a broad range from 30 to 60 hours (Cameron, 1991). A large study in Canada that has attempted to test the impact of CSH was a longitudinal, quasiexperimental evaluation of a Comprehensive School Health program in Dartmouth, Nova Scotia (Cogdon & Belzer, 1991). While the authors state that qualitatively there is supportive evidence for recommending the program, quantitatively there is no favorable impact on mental health and heart health compared to the standard health program. However, they suggest that the benefits may have more longevity than a standard program.

Many other initiatives across the nation reflect the international call for the alliance of education and health. The "Global School Health Initiative" in Europe, sponsored by the World Health Organization (WHO), advocates the "Health Promoting School" (HPS) characterized as "a school that is constantly strengthening its capacity as a healthy setting for living, learning and working" (WHO, 1992). The goal of this initiative is to encourage health promotion and education activities at the local, national, regional and global levels. The initiative is designed, under the umbrella of CSH ideals, to improve the health of students, school personnel, families and members of the community, through schools. The

development of a health-promoting school stems from an initial project tailored to meet the needs of the community, as defined by the community. The HPS focuses on improving the school environment rather than on changing individual student behaviour. The fundamental guiding principles for decisions and actions related to health promotion are founded on democracy, equity, empowerment, a healthy school environment, effective curriculum, adequate teacher preparation, assessing effectiveness, collaboration, community partnerships and sustainability through financial and human resources (Anderson & Piran, 1999).

Even though 37 countries and 5,000 schools have participated in "Health Promoting Schools" projects, there are only a few CSH programs that have been implemented and studied in Canada (Anderson et al., 1999). However, there are a few initiatives, such as in British Columbia where the Ministry for Children and Families currently coordinates the "Healthy School" projects (Myers, H., personal communication, 1999). In 1994 the ministry reported that 300 schools and 25,000 students had been involved with a "Healthy School" project (Healthy Schools Update, 1994). A similar initiative, coordinated by the Eastern Ontario Health Unit (Healthy School, 1996), provides guidelines and directions for schools prepared to embark on a healthy schools project. Anderson et al. (1999) describe a very successful healthy school project, which involved a world-class ballet school that used the "Healthy Schools" approach to prevent eating disorders in the school.

CONCLUSIONS

Comprehensive School Health manifests itself in many forms, but the fundamental ideals of coordination between health and education and the collaboration of students, schools, families and communities is needed to ensure that students live longer, healthier and

productive lives. Nevertheless, CSH should not be considered a panacea, but rather a tool that prepares students for healthy, life-long decision making (Brindis, 1993). Regardless of the considerable support for CSH, there is still much to be learned regarding its feasibility and effectiveness. Resnicow et al. (1993) propose 10 questions which they suggest need to be answered for CSH to be fully accepted, funded and implemented. Clearly, more research is required to establish a deeper knowledge base, understand the effects of curriculum and CSH models, and determine the effects of longitudinal studies, specifically in the area of CSH. Inoculation to decrease disease and death has never been so complex and multifaceted but CSH may be the "shot in the arm" that many students need.

SUMMARY

This broad literature review defined and described CSH, the approach at the center of this research. Also, a rationale for the need for school health education was outlined. Here, the review focused on the state of child health and the potential impact that schools and programs can have on improving the health of children. Additionally, several health education initiatives were described to demonstrate the effectiveness of comprehensive programs and to examine the current condition of health education in schools. The literature highlighted and described key components of CSH such as "community outreach" and "curriculum," which framed questions for the participants in the current study.

The notion that there should be as much emphasis on the prevention of disease as on the treatment of disease has been recognized since early Greek culture (1000 - 400 B.C.). Asclepius was a god of healing, with powers so great he could bring the dead back to life, but he was killed because he defied the basic laws of nature. Before his death he bestowed

health-related powers to his two daughters. Hygeia was given the power to prevent disease, while Panacea was given the ability to treat disease. Of the two daughters, Hygeia was the more prominent in Greek culture. Someplace in history, society changed its focus and in the contemporary setting there seems to be much greater emphasis on Panacea. The following chapters seek to explore the methods and findings which further enlighten Hygeia's quest to deepen the understanding of how to teach mortals to live wisely and preserve their bodies.

CHAPTER 3: METHOD

This chapter provides an account of the qualitative procedures used in the collection and analysis of the data for this study. It focuses on the description of the methodological theory, confidentiality and ethics approval, the research questions, the selection and description of participants, and data collection and analysis.

METHODOLOGY

The purpose of this study is to investigate what it means to be a teacher who is attempting to implement a CSH approach. It is anticipated that the study may illuminate the role of the health teacher in CSH, as well as the teachers' perceptions about CSH and their insights regarding the impact they may have on CSH in the future.

The study is interpretive research, a descriptive study that searches for a deeper understanding of the participants' lived experience in teaching health education. Because the value of this study is dependent on the respectful worth of experiential knowledge, I have been motivated and justified in this approach by Clandinin's work. My research is reflective of her study where "the intent is to understand the personal practical knowledge" (Clandinin, 1986, p. 12). There are elements in this study that are reflective of narrative inquiry. Connelly and Clandinin (1991) write that, "The study of narrative is the study of the ways humans experience the world. This general notion translates into the view that education is the construction and reconstruction of personal and social stories" (p. 2).

Asking participants to share stories or narratives will be one of the methods used to encourage expression (instead of primarily explanation) of how the teachers are experiencing CSH. By so doing, the study attempts to exemplify Mason's (1989) definition of qualitative

research by being concerned with how the social world is interpreted, understood, experienced or produced, based on methods of data generation, which are flexible and sensitive to social context, to produce understandings based on rich, contextual data.

My aim is not to provide causal explanations of why teachers think or behave in a certain way, but to deepen and extend my knowledge of why they find meaning the way they do. Reason (1994) uses the term *human inquiry* to encompass research which aims to move beyond the narrow, positivistic world-view to engage in practices which are "engaged deeply and sensitively with experience, participative and aim to integrate action with reflection" (p. 10). The process of going beyond was difficult; many times I have had to resist returning to a positivistic orientation, especially when I planned my interview questions. I wanted to engage in communication and dialogue with teachers and attempt to clarify meaning in a situation that is practical and specific. To do research is "to always question the way we experience the world, to want to know the world in which we live as human beings" (van Manen, 1990, p. 5) and to make meaning of it. Through "thick description," "experiential understanding," and "multiple realities," this study seeks to pursue a deeper meaning of what it is to be a CSH teacher by identifying common patterns and themes in their lived experience. Peshkin (1993) describes the value of descriptive research in stating, "the soundness of the nondescriptive and the prescriptive aspects of research rests essentially on what has been provided by the accuracy, sensitivity and comprehensiveness of its descriptive foundation" (p. 24).

CONFIDENTIALITY AND ETHICS APPROVAL

Ethical approval was obtained from the University of Regina Research Ethics Board (Appendix A) in March 2000. A Letter of Consent (see Appendix B) approved by the Research Ethics Board, outlining the details of the ethical considerations was signed by each participant. I was careful to explain their ethical rights and provided an opportunity for them to ask questions. The study was done in confidence. Anonymity of the participants is ensured as all the names and locations used are pseudonyms. The data are secured in a locked cabinet and will be destroyed in 3 years.

THE QUESTIONS

I developed a framework of questions that stemmed from personal interest, as well as from the literature. Because the intent was to have a semi-structured interview, the format of open-ended questions provides a broad scope of general topics that I anticipated would frame the interview, but not direct it. The prepared questions were used as prompts, not as drill questions. This type of interview has a sequence of themes to be covered, as well as suggested questions, yet there is flexibility for changes in sequence which form the questions that follow, and relate to, the conversation and stories told by the participant (Kvale, 1996).

In preparation for the interviews, I thematized the questions to be asked and spent considerable time developing the type of questions (see Appendix C) that may encourage the participants to offer greater description. I recognized however, that these questions were only a framework and that the interview would be more conversational than the list of questions might suggest. The prepared questions were not intended to be adamantly adhered to but to provide me with a level of security. In the end, this was not needed. Having said that, I think

it is important to note that some of my questions and responses to the participants' remarks or stories were guided by the thoughts that formed the original list of questions. While there was a variety of ways of asking, I primarily solicited responses that pertained to their experiences as a CSH teacher, the role of the CSH teacher, and why they were committed to this role. Because I had determined the interviews would be conversational in structure, the natural flow of the conversation was not interrupted with a question-answer format.

SELECTION OF PARTICIPANTS

In selecting participants, it was critical that the teachers be:

- currently teaching health education
- interested in health education issues
- knowledgeable about CSH
- using a CSH approach.

At present, Saskatchewan Education has implemented a "Catalyst Teacher Program" to facilitate the implementation of the renewed Middle Level Health Curriculum, which boasts a CSH approach. Saskatchewan Education selects practicing, Middle Level health teachers from throughout the province to participate in a 2-day in-service each year which "certifies" them to conduct Health Curriculum implementation workshops for other teachers. Each Catalyst Teacher is seconded for up to 10 days per year to conduct these workshops. The creation of the Catalyst Teacher has created a unique group of health teachers; it was, therefore, necessary to draw from this population.

These teachers are distinct in that they have voluntarily been involved in the attempt to actualize the theory and philosophy of Comprehensive School Health and have had to

promote the notion through the Health Curriculum Implementation workshops. As ambassadors of health education, they have had a vested, intensified interest in attempting to think about and implement the curriculum and they have experienced both the glory and the frustration of creating a meaningful school health program. These qualities are potentially a valuable resource for informing the reciprocity between CSH theory and CSH in practice. I would like to emphasize that the rationale for using this population is not to study the Catalyst Teacher program but as an efficient means of identifying participants with the desired characteristics for this study.

Catalyst Teachers are strategically positioned all over the province, which makes personal contact for interviewing somewhat challenging. Fortunately, four teachers were located within a reasonable distance and, for this reason, I initially approached these teachers. Because I have been a part of the Catalyst Teacher in-service days, I am familiar with the names and faces of all the Catalyst Teachers. Through this same network, I have access to their names, addresses and telephone numbers and, using these identified the four individuals who participated in this study. During a telephone conversation I briefly outlined my study and asked each to the first meeting where I could explain the study and the Consent Form in greater detail. Each participant was accommodating and interested in becoming part of the study. Before the interview began, each participant signed the consent and a copy was left with each person.

THE PARTICIPANTS

I feel compelled to note that the participants made a smooth entry. They were almost eager to participate and their willingness, positive attitude and flexibility was advantageous in developing a research relationship.

The following profiles were developed at the time of the interview.

Rhonda

Rhonda has spent the last 24 years teaching in a variety of schools in an urban setting. Physical education and health were two of her specialties in university. She has primarily taught Middle Level students, although she has elementary experience as well. She has always taught health, in addition to other homeroom teacher responsibilities and has participated in the rewriting of the "revitalization of the Middle Level" curriculum, as well as being a Catalyst Teacher. Rhonda has recently expressed a desire to "retire" from the Catalyst Teacher group and will only be called upon if there is a crucial need.

Linda

For the last 6 years, Linda has been teaching in a rural school division. She is currently the Middle Level and high school physical education and health teacher, as her major and minor in university were physical education and health, respectively. Linda has taught both Grade 8 and 9 health but is presently teaching it only in Grade 9. She has been actively involved with the Catalyst Teacher program for 2 years and has taken on a number of other roles in her Division regarding health. Linda is highly involved with sports and extracurricular activities within her community.

Tim

Tim is an administrator in an urban elementary school. He has been there for 2 years and, prior to that, taught in another urban setting in the province for 7 years. Tim has been involved with the "renewal" of the Middle Level Health Curriculum over the past several years and has been a Catalyst Teacher for 2 years. He has recently resigned as a Catalyst Teacher but continues to play an active role in implementing Middle Level Health Curriculum in his division and actively contributes to health education in his school. Tim has taught Grades 6 to 9 health over the years but is currently teaching only Grade 7.

Bev

Bev teaches Grade 8 health in addition to being the teacher-librarian in a large high school in a small rural community. She has been at this school for 22 of the 28 years she has taught. Bev has been involved with the provincial health curriculum in a variety of ways since 1984. She is currently a Catalyst Teacher and has been actively providing health workshops around her school division. One of Bev's specialties in university was physical education and health, although she has not taught physical education in several years. She has taught Grades 6 to 9 health and has been very involved with coaching and school sports.

TRUSTWORTHINESS

Linda and I had been acquaintances before this study because we have attended common functions and have a few common acquaintances/friends. Sharing these commonalities and a certain level of "social comfort" would, I believed, provide a foundation for a trusting relationship. The other participants, Rhonda, Tim and Bev were known to me only superficially through the Catalyst Workshops. We were barely acquaintances, so I was

uncertain about how they might respond to the invitation to participate in the study and about the level of trust that may or may not be established. As I will elaborate later, there was significant evidence that rapport was established and reason to believe that a trusting relationship was initiated with all participants.

INTERVIEWS

The interviews were completed within a few weeks of each other and subsequently transcribed. I chose to allow the participants discretion in choosing where they wanted to meet. Linda came to my home, Rhonda to my workplace, and Tim and Bev met with me at their schools. I was acutely aware of my research protocol and initiated the interviews with perhaps a slightly regimented *briefing* (Kvale, 1996). I described the purpose of the interview, went over the consent form, and asked each participant to pose questions if they had any. All the interviews ran longer than intended as most were about 2 hours, and one was 2.5 hours. Cognizant of the importance of rapport in developing a research relationship (Glesne & Peshkin, 1992) I was concerned that we might not "hit it off;" however, early in the meetings I realized that rapport, at least initially, had been established quickly because the participants spoke freely and openly about a wide range of issues.

After the transcripts were prepared, they were mailed to each participant and we scheduled a second interview, to be conducted over the telephone. During the telephone interview, we discussed changes the participants wanted in the transcripts. They had the opportunity to clarify or elaborate on any comments they had made during the interview. At times, I would seek clarification of certain parts of the transcription. In the cover letter sent to each participant along with their transcript, I asked them to relate a story about teaching

health education. During their telephone conversation, they told their stories which I recorded on paper.

The cover letter was particular in asking the participants to check for meaning as I had used an oral computer program to transcribe the interviews and there were many places where meaning could have been potentially changed because the program does not necessarily print what you think you have said. I did, however, check the transcriptions against the tapes before they were sent to the participants. Only a few minor changes were made on two of the transcriptions and no significant amount of information or changes were made by any of the participants.

The candidates agreed to be available during the writing of this thesis should I require clarification. Such contact was required with one participant in order to clarify one point she had made.

ANALYSIS

Technically, the interviews went smoothly. Aware that it is important to transcribe fairly quickly after the interview (Altrichter, Posch, & Somekh, 1993), I promptly transcribed each interview with the assistance of the computer program, "Dragon Naturally Speaking." This oral transcribing program permitted me to repeat each word of the interview into the computer's microphone, the monitor displaying the typed interview as I spoke. Listening to the tapes repeatedly helped me come to know the conversations quite intimately.

The interviews were studied and an in-depth interpretive analysis of the data was conducted. During the analysis phase I followed Altrichter's et al. (1993) constructive stages of analysis as follows:

- ***Reading the data.*** As I listened to the tapes I read and reread the data and eventually possible themes emerged from the patterns.
- ***Selecting the data.*** This stage involves grouping important details from unimportant ones. I began highlighting sentences with certain colors that indicated particular groupings and crossing out the less important information. All the transcriptions were coded with a variety of highlighter colours, noting key words in the margins. In the process of category generation, I was looking for themes and patterns (Rossman & Rallis, 1998) which were identified with different colours and key words. After subsequent reads, I often found myself crossing out key words and changing them as my understanding deepened.
- ***Presenting the data.*** This stage involves coding and putting the data into a form that is easy to see at a glance. At first, I used the information synthesized through the literature review to frame what I understood about the participants' information. I organized the headings and possible themes, making notes and rough charts to get some sense of the eight interviews. After recognizing the material I wanted to work with, I coded it so that I could access the quotations efficiently during the writing phase.
- ***Interpreting the data.*** When I felt that I had "dwelled" in the data for a time and had become comfortable that I had unscrambled the chaos, I hand wrote a data summary that served as another foundation for teasing out the final themes. At the end of this process, the data seemed to have "matured" in my mind, and I was able to look at the patterns and chart the similarities and differences, even subtle ones, between the participants.

Once the themes were vivid and distinct, I was able to develop statements about the findings of the study, draw conclusions, and consider recommendations.

CHAPTER 4: THE FINDINGS

The purpose of this study is to explore what being a teacher using CSH means to four health teachers. The complex social problems that exist for our youth have spilled over into our schools, calling teachers to deal with an increasing amount of health-related issues that go well beyond health instruction. The theoretical concepts underlying CSH provide a framework for educators to begin to restructure the way schools interact with the community and social institutions to help address children's health issues. Presently, we know very little about what teachers are able to do and what they think they are capable of doing in terms of providing instruction, facilitating health services, involving support services and enhancing the physical environment. What is the role of the teacher in CSH? What do the teachers think they are capable of doing and changing? How do they perceive the challenges and successes of the four main elements of CSH? These are the questions that needed discussion.

It was hoped that in talking to the teachers the theory of CSH would come to "life" in a more three-dimensional way. Having a more thorough understanding of CSH gives a Saskatchewan audience a foundation on which they can continue to build ideas and programs which better meet the changing needs of today's youth not only from a health perspective but also from an academic point of view.

The metaphor of comparing a heart to CSH, as outlined in Chapter 1, serves to deepen the understanding of the dynamic and interrelated components of CSH. Comprehensive School Health is a conceptual framework, similar to the framework of a heart. CSH has four main parts - health instruction, support services, social support and healthy environments - that are intended to work together to ensure a thriving, healthy system. The system, however,

is highly dependent on the catalyst that initiates and maintains the entire function of the heart. Despite the fact that CSH has been in existence for more than 20 years, it is a new focus in Saskatchewan health curricula. It has the potential to be strong and vital but currently it seems to be suffering from several "heart conditions." Three such CSH "heart afflictions" - Megaheartopia, Bradycardia and Arteriosclerosis - will be illuminated in this chapter, illustrated by the participants' (block) quotations which will be italicized throughout. The chapter concludes with a discussion which focuses on the "cardiac care unit," the team of individuals who address these conditions.

The findings from the interviews are in narrative form. There are four themes, each with emergent subthemes. Discussion of these themes and subtitles will follow the outline below.

1. Megaheartopia: Rhonda, Linda, Tim, Bev
2. Bradycardia: Rhonda, Linda, Tim, Bev
3. Arteriosclerosis:
   (a) Rhonda
      - Instruction
      - Healthy Environments
      - Social Support
      - Angina

   (b) Linda
      - Instruction
      - Healthy Environments
      - Social Supports
      - Angina

   (c) Tim
      - Instruction
      - Healthy Environments
      - Social Supports
      - Angina

(d) Bev
- Instruction
- Healthy Environments
- Social Supports
- Angina

4. Cardiac Support Team: Rhonda, Linda, Tim, Bev.

The data reported in the following chapter are based on two, in-depth, semistructured interviews with each of four health teachers. The participants represent both an urban and rural perspective from various regions in the province. They have all taught health for more than two years and are currently teaching health to Middle Level students. Trained as facilitators for Middle Level Health Curriculum Implementation workshops, they know what CSH entails and are currently implementing a CSH approach.

MEGAHEARTOPIA

Regina Medical Journal
"New Disease Discovered"

Megaheartopia is a recently detected disorder. (within the last few days) discovered by a researcher apparently unknown in the scientific community. The researchers' subjects were CSH teachers and during an interview that focused on the meaning of being a CSH teacher, the teachers suffered several emotional outbursts, inexplicable in medical terms. Defying all medical and reasonable explanation the teachers engaged in several attempts to explain their desire to teach CSH and they spoke willingly, from the heart, about their experiences with children that reinforced their commitment to health education. Their tone of voice, at times teary eyes and gestures could not be adequately captured in this report. Further to this, the teacher experienced several episodes of, what some might call, delusions of utopian which also may be construed as hopefulness. During examination and under closer scrutiny, their hearts appeared much larger than normal. Initially considered quite rare, this condition may be more widespread than first believed. Further studies are warranted from Cardiologists in the field of education for a closer examination of Megaheartopia.

I jest with Megaheartopia, but the theme was so prevalent in the interviews that it can not be overlooked as an obvious attribute in these educators. Megaheartopia is part of the

heart metaphor initially outlined in Chapter 1. Oversized hearts, symbolic and symptomatic of committed, dedicated health teachers were evident in all interviews. The participants seem to have a philosophy of education that not only values, but is also grounded in the belief that there is a need for, primary and secondary health intervention with students. This belief is so integral it is almost synonymous with their understanding of education.

First, they were all confident that school health education was not only needed but, by and large, it was effective. What does *effective* mean to them? Health education is effective because it provides a medium to develop strong pedagogical relationships and student-centered teaching. As well, it provides structure to channel their personal sense of hope and moral obligation that their role in education will contribute to the quest to improve student health. The following section describes each participant's affliction with Megaheartopia.

Rhonda

Rhonda has been involved with many health education initiatives over the years. Her commitment to health education is exemplified through her many years of service to creating and improving health curriculum. She was involved with the 1984 version of the Middle Level Health Curriculum and has been involved with the latest edition as she describes, "I've also been a part of the writing, actually the rewriting . . . I feel very immersed in it." Health instruction is something that Rhonda strongly advocates and remains highly dedicated to it. As she states:

> *In schools, health is vitally important. Even though they get lots of information and if it is not from their parents, some times it is from a book or TV – It is kind of like family life education. We have to pull out what is the right and wrong information and sort that out with them.*

Rhonda is particularly sensitive and passionate about improving the conditions for children and expresses an overwhelming need to focus on health education:

> *The school I am at right now, it is in a very low-income area, quite often students have not had breakfast, often at a very early age they are smoking. I have some drug dilemmas in my classroom right now. I feel it. My heart is in it. I feel that if I can at least educate them maybe there will be an improvement. Some people do not, it is not an area of interest they may think that it is something that I can not deal with. They think that it is a home issue. The way they deal with it [is] they think it is more important to do reading, writing and arithmetic. Where I do not know . . . I think that this [Comprehensive Health Education] is equally important. And if it is not happening at home, it is our job to make sure that it happens at school.*

One of the stories that Rhonda shared exemplifies her belief and hope in health education and her affliction with Megaheartopia. She describes Jessica, a Grade 7 student, who had started sporting large, obvious hickies on her neck. While Jessica was parading around in her classroom showing off these hickies, Rhonda began to develop a dialogue with Jessica. It started off in a conversation about the appropriateness of revealing and bragging about the hickies to a meaningful conversation about her perception of her self-worth and about her sexuality. During the unit, Rhonda used the sexuality information that she talked about in class to initiate conversations with Jessica. This did not transpire with ease. Jessica's attitude was sometimes aloof and arrogant, but the health instruction during the sexuality unit bridged the developing relationship and Jessica's behaviour. One day, after watching a video that dealt with commonly held myths in sexuality, Jessica was noticeably flushed and agitated. Finding an excuse to have a private moment with Jessica, Rhonda offered Jessica time to express herself. This time Jessica, only 12 years old, displayed a more humble and accepting attitude, disclosing she had been sexually active for quite some time and had believed the boys when they told her that "pulling out" was an effective form of birth control. Rhonda was able to provide the necessary information at an age-appropriate level.

but most importantly Rhonda felt Jessica would respond and act on the information because she felt Jessica trusted and respected what she said. Rhonda is not naïve; she was not suggesting that Jessica would radically change her behaviour, but she did believe the information would delay, if not offset, the strong chance that Jessica would get pregnant or contract a sexually transmitted infection. "Maybe just maybe, there was a seed planted that might change the way she thinks about herself or how others see her." For certain, a relationship evolved that had the potential to decrease health-risking behaviours which was fostered not only by Rhonda's caring ways but also through the legitimate structure of the health instruction.

Rhonda shared another incident which displays her sense of purpose and conviction concerning the merits of a holistic approach to education, as well as her educational priorities.

> *Some of them have gone through, in 6 or 7, years more than you and I could imagine in a lifetime. One little boy told me around Easter time [that] it all started when he fell off his bike and scraped his knee. He had to wait four hours until his mom got home, then he had to wait at the hospital for hours to get the stitches and got home - that was Easter night. I said, "That is too bad," but he said, "That is not the worst of it." And he just kept going on. "When I woke up on Easter morning there was an note that said that the Easter Bunny had run out of chocolate." I cried; I thought. It was at least a week after Easter and I went to the drugstore and bought a hollow bunny and I filled it with fun bars and juice boxes, some chocolate, but I did not want too much chocolate, you know. I called him down to my room and he peaked in and I said, "This letter says 'To Tyler from the Easter Bunny' and you are the only Tyler I know." He said, "You are the Easter Bunny" and I said, "No, I am not the Easter Bunny." The love on his face said the world was okay because there really was an Easter Bunny and he hadn't forgotten him. That is a given: your kids should not think the Easter Bunny ran out of chocolate. . . . What is the bottom line? What is really important here? It is not page 26 in your math book, because for those kids it certainly is not important.*

Developing a relationship with her students where "they feel very comfortable" is an important part of teaching for Rhonda. She has worked very hard to develop a rapport and

connect with every student and values her health class because, in this class, "I get to every student."

Linda

When Linda speaks of the value of health instruction it is with passion. Clearly, she articulates a high affinity for quality health education, especially when she reflects on the health issues that are prevalent with her students.

> *I do not want to say that it [health education] is more important than math but not being able to solve the quadratic equation will not kill them . . . a STD could kill them. Kids are having sex, whether parents want to agree with me or not. Kids are committing suicide. They are into a lot of high-risk behaviours. They need to deal with it and it is frustrating as I look at our school, there are still girls getting pregnant.*

Linda illustrates her high degree of commitment to CSH in volunteering to write a comprehensive unit plan that would be accessible to all health teachers in her division. At the time of the interview, she was going through the process of "writing a unit for the entire school division . . . so I am making up the unit and getting it approved." Linda expresses frustration that, despite a concentrated effort to improve health through quality education, students continue to engage in high-risk behaviour. The necessity for intervention is frequent. Despite her frustration, she remains devoted to the merits of health education and shows tremendous perseverance and dedication to student health, even when health improvements are slow to change.

> *I spend a lot of time talking with the guidance counselor if I feel that someone needs to go in. I have spent I don't know how many hours sitting in the bathroom talking to girls. If someone has a problem, it is automatically my problem. If it is a guy teacher, I am the one that is called, if Karen is busy. If I am in the junior end and I go to the bathroom and there is someone in there, I have to deal with it.*

Linda is proud she "wear[s] my emotions on my sleeve" and confesses to be a very caring person but is under no illusion that caring is easy and glamorous - increasing emotional ties will inevitably complicate a relationship. In fact, caring is difficult. In an incident where she tried to be thoughtful and caring to a particular student, she was vulnerable to criticism from the students' friends, parents and, to a certain extent, her administrator. Despite the angst that accompanies having Megaheartopia, Linda describes her hopefulness and sense of purpose as a teacher.

> *I teach them in Grade 9 and now [in] Grade 10 Math. They say, "We did not do this last year." I say, "[the] purple sheet , the one I told you never, never lose." "Oh yes, maybe I did see that!" They might remember the color, pretty color, but they do not – in the big scheme of things - [they] can not remember. What I want them to remember is Miss L. helped me through . . . Grade 9 when this guy dumped me, or when this girl cheated on me, or whatever it is, or they don't get pregnant, or they can come to me and tell me that their friend said they wanted to kill themselves [sic].*

Linda is not under any illusion that health instruction, or even CSH programming, would make any radical differences in the students' health and she does become frustrated, "girls are still getting pregnant in our school: sometimes I think is it something I am doing?"

Optimistically, Linda focuses on areas where she might have the greatest impact. The allotted health instruction time is valuable but she recognizes the greater depth in the pedagogical relationship when she sees the students for more classes than just health. Linda explains, "I have a different relationship with my homeroom. I know what they do on the weekend. I bought a car from one of their dads." She can be more sensitive to their needs when she has good rapport and "if someone is feeling upset and I say "you are having a problem . . . just get up and go to the bathroom . . . and I will come and check on you."

Tim

As an administrator of a school in a lower socioeconomic area, Tim deals with health-related issues on a daily basis in his office, as well as his classroom. Sometimes it is as simple as dealing with parents and their children who have conflicting views about using make-up or wearing a particular kind of clothing. Sometimes it is as demanding as dealing with students with complex emotional and behavioural problems. Currently, Tim is engrossed in several committees and projects where the primary concerns are health-related issues. The common thread of these endeavors is the need for greater focus, understanding, and coordination of health services with the common denominator of improving children's health conditions.

Tim is more than just hopeful that health education is effective, he seems to believe it is the most viable way to work towards a more healthful society. While he recognizes the role and value of the parent in health education, he also segregates school health instruction into a unique category. School health has particular components that other health information might lack.

> *As a parent, if I was not in education, would I ever think of talking to my sons about eating disorders? I know when we did the Family Structures unit, we have a lot of parent situations here - a lot of children living with grandparents and different things . . . we got into a real thing on structures and roles and I thought it was very interesting in terms of what these kids thought: How we shared with each other and I think it became an appreciation for some of them anyway, an appreciation for where the other kid was coming from . . . the awareness that kids got from that and the appreciation for other [kids].*

Tim also notes that school health offers more than just awareness; it is also concerned with taking healthy action. He provides the example of teaching the Grade 8 theme of supporting peers. Here, students practice supporting each other and, regardless of the topic or

grade, the idea is to make informed decisions that increase health-enhancing behaviours. Tim states, "I think that if it were left to the home it would be just a total awareness thing."

Bev

In Bev's case, the symptoms of Megaheartopia are manifest in a conscientious effort to provide a highly student centered classroom. Students democratically vote on the units they want to take each year and have input into the assignments and activities that Bev develops. She is a strong advocate for resource-based learning; consequently, many of the students' assignments are personalized and customized according to their needs. While the students do a lot of research and reporting, Bev uses a variety of approaches to meet the needs of a range of learning types. Research may be a trip to the library, a personal interview, or field trip.

> *I did a lot of resource-based learning because of the library. The kids liked the resource-base learning and, also, if you have some difficult students, the kids who really want to learn can and they are not influenced so much. As we did more debating and activities, the kids got more involved. Some years I had just excellent classes and we just went off on tangents and the kids were interested as long as they were learning something about health.*

One of the attractions of teaching health is the freedom to be truly student centered without the dark shadow of "content-oriented" expectations accompanied by the "lecture, practice and drill and all that," as in subject areas such as math and English. "In health, discussion is a big part of participation and what I have always liked about it." Affording students this approach to learning ensures that students, at all levels, have the opportunity to succeed; this is what makes Bev's class truly student centered.

> *This one girl I had in Grade 8 and she was just "working her butt off". Every time we had an assignment, it would come back all typed and just perfect and I thought, "This is a really good student" and she was always participating in class. I give 25%*

> *[of the final grade] for participation . . . This girl got 93% and I said "really good job!" I found out after her report card that that had been her highest mark ever. She was in Grade 8 with a Grade 3 reading level. She was a resource-room kid. I did not even know it and it made me feel good that this was an area where she could do well in because it doesn't reflect on her other disabilities . . . some kids who are not normally successful can succeed here.*

Developing a classroom atmosphere of participation and acceptance has contributed to the health instruction component by linking and making meaning of the health content through a trusting relationship.

> *Last year [after] we talked about diet and exercise, then it led into eating disorders and I talk a lot about what to do "If. . . ." I had several girls come back to me throughout the year and say "I think so-and-so has an eating disorder. What should I do?" I have had kids tell me [that] "I think that that kid is changing and I think he might be on drugs or suicidal."*

Connecting with students is an important part of being a health teacher for Bev. She particularly enjoys the freedom to use health classes to respond directly to the daily needs of students. She describes a situation where she overheard a student say that during health class they had "gone on a tangent." From Bev's perspective, they were not on a tangent at all. She has integrated the content so intricately with the students' needs that they did not recognize their health class as school work.

As with Linda, Bev experiences the dark side of being open and caring: developing a strong pedagogical relationship leaves her open to more complex, uncomfortable situations. Bev describes several situations where students felt comfortable enough to discuss highly personal and sensitive matters in confidence. Bev reports these types of disclosure made her feel very uncomfortable at times. These personal conversations with her students, however, reinforce the notion that very unique relationships exists between students and their health teachers. The pedagogical relationship that is established is both parental and professional in

nature. Bev says, "some kids will say things to teachers that they would never say to a parent" but she acknowledges that a pedagogical relationship is not guaranteed, even though she tries to be student centered and caring.

> *Every kid is different. Not all teachers are going to interact with some kids in the same way. Even within health there will be kids you will know that will never tell you anything, and there are some kids that you wish were not even there. Some kids can wreck the whole atmosphere and it has happened to me, too.*

Despite the rather sensitive situations that seem to accompany teaching health, Bev remains true to her advocacy for health education. Her hope is kindled in the ease that health education is relevant to the students' lives. Whether it is facilitating greater acceptance and empathy for students with leukemia or cystic fibrosis, or seeing the fascination students have for understanding and grappling with issues related to death and dying, or their ravenous appetite for sexuality information, Bev is reminded of the need to interact with health issues in their lives. To help students make the relevancy connection, Bev uses a newspaper activity, "It helps them realize that health is an important issue in our community. When you think of the amount of dollars that our province spends on health . . . so much money goes towards health; health is an important thing."

BRADYCARDIA

The second heart condition that emerges from this study resembles Bradycardia. Bradycardia is a medical disorder where the heart beat is much slower than it should be for maximum efficiency (Luckman & Sorenson, 1987). An intervention for this medical disorder is to insert a pacemaker. As the participants describe their work, it becomes clear that they believe Comprehensive School Health Education (instruction), for a variety of reasons, is much slower and less efficient than it could be.

Bev. Linda. Tim, and Rhonda have a history of assuming leadership roles in health education. Sometimes these roles have been formal, such as with the Catalyst Teacher commitment, but often their leadership has been informal as advocates and guides for health education. When the participants described their role in health instruction (one specific component of CSH), they functioned as cardiac pacemakers. A pacemaker, according to Luckman and Sorenson (1987), is "an electric apparatus used for maintaining a normal rhythm by electrically stimulating the heart" (p. 1248). A pacemaker, inserted directly in the chest, becomes an integral part of the heart yet it is always a foreign object.

A comparison could be drawn with the teachers who are an integral part of their school system but have elements of being a foreigner. Their interest and commitment to health education set them apart from other teachers. The teachers are like pacemakers in that they have tried to be catalysts to initiate change in school health instruction. They also have a regulating role, which involves balancing the desire to meet the ideals of CSH and simply surviving the daily demands of teaching. The participants feel personally accountable and responsible to other staff members and administrators for providing direction for quality health education. They generate a rhythm in their willingness to accept leadership in their school, motivated by both self-imposed measures and by more overt expectations from others. Currently, Comprehensive School Health is dependent on individuals to initiate and maintain a pace that will drive the initiatives related to curriculum and instruction in CSH. As a cardiac pacemaker, the participants are attempting to initiate that spark of energy, knowledge and skill that brings CSH to life. The following section describes each participant's perception of the bradycardic tendencies of CSH education and activities that

demonstrate how the participants function as pacemakers in their attempts to improve this condition.

Rhonda

Rhonda believes that health instruction is a significant component to Comprehensive School Health but it is not thriving robustly in schools: "Unfortunately, health isn't being taught to the extent that it should be," noting that some teachers specifically plan to avoid health instruction. While she is sensitive to the fact that not all teachers would have the same kind of commitment to health education as she does, Rhonda is frustrated by the blatant neglect of adequate and meaningful health instruction that sometimes occurs.

> *I see some of the timetables - Guidance the last period on Friday afternoon or on the period we always have Assembly. Oh, come on. And you know they are putting those [classes] . . . ahead and see that they really do not have to teach it.*

Because Rhonda "strongly believes in health" she assumes pacemaking roles in her school to generate support and guidance for teachers who are struggling with health instruction. Rhonda states, "I make promises: 'I will teach your health.' Family Life is the big one right now. Some of our teachers say that they are not comfortable with it. I will say, 'You do that social unit for me . . .'" Offering support to other teachers by exchanging classes, ideas, and activities is one way Rhonda has been able to assist others with their health instruction.

In terms of CSH, one of the fundamental elements required, according to NPSHEO (1984), is a well-planned, sequential curriculum that has specific program goals and objectives. In Saskatchewan, the Middle Level Health Curriculum is current and has a sequential nature with specific program goals. The merit of the curriculum has resulted in a

reasonable amount of acceptance from all participants but Rhonda, who had been on the curriculum (re)writing committee. Rhonda recognizes, and is sympathetic with, a number of her colleagues who engage in minimal health instruction. Having experimented with a variety of resources and ideas, Rhonda hopes to share and create revisions to the curriculum to enable other teachers to engage in quality instruction. Rhonda experimented with, and has formed opinions about, the curriculum.

> *These kids had never been through the decision-making process, they are all learning, and I don't make them [do the decision-making process everytime]. That is always the first unit that we do and I don't follow it step by step of the whole process through the year because I find that it kills it. So we touch on it. It fits into a lot of the curriculum area. I don't, we don't, follow it with everything we do. For me, there are a lot of good things in the health curriculum and I pull out the good parts, but I – it is not my bible. I have a lot of other good things that I use that work for me.*

In the end, Rhonda did not feel that the changes made to revise the curriculum would support teachers who were inexperienced in teaching health. She summarizes her concerns with the curriculum as "too much information and not user friendly." The lack of concrete ideas and activities was a particular concern. At a time when teachers have been bombarded with several new curricula in a variety of subject areas, she thought it especially pertinent to have clear, supportive curricula. Rhonda senses that nothing will change or improve for health education when teachers are overwhelmed and inadequately supported. She specifies that young teachers may have difficulty dealing with the inaccessibility of the resources in the curriculum but she felt that they, at least, have been recently trained in resource-based learning. Many veteran teachers, according to Rhonda, are not as resourceful and confident in choosing and finding quality content and activities in health education and therefore just do not do it. Rhonda feels that the revisions "did not change anything and it (the curriculum) is still a paper weight to hold open the door."

Rhonda, a seasoned health teacher, addresses the demands and the deficits in the curriculum in this way:

> *I strongly believe in the health area and I think that I would say "Okay" and follow what is laid out. I will follow the guidelines as they are made out for us and touch on the areas that I think I should touch on and add in some of my ideas.*

While Rhonda is eager to function as a pacemaker to help teachers implement quality health education, she changed her mind in terms of the venue of her contribution. At first, she was a Catalyst Teacher but this required her to promote health education through the Middle Level Curriculum Implementation workshops and she realized that, "I am not sure that I'm in total support of it." Rhonda was, at times, embarrassed to be associated with the new Middle Level Health Curriculum. Health instruction and in-service were vitally important to Rhonda but the manner in which the Catalyst Teacher in-service was presented was "so adamant . . . that this is the way it should be" that she felt uncomfortable.

> *I am sitting around and looking and they [my colleagues] are looking at me and saying, "So you support this?" My husband was at a [health] in-service and the people kept saying, "Your wife supports this, does she?" He would say, "Hold on just a minute here." That is not a good feeling.*

Rhonda resigned as a Catalyst Teacher because in-service promotes a curriculum she believes is flawed, and she is so passionate about health education that she is intolerant of the flaws. She said, "I do not know what we can do for health" but she had higher expectations for health education than merely superficial and general health instruction.

Linda

Linda feels there are many dedicated health teachers but also notes. "A lot of time you are the health teacher because it fits into your time table and you have to fill out your time table." It was from this vantage point that she describes the marginalization of health education and the difficulties for CSH education when the conditions are so unfavorable. One of her main concerns is the teachers who were required to teach health but did so without commitment or sincerity. Linda describes a particular situation when she "spoon fed" one of her colleagues who did not want to teach health.

> *It's so bad. Lots of the time it would be, "Linda what am I teaching in health today?" When he would have a sub he would write, "Go see Linda" [in his daybook]. So I would say [to the sub], "This is what you are teaching."*

Linda reports that even her administrators were cognizant that some teachers assigned health education lacked knowledge in the subject area. Linda appreciated the administrator's comments. which led her to believe that they not only acknowledged the deficiencies in health instruction but also wanted to facilitate a resolution.

> *[The administrator states] "These people need help with health and you are going to help them and you will give them your lessons." And I was fine with that because once they got to my grade I knew what they had done.*

Linda also feels that teachers are not the only group to marginalize the importance of CSH education. In speaking about parents and community members. Linda says:

> *It is not important to people . . . they [schools] are getting pressure for more science. more technology. I have never heard that parents come into the school and say we need more health . . . . What does society think is important? What do parents think is most important? The government agencies want standardized testing. Really they want to push for the three Rs.*

Despite Linda's general frustration with the lack of respect for CSH education. she finds places where there is support and encouragement and feels she is needed. As a busy Catalyst

Teacher. Linda facilitated several workshops and volunteered to write a unit that would be available to, and recommended for, her division. Linda states:

> *Sue [Director] thanked me for them [workshops] and she has been to several . . . and so she knows that I am doing this curriculum unit. I approached her and I said, "I will do this. It can be approved and then everyone can do it and I am not asking anyone to do it with me, but I said that if any one wants to be a part of it, join in! . . ." [what they say is] "Linda, hurry up and do your XX unit because I am doing it soon."*

The thought of becoming a facilitator and in-servicing her colleagues was not attractive and Linda said the thought of it made her want to "pass out." Overcoming her fear of speaking, she became a Catalyst Teacher. She had always been "into the health aspect" and wanted to improve and refine her abilities as a health teacher and share her experiences with others. When the occasion to become a Catalyst Teacher arose, Linda felt it would be a good professional growth opportunity, but realized, "I will teach health but to be effective you need to want to do it and you have to put in the time." Because she was going to put time into learning the new curriculum anyway, it seemed advantageous to be supported by the Catalyst Teachers.

For Linda being a pacemaker meant in-servicing teachers about the Middle Level Health Curriculum. This proved to be a tremendous challenge. Sometimes teachers are less than receptive to the in-services. Although Linda advocates for in-service and health workshops, she qualifies her statement by noting that only teachers who would find the information relevant and meaningful to their current teaching responsibilities and have a commitment and interest in health should be in attendance. It is clear Linda does not want to give in-services to, or participate in workshops where a majority of the teachers are not interested in health education. Linda compares these sentiments to the irrelevancy of her

taking a social studies curriculum in-service when she has not taught social studies and never intends to: "I won't remember it anyway because it is not relevant to me . . . unless you are doing it and committed to it, it will mean absolutely nothing." Linda understands that some teachers are not interested in teaching health and, in her opinion, there is no purpose in noncommitted teachers being forced to attend health in-services.

Tim

Tim describes the familiar scene of teachers feeling disappointed when they are assigned to teach health: "When we got our teaching load this spring someone said, 'Oh, I have Grade 8 health' and they come to me and say 'Is there any way I can trade you for something else?'" Because Tim is a strong advocate of CSH education, he is happy to exchange classes but this arrangement is not always feasible or possible. As a result, there are often teachers in his school teaching health who have little interest, training, or knowledge in terms of CSH education. For this reason, Tim advocates that health specialists be exclusively assigned to health courses. Even though Tim is an administrator and in a position to make some of these decisions, he is not yet able to ensure this will occur. First, the small staff impedes a lot of the flexibility afforded to larger schools. Second, there is some opposition to specialists, as some teachers want to remain generalists. As a compromise, there are both specialists and generalists in Tim's school.

Tim operates as a pacemaker in curriculum issues by contributing to the writing and development of health units for his division. He became part of a team representing three school divisions. As a writer, he was asked to create all the undeveloped, but required, units from Grades 6 to 9 health. He also serves as an active Catalyst Teacher. Both activities are

significant commitments in time and effort and speaks to the teachers' needs to have more detailed curriculum material in health education. While the curriculum mandates generic skills such as decision making, refusal skills, and problem solving, the curriculum is viewed as inadequate because it does not include activities, notes, or detailed content. These elements are imperative to Tim, who views the curriculum as unfriendly at times. He is particularly concerned about the quality of health education when new or uninterested teachers have to navigate their way through health education.

> *I think with health . . . that would be scary. What do you turn to, then, if you are a first-year teacher and you opened it[curriculum guide] up and see that you need to teach Family Community Violence in Grade 8 and all they have is objectives. A lot of people would be going "woo"!*

Tim, also, resigned as a Catalyst Teacher this year. He was glad to have been a part of it because it improved his knowledge of the curriculum, provided "awareness in different things," and gave him a better understanding of Saskatchewan of Education. Tim delivered several in-services as a Catalyst Teacher and began to deviate from the "canned" script provided by Saskatchewan Education because he felt it did not meet teachers' needs. He felt he could better serve CSH in his division by becoming more involved in the local unit writing process and move beyond curriculum issues to health issues of services and policy. He does not want to "drop something that I got involved with" but "I feel that I have got into helping the division here" (in a significant way). One way he provides service to his division as a pacemaker is "trouble-shooting." Perhaps because he is also an administrator and a Catalyst Teacher, he often fields questions and telephone calls where advocacy is needed.

> *Here, locally, I was receiving a lot of calls that I just did not know the answers to. I was doing my best: I was writing letters to find out and I was saying to people that I will look into it and different things along that line.*

Bev

Bev recalls being "stuck" with health many years ago saying, "they gave me the leftovers - the things no one else wanted." Now, teaching health education is Bev's priority. The years of growth have helped her understand the Bradycardia in CSH education, whereas she notes some teachers are still assigned health even though they are not too keen about it.

Bev states there are elements of CSH she has no control over, but she did find health instruction a place where she could contribute to health education. Functioning as a pacemaker, she attempts to support other teachers in their efforts to improve health education and has assumed a number of leadership roles. Some of her roles have been both formal and informal. The following presents an example of an informal pacemaker role.

> *The years when I taught all the health, or even when I didn't teach it all, I would coordinate it all. There were a few years when I taught [Grades] 6, 7, 8 and there were others that taught health too. I always coordinated things: I would write the letter for sex education, make the group letter, and have them all sign it.*

Having taught health for many years, Bev remembers the original version of the current curriculum as "huge and horrible" but grew to like it as she became more familiar with the contents. Now, having taught all of the Middle Level health at some point, and having tried and tested many units, she is very comfortable with the recommendations of the present curriculum. Having this comfort and interest has given her the reputation as the "health expert" in her school, even though she states, "I am not any more (of an expert) than any one else."

Bev's formal contribution as a pacemaker was her appointment as a Catalyst Teacher. Bev is a seasoned in-service facilitator having been a workshop facilitator in other subject areas in the past. She says she continues to be involved in this voluntary program because of

the self-satisfaction, professional development, resources, and the people she meets. On the other hand, she also notes the personal costs and inconveniences are many. The challenges, however, are downplayed when Bev compares it to past facilitating experiences where the physical and financial expectations were more demanding. She describes the inconveniences of being a facilitator at in-services where travel is required.

> *It is a lot of organization. Who is going to give my kid a ride to school? I have to get someone to bring him and someone to pick him up and take him to all his activities - all those kinds of hassles, especially when they are overnight. [In the past] they just paid for our sub and our gas money and the fact that I had to leave here at 4:30 in the morning and drive somewhere and the extra babysitting and all that. We did not get an honorarium, now I do. The hours that you put into preparing was a lot. [In health] it is all there and you do not have to do a great deal of preparation – [just] a few hours.*

At the provincial level, the Department has made improvements to ease some of the inconveniences, but Bev did not ask for much and was grateful for small conveniences.

> *One time I had to go to a workshop in Buffalo Narrows and, rather than leave after school and drive until two in the morning because I was the teacher-librarian all afternoon, they said that I could leave at noon because I did not need a sub and they let me drive when it was mostly light. I just had to rearrange [the students for the afternoon].*

The Catalyst Teacher commitments are more formal and in-depth obligations, but there are many less formal ways Bev tries to help others. She offers advice, lends lesson plans and units; as she states it, "I gave her some activities that gave her some breathers."

After identifying a number of problems impeding the efficiency and quality of health instruction, the participants concentrate their efforts on one goal: to improve health instruction by assisting others. As they suggest, there are both formal and informal avenues to be a catalyst in health instruction. Their willingness to provide time and attention to other

teachers to improve or change the way they instruct health education defines them as pacemakers in a Bradycardia situation.

ARTERIOSCLEROSIS

The third heart condition that emerges from this study resembles Arteriosclerosis, a condition where the heart muscle must have an adequate blood supply to function properly. Should one of the coronary arteries be blocked and circulation fail, infarction of the heart muscle inevitably results. Because of insufficient blood to the myocardium, the result is a major disorder called Angina Pectoris. Angina Pectoris is most often caused by Arteriosclerosis or a narrowing of the arterial walls as an accumulation of cholesterol lines, and eventually occludes, the coronary vessels (Luckman & Sorenson, 1987).

Similar to Arteriosclerosis, the participants describe how the "arteries" or infrastructure supplying the vital requirements for CSH are experiencing some severe blockages which impede the efficiency of the CSH components. Unlike Bradycardia, where pacemakers provide intervention, Arteriosclerosis seems to develop without any measures to check it. As a result of the accumulation of barriers and challenges related to CSH, each participant described his or her version of CSH Angina Pectoris. Even though CSH embodies four necessary interrelated components, this section will only focus on three. The fourth element, Health Services (Community Involvement) will be discussed in the last section of this chapter. The purpose of this section is to explore participants' perceptions and activities, illuminating the barriers related to health instruction, health environment, and support services. Each section will conclude with participants' comments that detail their

sense of being in a situation of persistent obstacles. These barriers represent the participants' notion of angina.

Rhonda

Instruction

Rhonda outlines inadequate time, money, and accessibility to resources as the three main blockages that affect the quality of CSH instruction. The shortage of these three important elements were the source of Rhonda's chronic frustration with implementing CSH.

> *[Resources] That is half of the problem. I knew this when we were writing and we would sit and say these are wonderful resources and it might even be a video that you can get from Media House and only cost one dollar. But it also involves picking it up, getting it sent out, and our librarian is forever saying, "These are the books we need maybe in next year's budget." There just isn't the money. There is lots of resources . . . but the money is not out there. So again, it means that if you need to have something for the next lesson and you say, "Oh I need this, but I have to order it but I need it for tomorrow so I guess I'll order it next year." There is a problem in sitting down and taking the time to figure out what you need . . . it is just that time element.*

Because Rhonda is highly committed to health, she expends extra effort to ensure she has a quality program, however, she recognizes the personal sacrifices she must make.

> *It is a matter of the time element . . . this is my 24th year of teaching and I am still taking home probably a minimum of one hour worth of work every night and if I don't do it, I feel so guilty I get up an hour early and get to school . . . I believe in the health area so I will take the time to do it but I know that other people do not.*

Healthy environment

Having barely enough time to satisfy her standards for CSH instruction, Rhonda does not concern herself a great deal with other parts of CSH, notably healthy environments. Rhonda spoke very little about being involved with other elements of CSH, such as creating and developing healthy school policies as a part of a healthy environment. In terms of involving herself in policy initiatives, she states that "we have very explicit (health) policies"

which were developed by her school division. She notes, "It is black and white. It is like - 'these are the rules.' Suspension is your option if you are not going to follow it. The board has done quite a good job of laying it out."

Social support (parental involvement)

Lack of time is noted as a barrier in generating social support (parental involvement), another fundamental element in CSH. Rhonda, however, always invites parents into the school when she is teaching her Family Life unit. This year, Parent Information Night is the only time she had formally invited parental involvement. Parents' Night, however, is a well-established tradition as Rhonda describes.

> *On Parents' Night the kids come in and I have a video that I show. It is just the basic stuff. Basically, we go through what we have been talking about and I always write up the different topics and concepts and then kids will talk . . . . I think that here in this area that I am teaching . . .the parents . . . the knowledge is not there for them either. It is almost like we are not only getting the kids but the parents too.*

Parental involvement in this school is less prevalent when compared to other schools where Rhonda has taught. She attributes this to the nature of the socioeconomic makeup of the school, but that is not to say the parents are not supportive. Rhonda describes parents as fitting into two types: either they are "out of the picture" or easy to work with because they want better for their children. She cites a campaign affiliated with a science carnival where the children had to collect pop bottles to fundraise for a charitable contribution to the neonatal unit. Parents generously donated their pop bottles even though many could have kept them and used the money for their own basic needs. Community involvement, support, and membership occurs in many subtle ways, even though not directly associated with health education or a CSH program.

Rhonda acknowledges that parental involvement is important, but many teachers are nervous about planning a Parents' Night. As a result, parental involvement is usually limited to information nights. One of the suggestions Rhonda made to deal with the uncertainty of Parents' Night was to use a prepackaged program that outlines how to conduct a parent meeting.

> *The nice thing about that program [Lions Quest], and I haven't used it in three years, is the Parents' Night is boldly laid out for you and anyone could use it . . . that is why a lot of teachers use that program . . . it basically tells you what to do and what to say and it can make you very comfortable.*

Angina

While Rhonda strives to implement CSH, she faces a number of barriers that interfere with her optimal vision of CSH. This, in addition to the high demands of teaching, has left her feeling highly stressed. Lately this stress has made her physically ill and she has requested a transfer in hopes that she will be placed in a school that is less demanding in terms of health issues.

> *The emotional part wears on you. I know I need a change . . . I have to learn. My husband is very good . . . I can deal with this at school . . . as best I can from eight in the morning to four at night, but when he comes home he leaves it at school and I bring it home, and he never tells school stories at the supper table and I never stop. It is really draining and the older you get you sort of think, "Oh boy . . . ."*

Linda

Instruction

Linda underscores two notable factors that interfere with an optimal CSH approach. She is particularly attuned to the financial restraints and high costs of resources.

> *We do not have money. They have funneled some money to me as a Catalyst Teacher [saying] "Go out, buy something," but when one video would wipe out the whole thing, it just costs a lot of money. I hoard the resources and I get questioned about it.*

I want to know if I am responsible for health. I want to know where the stuff is so I lock stuff up so it doesn't go missing.

Linda identifies large class sizes and inadequate facilities, both ultimately related to lack of money and resources, as problematic barriers for quality instruction. She describes a project which was impeded by these concerns.

In nutrition we talk about healthy eating, we talk about fad diets, anorexia, and bulimia. We take a menu and they can take a "lunch" or "dinner;" then, they have to decide how to lower the fat . . . . With the class numbers - I have 36 - I do not know how it is going to go . . . last year we split them up. Even 22 in the home ec lab is ludicrous.

These obstacles were problems she had to contend with as best as she was able.

Healthy environment

Linda does not feel she is involved with the Healthy Environment component to any great extent. She describes Healthy Environment as primarily shaped at the division level. At the school level there is little teacher involvement, except for what Linda calls a few "players." These are teachers in the school who hold unofficial authority but, on occasion, seem to be able to effect change at the school division level. From Linda's perspective, being the health teacher and advocating policies based on healthy choices does not possess any power at any level. Healthy policies are clearly outlined in the student agendas and Linda seems satisfied with not being part of the policy making: "I would hate to see that every single person in our school who taught health having a say (about policies)." Linda is clear about not being particularly interested in the Healthy Environment element of CSH.

I do not want anything to do with it most of the time. I just want to be in my classroom, teaching my stuff. I do not want to deal with everything else and I would like to be alone to do what I do best, which is teach, not make decisions. I make enough in my classroom and I can pretty much do anything that I want in there.

On the other hand, she is frustrated with some policies that are contradictory to a healthy lifestyle.

> *For the record, I am completely opposed to having smoking on the school grounds. Philosophically, I am the health teacher, and we are letting them smoke? I do not like it [the smoking policy] but I will support it 100% because it is a school policy.*

Social support

Linda has incorporated very few parental-involvement opportunities in health. She recalls her students saying they would be uncomfortable with their parents participating in CSH. She rarely incorporates parental involvement in her classes even though she states, "I have always said, 'If you (parents) ever feel that you want to come in and listen to a class and you can help me out.' I have never had any one take me up on it." Linda describes her views on parental involvement.

> *Had a doctor that was a parent [but] "No." The invitation has always been there. It is different when they actually have to say, "Yeah, I will come in." I can't remember what we were talking about and I said, "Hey, your mom is a massage therapist we could bring her in." No way. They [the students] would not go for that.*

Linda's perception was that parents were not very interested in knowing what was going on in health education and did not want to participate in any way. Linda laments, "at Meet the Teacher night, when I go through what we are taking, three parents from a class, no parents from a class [show up]. Most of them do not know what we are taking." Even though Linda suggests many reasons why involving parents is difficult and time consuming, she is going to have a parent information night before she starts her Family Life unit this year.

Angina

There is a certain degree of frustration in Linda's tone when she notes the many elements of CSH that need attention. In advocating for health education, Linda gets frustrated.

> *And I said, "You know that is the class that needs it the most! (I am going - "ugg"). This [health education] is important. In the last few years, I have been making myself sick: I got checked for gallbladder and ulcers on Monday, that is why I was not in school. I am, "Like, is this worth getting sick over?" I am getting that frustrated.*

Perhaps Linda summarizes the theme of blocked arteries best by saying, "it is survival in there and I have been teaching it for 6 years and it is different every time."

Tim

Instruction

Lack of funding is a general undertone for many of the concerns expressed by all of the participants. This lack of money seems to impact resources in a variety of ways. Tim discusses a common concern that even if resources are available, they are not always accessible. He talks about "the fingertip thing" which means that sometimes the resources might be available, somewhere in the division, but if they are not readily at the teacher's disposal they are not used. Another problem was that many of the materials in his division resource center are purchased by a librarian (not a teacher-librarian) who does not understand that teachers need resources that match the curriculum bibliographies. As a result, resources are purchased that are not necessarily supporting the curriculum. Tim reports that he and other teachers found this problematic when trying to follow curriculum suggestions.

Healthy environment

In terms of policy making, Tim is an administrator and privy to many decisions regarding policy but since he is new to his school division, he is still orienting himself in this area. He did, however, acknowledge that since he has moved into administration there is a different awareness level associated with being in "the office." Promoting a healthy environment is an integral part of the "Wellness Club" at Tim's school. This club is an extracurricular activity incorporated into the Fly Higher Program (smoke-free program) that "has done a lot of health promotion stuff with in our school." One of the initiatives is an intercom campaign where they start off the morning announcements with messages heralding, "Did you know that . . .?" They also had poster campaigns and interesting information signs over the water fountains.

Social support

Tim is very aware of the need for parental involvement as an integral part of a CSH program. He supports involving parents in a variety of ways in a CSH approach, saying, "I think if we do not do it at the schools and think of the comprehensive idea," parents have a difficult time ensuring their child gets the best possible health information. Tim says he has not focused his efforts on improving parental involvement, mostly because he is new to the community, although he notes, "I would like to do more of bringing in not just agencies, but parents. Maybe I will get that (element) back." Tim's past experiences with parental involvement have been positive. For the most part, he reports that parents are "glad" that the teachers are covering health topics, especially HIV/AIDS.

Angina

Tim discusses his sense of overload in a pragmatic way, as he outlines the challenges of balancing family life with the many demands of being a teacher. He describes his commitment to his own children and family responsibilities as his priority. He has recently made changes to lighten his workload and laments, briefly, that certain goals and projects would have to wait until they moved up on the priority list. One of the items recently deleted from his load was his role as the Catalyst Teacher. Tim did not expect this would radically reduce his workload as he is still very involved at the division level with health education.

Bev

Instruction

As the other participants, Bev agrees that the obstacles for optimal health instruction are focused on lack of money for buying resources and on lack of time. Because Bev is the teacher-librarian, she seems to have greater control over resources and has managed to acquire some relatively significant resources over the years. However, she states:

> *Yes, I know that even a lot of the stuff that I have asked for . . . "Well, you can't have it this year." Some things I have asked for year after year and sometimes, eventually, you get it and sometimes you never do. It depends.*

At a time when "budgets keep getting cut in education and it is difficult," Bev wonders how one does more when "we are already doing more with less. How are you going to do even more?" She feels it would be reasonable to expect more money to implement CSH, but is very skeptical it will ever occur, "they (government) are already short of funds so I can not see them putting in a lot of money." If money is found, one of Bev's dreams to improve her CSH education would be to increase and improve the field trips. According to

Bev, another serious infrastructure problem impeding CSH education is administrative decisions that marginalize health in subtle ways.

> *I hear the situations of other teachers from the workshops, lots of schools are like this. One school said that they were only scheduled for a hundred minutes per week and one of those periods was taken for Band. One of the health periods was for band!! I see the same thing happening here. In my class, in the first term, one of the students was blind and he got pulled out [of health] to go for Braille…I think he would have got way more from health but I do not get to choose what class he has to miss for Braille.*

Healthy environment

Bev notes that she feels quite removed from policy making as "most of it would come from central office, I would say. I guess if there was something that you noticed." The smoking policy was a central office decision, and Bev points out that although teachers were not a part of the development they are expected to be "patrollers." She is aware of some school-based policies: She is glad to see a junk food policy that removed the junk-food machine from her school, but she acknowledged that the decision was based more on vandalism issues and less on health reasons. She describes some of the school-initiated nutrition policies.

> *We have a servery in our school. We took everything out containing anything with nuts or nut oil. We have also suggested [there should be healthy food]. We have healthy foods. We have vegetables and dip and that kind of food. There are no pop machines in the elementary end and we sell milk everyday.*

It is difficult for Bev to comment on other policies, as she was unfamiliar with the specific nature of many of them. For example, she did not know of a harassment policy but suggests that it might be one part of the main rule of the school, which is to respect other people.

Social support

Over the years, Bev has involved parents in a variety of ways, such as guests on panels and for interviews. Several years ago when she started teaching about AIDS, she had a very well-attended parent meeting and continues to keep parents connected during the sexuality unit through detailed letters and permission slips. For example, she uses a specific permission slip for students to be involved in a condom demonstration. While she has had almost no opposition to this health activity, she acknowledges that, "I think that they (parents) like to be involved." Bev describes her "parental involvement" as keeping parents informed and connected to her health classes through occasional activities and letters that incorporate their permission. She finds that "most parents are very supportive that way."

At the same time, she thinks health can be difficult to teach because parents do not support health education in the same way they would other subjects, such as math or English. Bev imagines the parents saying, "It is only health!" In response to those remarks Bev believes:

> *Health is an important thing. I think all of the parents know that. They know that it is an important issue, yet they don't think that it is in school. It is a contradiction.*

Another major deterrent to involving parents is Bev's perception that students are opposed to their parents' involvement. She recalls the students saying, "No, no, not my parent. Don't ask my parent."

Angina

Bev has a regimental work schedule that begins at 8:00 a.m. and she stays at school until 9:00 p.m., three times a week. This time is primarily used to prepare for classes. She is also heavily involved in extracurricular activities which extend her hours at school on other

days of the week. She says she is overwhelmed at times. This spring she was adamant that her administrator ease her load. Next year, for the first time in her career she will have one preparation period.

THE CARDIAC SUPPORT TEAM

DeGraw (1994) calls for a reconceptualized notion of health. He describes an optimal situation as one that relies on a community-based system, is highly student focused, and needs driven. A cardiac support team is based on similar principles and that is why an entire team of specialized professionals care for one cardiac patient. Through incidental comments and the participants' responses to questions about CSH, it became clear that the defining component of CSH, which differentiates it from just "health education," is the community-involvement element. For example, in discussing resources Bev volunteers, "that is where our Comprehensive School Health works in – using the agencies – a lot of the agencies will come out (to the rural area) now." Having recognized this during the interview, the next area I inquired about was the participants' meaning of "community involvement." Rhonda, Bev and Linda discuss community involvement mainly in the context of health instruction. Community involvement is basically synonymous with guest speakers and field trips in the community, although not limited to these. Even though they seemed to downplay their current use of community resources throughout the interviews, there are numerous references to the use of a variety of support services and people. Perhaps this is partly because teachers do not have much control over the amount of time that most services are offered or provided to the school. There is evidence that a variety of community members representing a variety of perspectives were exposed to the students and the school. The third theme explores how

each of the participants view health services (community involvement), who makes up their cardiac team, and how it functions.

Rhonda

Rhonda has the support of a variety of people but the extent that she is able to use them is very limited.

> *The Public Health Nurse is in the school one morning per week and the Resource Officer stops in once in a while when he is in the neighborhood and he will set up the classroom visits, but often has to cancel because he is one person trying to do 12 schools, plus a high school thrown in. So you know that you will not have access to him very often.*

Most readily available are the Resource Officer, a Public Health Nurse, a "grandma-type" volunteer, a university preintern, psychiatrists, social services, and basically, "if you were in a dilemma, the principal MIGHT be someone you could go to, but it is basically 'Where do I go from here?'" Rhonda seems flexible and open to have guests in her classroom and it is not because of disinterest that she does not have a greater community involvement. She describes the complexity of getting people to come on the school schedule and the time involved in organizing and communicating with other people. This added variable made her already complex classroom that much more demanding: "It involves pulling in a variety of different agencies or going on field trips, it is a little more work. Yes, I think that is a deterrent."

When particular health issues hit a critical peak, it is usually then that community resources are called upon: in some ways it is a last resort. Rhonda describes the bullying and racial harassment that is a significant problem in her school. To combat this problem, one approach of the school is to use their Resource Officer as the "bully speaker" in every

classroom. Because this "project" is not a direct part of her health instruction, Rhonda seems to separate this type of health education from her health course.

Rhonda is creative in the way she incorporates the community resource people. She does not always have them as guest speakers - sometimes they help with individual children or small groups of children. In some projects the helpers assist Rhonda to assess student work. In this way, Rhonda's students consider these assessments more authentic because they have been through a type of triangulated marking design. There are many roles that community members can fill in an effort to develop healthy schools. Rhonda describes a common situation where she feels outside help would be an asset.

> *Danny is a good kid, but they have really became friends and Danny does not have a good home life and without the direction there. I am really worried they will not even notice what he is getting involved with. It would be really nice to have someone there just to spend some time with him. You just don't have the time for one on one.*

When Rhonda spoke, it was evident she was reiterating the variety of needs in her classroom and validating the overwhelming sense that she cannot fulfill them all. In many ways Rhonda has tried to address the shortfall in community member participation. For example, she had broadened the scope of the extracurricular activities to include programs that were responsive to health concerns. Recognizing that many of the Grade 2, 3, 4 students are responsible for their own nutrition and often in charge of cooking at home, Rhonda teaches an after-school nutrition class to improve their knowledge, skill, and safety in the kitchen.

Linda

Linda uses fewer classroom resources than the other participants. She primarily relies on the guidance counselor and the school psychologist, but she seems to have access to them

on a more regular and intricate level. In terms of health instruction Linda does not care for having other people teach in her classroom, especially in the more sensitive units. The thought of a substitute teacher or an intern teaching her own material does not appeal to Linda and she says she would rather teach the classes herself. She has not made any arrangements to bring in outside agencies or professionals from the community. She has, however, developed a trusting relationship between the school guidance counselor and the school psychologist. The guidance counselor serves as a guest speaker and she is planning to include the counselor as a primary teacher for the upcoming Dating Unit. The counselor also serves as a resource person and one that Linda can refer her students in need to.

Linda has access to a school psychologist and employs him as a resource for her students with severe or critical health concerns. Linda describes, but is not associated with, a community-based Wellness Center that promotes the Fly Higher Program (female smoke-free program) and other healthy lifestyle activities as an option for students who were prone to hanging out on the streets. The guidance counselor is one of the Wellness Centers leaders but, other than that, the community-based program is quite separate from the school health program. Linda does promote the Center in her health class.

There are other health initiatives, beyond the health classroom, that the school administration has supported. For example, the R.C.M.P. and school administration initiated a type of "Crime Stoppers Program" for high schools: yet, this is not related to, or integrated into, the health program at all. There seem to be other health-related issues that demonstrate the need for community involvement and problem solving with school and community members, but at the moment they remained unresolved or politically volatile.

> *We just took a lot of flack from the community and the R.C.M.P. because they [the smoking high school students] were wrecking people's fences and yards and congregating on the streets and the R.C.M.P. would not move them.*

Community programs and problems related to health issues are viewed separate from the health instruction which focuses on unrelated health issues. Despite the fact that there were concrete issues that needed resolving, Linda was skeptical that any design, CSH or any other, would provide a structure for resolving these issues. She believes that the community, including parents and school staff, will continue to emphasis and put their efforts towards technology and science related issues, with little regard to health related issues. Linda observes that money, time, and emphasis is not focused on fostering community involvement and problem solving. It is placed on priorities rather than developing healthy situations for kids.

Tim

Tim's situation differed somewhat from the other participants' situation because he is new to his community and is in an administrative role. Tim incorporated limited community involvement into his health classes. Yet, he had extensive knowledge of the agencies that support students' health, as he is part of a school division committee studying community agencies that provide direct and indirect health-related services to schools. The committee is in the early stages of their mandate and are trying to develop a thorough understanding of the local programs and services available for youth and people who might best use them.

Although I do not believe it was intentional, his comments led me to believe he is somewhat skeptical that interagency involvement would develop into anything significant, at least in the near future, as the information he receives from other sectors is often dismal.

> *When I called Social Services, I said that it was my part on the committee to ask but they do not ever see having on-site (services) because the funding is not there and they simply do not have the people to staff many elementary schools. But the communication thing has got to become better.*

On the other hand, Tim is beginning to use the term *interagency* for teachers becoming part of a team, along with other health-care professionals, involved with particular students at an individual level. As well, he envisions a role for other agencies within the context of school life and classroom instruction. In addition, Tim described an interagency meeting he had attended. As a professional, his role would be to deal with particular students who were associated with several Social Service agencies. Tim was quite excited that he would be part of this professional team, having never been part of an interagency, multidisciplinary meeting such as this. He perceives the role of the teacher as more of an observer and learner than a contributor on this professional team: "That is the idea. We are supposed to get quite an awareness of the background of this young fellow."

In his role as administrator/teacher, Tim has referred students to, and utilized the services of, many organizations, but the most prevalent community resource was the Police Liaison Officer. Tim described how the officer has worked in classrooms and with individual students and is available for consultation on legal matters. From Tim's perspective the Police Liaison Officer is an invaluable resource and he expressed concern that the School Resource Officer Program was in jeopardy.

> *[The police liaison program] is going to change. They are doing some restructuring but that will be mandated by them. He visits each school. He is coming this Wednesday. I think we get 12 visits for the year.*

Even though the Resource Officer is presently allocated one day a month at Tim's school, he had been extensively involved with the health of the school. Tim points out that

the R.C.M.P. officer would often come to the school on demand, when requested, and frequently contributed his own personal time. This may account for the strong connection between Tim and the police officer.

Tim reports that the Family Services Bureau (FSB) is strongly connected with the school. An FSB social worker, who was a guest speaker in Tim's class, also provides anger-management courses and after-school counseling for referred students. Tim works quite closely with this community resource, describing it as an opportunity to bridge school and community health. Another intricate connection between the school and the community was the Community Wellness Center. Unlike many Community Wellness Centers, this one is strongly associated with the schools. Tim says "they provide a full-time service for students. It is out of school programs but they are involved with schools and counseling." The Center has also offered to provide guest lecturers but Tim has not yet used them. One area that the Teen Wellness Center counselors (who are not teachers) contributed to was in the division initiative to develop and write the health units. As noted earlier, Tim and two other school divisions seconded teachers to write complete units for the undeveloped areas in the Middle Level Health Curriculum. Each of the three school divisions was responsible for one grade level and the remaining grade level (Middle Level Curriculum is Grade 6 - 9) was developed by the individuals from the Teen Wellness Center. In the end, the team of health teachers from three divisions and the individual from the Wellness Center produced a thick binder of developed units for all health teachers in all the school divisions. This is a rare example of joint community-school project.

Tim's superintendent is open to extending this community process in CSH and to including others in the decision making and planning related to health education. Tim states

that the superintendent wanted teacher feedback to determine their perception and desire to initiate a health "liaison committee." The Middle Level Health Curriculum advocates use of a liaison committee to facilitate bridging the needs of community health and school health. Tim and his fellow committee members advised the superintendent that no liaison committee would be needed because they had developed these instructional units for the teachers to use, speculating there would be little need for a liaison committee and community input. As a result, no liaison was ever started.

Bev

During Bev's conversation there were many references to community involvement, although almost all related to CSH instruction at a classroom level. Bev has used a vast array of community members as guest speakers and is the only participant to take the students on health-related field trips. The people she had in her classroom included Public Health Nurses, the R.C.M.P. and school counselors. These individuals are often the only health-related resources available in rural Saskatchewan.

> *We have a school counselor that comes one day a week . . . that is not much for a school our size, but I have had her come in and talk . . . . We have shared services that is very difficult. They are only in our school once a month. It is very difficult to get them to come into the classroom when they are not here.*

On occasion, she made special arrangements for organizations such as the Lung Association, The Heart and Stroke Foundation, AIDs organizations, and a health district speaker to make special presentations.

> *In the Grade 9 unit, Promote Health in Your Community, we promote health in our school because it is kind of hard to do outside of the school. What I did was send the kids down to Grade 3 to teach them how to brush and floss and putting on 'haunted houses' and that kind of stuff and that is how the AIDS presentation was done. The community is invited to attend. It would go out in the newsletters that a presentation*

> *was [coming up] and sometimes . . . parents will come . . . . With older kids it gets more difficult because most of the parents go back to work and have a hard time justifying taking time off.*

Bev has been very resourceful in asking community members who have particular diseases such as leukemia, diabetes, and cystic fibrosis to speak to her class. For 5 years, as part of the Death and Dying unit, Bev has taken her Grade 9 class to a funeral home and crematorium. During this field trip a health educator who works for the funeral home gave them a tour and discussed issues related to death and dying. One of the components that Bev encourages is a discussion about different traditions within a variety of cultures, with the students learning similarities and differences between the customs. It is experiential in that the students are permitted to act as pallbearers and carry a casket, determine the cost of urns and other funeral expenses, climb in and around the hearse, and push the button on the crematorium.

These endeavors, it seems, have not been primarily motivated through her involvement as a Catalyst Teacher or through her knowledge about CSH gained through the new curriculum, as she has been involved with these undertakings for many years.

> *It takes a lot of work at first and it depends on how long you've been in the community. The longer you have been in the community the more connections you will have. When I first came here it was very difficult because there is no "community" here and if you connect with the city, they already have lots of schools. They do not want to be driving out and we do not have money to pay them mileage and it was very difficult. Some of them I just gave up on and you phone them and they never want to come. I try to bring in guest speakers because I think that makes the class interesting for the kids.*

Bev's focus is clearly on involving community and agencies at an instruction level as part of her classroom CSH education and not as a part of a CSH program within the school. There were, however, elements of coordination at a school level that suggested a "larger

vision." For example, when the Public Health Nurses stopped lending a valuable (both instructionally and economically) reproductive kit for sexuality education, Bev convinced the school board to buy it for the division. Also, at times, classroom instruction has been influential in health promotion that involved the entire school.

> *The other health teacher, her class was doing AIDS in Grade 9 and I was doing AIDS in Grade 8 and the theme was "Promote Health." They learned a little bit about AIDS and then did a presentation for the school in the gym and they brought in speakers . . . and a few other people. It was just presentations but they had the gym all set up and they could take turns going and then they would have the speakers in between. I think they had from Grade 5 [and] up for the whole morning.*

CONCLUDING STATEMENTS

The preceding has been a presentation of the data collected in the two interviews with four CSH teachers. The purpose of the study is to explore what it means to these four people to be a teacher using CSH. The data reveals a broad range of information about the role of the CSH teacher, what they are capable of doing and changing, and how they perceive the challenges and successes of the four main elements of CSH. To deepen and clarify the information that is illuminated in this study, a metaphor using the heart and cardiac conditions supported the communication of the themes: Megaheartopia, Bradycardia, Arteriosclerosis and Cardiac Care Unit. These themes represent common elements found in all the participants' stories.

From each of the themes presented in Chapter 4, particular issues emerged as critical points in understanding what being a teacher using CSH means. In the following chapter, these poignant items are discussed and analyzed, with support from the literature, to gain a deeper understanding of what the common themes reveal about what it means to be a teacher using CSH.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

From the findings of this study, a clear picture of what being a CSH teacher means to these four participants has emerged. The participants have described a unique profile of the role of the CSH teacher and have illuminated the successes and challenges of the four elements of CSH. The findings will be discussed in greater detail in the following sections under four headings. The first section entitled "Is There A Doctor in the House?" discusses the need for coordination in CSH. "Being a Cardiac Team Member" examines the power struggles and the different levels involved with community involvement. "Coping with a Heart Disease" studies how the participants coped with the obstacles when implementing CSH. The final section, "Valuing the Patient" analyzes how teachers maintain their commitment to CSH through the strong bonds with their students and by focusing on health instruction.

"IS THERE A DOCTOR IN THE HOUSE?"

Even though a cardiac patient may have several specialists contributing to his/her care, the doctor plays a crucial role regarding decision making and coordination of services. While all team members may contribute equally and provide a vital service, the doctor's role as team leader sets him/her apart from the rest of the group. Similar to a cardiac condition, CSH also needs a leader. The participants describe their roles as leaders and pacemakers but, depending on the situation, they are also followers.

Leaders

When the participants volunteered for the Catalyst Teacher program, they were searching for experiences and opportunities that offered a connection to other health

educators. They wanted guidance to improve their health programs, more information on the emerging approaches and issues in health education, and were keen to learn and implement change in their own practice. On a journey that started as a desire to improve their own practice and their students' health, the participants became the catalysts for change and leaders for other teachers. They did not perceive themselves as experts or leaders in health education but they have become unofficial coordinators of CSH education.

Each participant describes his or her unofficial duties as the Health Education Coordinator for their school and, in most cases, their school divisions. Their primary responsibility is coordinating particular aspects of instruction, sharing and developing units, and coordinating community involvement such as guest speakers. Resnicow and Allensworth (1996) adamantly describe the need for "a dedicated individual to coordinate school health programs" but they recognize that this position requires the undivided attention of a professional who has been freed from teaching responsibilities. The implication is that successful implementation of CSH requires a Health Education Coordinator that is dedicated to the management and coordination of all health education policies, activities and resources within a particular setting or circumstance. No such coordinator position exists in any of the participants' school divisions. By default, the participants have become the quasi Health Education Coordinator because of their knowledge, commitment, and generosity. The problem in acquiring this unofficial position is their inability to fully carry out the responsibilities expected of a "true" coordinator because this is not a legitimate, acknowledged position. Being quite humble, they are careful not to impose themselves on others and generally provide leadership only when requested. They are also dividing this responsibility with an already full workload and, as a result, are limited in what they are able

to accomplish. Because of the need for a CSH Education Coordinator, the role subversively edges its way into each of the participants' lives. In all four situations, the participants quite naturally assume leadership roles in terms of instruction. The other three elements of CSH (health services, social support and healthy environment) are more on the periphery and they all struggle with implementing social support (parent involvement) and the Healthy Environment components. The Catalyst Teacher program offers them the coordination and guidance they were seeking in the area of health instruction. Because they are all teachers, curriculum issues were important to them and pertinent to their teaching responsibilities. It is, therefore, sensible that this would be an area of teacher commitment and also a comfortable place to devote energy, as their roles as health instructors are well defined by traditional teaching responsibilities.

Followers (But Not By Choice)

In addition to not having a legitimate coordinator, another problem emerges - the minimal amount of health management within the school. While Seffrin (1990) contends that a management system is a vital component of CSH, the participants are often detached from managing anything other than health instruction. They are definitely not the managers of school health programs where the entire school is involved. In fact, they are only minimally supportive of some of the school-health initiatives implemented by the administration. All four of the participants' schools have implemented the same canned health program called "Second Step," a very popular product because it is an anti-bullying, violence-prevention program. Health teachers had not initiated implementation of this program and generally do not associate it with their health course. Yet, the school

administration mandates Second Step for certain grade levels and the program is often expected to be taught in health periods. Bev comments that she is grateful that "Second Step" was mandated to other teachers in her school because it would put her in an uncomfortable position. Bev states, "Now, who do you follow?" You know you should be following the Department but your Director is really close and if you are not doing what he says . . .?"

It is here where the management system falls short. The intent of an effective management system is not only to inform but also to work together as partners (Seffrin, 1990). The participants do not feel they were partners in the decision for, or the implementation of, "Second Step" and other school health initiatives. It is, therefore, met with resistance and resentment as it was considered an unnecessary add-on and duplication of the CSH curriculum. Instruction is one of the sacred areas in CSH where teachers feel confident. This is their territory. They do not, however, challenge the authority that mandated "Second Step," even though it is contradictory to their belief in CSH.

The participants are far more likely to be followers in other areas of CSH, such as Healthy Environment and Social Support, but there does not seem to be much leadership in this area. If there is administration activity in these areas it does not necessarily filter down to the teacher. It appears that both teachers and administrators want power at an instructional level. Administrators have the authority to mandate certain requirements but teachers hold the power to direct the quality of what is dictated to them.

COPING WITH A HEART CONDITION

Throughout their time as CSH teachers, the participants have dealt with a myriad of potentially deflating barriers. Chronic lack of time, money, and inadequate, inaccessible resources obstruct optimum functioning and contribute to their sense of frustration. Also, they feel health education is marginalized by the lack of parental interest and sometimes weak administrative support. All these factors contribute to their sense of being overwhelmed and exhausted. The problems are not only related to CSH, but also to the number of roles to which teachers are professionally and personally committed. Presently, the conditions are such that "in all kinds of communities teachers' energies are sapped by having to attend to students who are upset, angry, depressed or ill" (Tyson, 1999). It is not surprising that the four participants are experiencing a sense of exhaustion. The enlightening component is the level of endurance and commitment to CSH that the participants exhibited under these conditions.

Even the two participants who recently resigned from Catalyst Teaching state it is not from their lack of interest or belief in CSH. In fact, the opposite might be said to be true. Instead of spending time being Catalyst facilitators, they both feel their services would be better used in other capacities to ensure CSH occurs in their own schools. Their roles have not weakened or lessened; they have only changed.

Faced with daily reminders of the need for a supportive, healthy and quality health instruction, the participants find ways to cope. Sacrificing their own time and effort has become a way of life. There is no expectation that they would receive any "reimbursement" for the extraordinary amount of time they dedicated to teaching health and all that it

NOTE TO USERS

Page(s) not included in the original manuscript and are unavailable from the author or university. The manuscript was microfilmed as received.

95

This reproduction is the best copy available.

UMI

policy development. Students are never mentioned as potential contributors to policy development.

They are all quite unapologetic about their disinterest in contributing to healthy policies. Each participant is relatively comfortable with allowing his or her division to set most of the policies. Grebow et el. (2000) suggest it is the role of the educator to make recommendations to improve policies after careful consideration of the division's mission, goals and budget. It is probably too daunting for health teachers to refine and contribute to every health-related policy; however, there is no protocol or structure in place for them to contribute at any level. There is, however, more to the participants' disengagement with policy making than being overwhelmed with a heavy workload. Teachers are not in a legitimate power position to implement change or affect decisions about many policies. While their input might be considered valuable, and may even be solicited at times, they have no direct influence or power over policies in their school and, subsequently, direct their interest and energies to places where they have greater power for change. Although the participants are disengaged from the notions related to Healthy Environments, there is one tension that did arise which seemed to evoke some emotion. Often school policies are blatantly contradictory to good health practices. Even though the participants are clearly irritated by the policies, and they describe the conflicts of interest that are generated, it is never considered of enough significance to warrant taking action.

Social Support

The participants are more sensitive to their neglect of the social support element, particularly parental involvement. They know it is in the best interests of the students to

develop connections with parents, but they do not follow through, to any great extent, with this element of CSH. All the participants seem to harbor some guilt that they have not been more diligent in creating greater parental involvement and they made suggestions about how they wanted to improve this element. One of the obstacles to implementing greater parental involvement is their belief that parents were rather unsupportive of health education; however, this premise is not supported by current research. A survey entitled, "What Americans Believe Students Should Know" (Lawton, 1999) reveals that adults ranked health education as the number one consideration, more than history, language arts and math. The participants are also deterred from implementing parental-involvement initiatives because their students discouraged it. Students are not particularly keen about involving their parents. This is noted in a Saskatchewan study by Schissel and Eisler (1999). They asked students where they preferred to get their information regarding sexuality. Not surprisingly, parents ranked very low as a preference for information and teachers ranked very high. Without the support of their students, coupled with the extra time and organization that inevitably accompanies parental involvement, including parents is kept at a minimum.

Even though there are elements of parental involvement, it is not driven with the zest of a fundamental philosophy that parents need to be intricately connected with the decisions regarding health education and healthy situations within the school environment. The fact that CSH advocates parental involvement does not seem to motivate the participants to change their previous behaviours. Given the fact that they already feel overwhelmed with commitments, it is highly unlikely that they will pursue greater parental involvement. Perhaps the participants are in a position of conflict, knowing that parental involvement is important but not persistently and actively pursuing it.

BEING A CARDIAC TEAM MEMBER

The one defining CSH component that separates health instruction from CSH - for all participants - was the involvement of health services (community involvement) in a health program. The participants depict how the need for a cardiac support team, or greater community involvement, often evolves from the variety and intensity of students' health needs. Even though community involvement is considered a worthy pursuit, this level of involvement in CSH is ad hoc and sporadic. Involving health services, such as a social worker, is often perceived as an isolated event and is frequently unsupported by a strong infrastructure. Additionally, the participants' lack knowledge and confidence about teaming with community agencies, makes them generally tentative about their role in the school as an interagency team member. As the following section outlines, the participants are more likely to be involved with health services through classroom and instruction events than in school-wide programs.

Although they are often tentative about community involvement, there are areas where the participants feel very confident and resent health services interfering on their territory. As in any relationship, connecting and communicating with the community proves to be in need of nurturing. The final component of this section will illuminate the controversies involved in forming relationships and interacting with individuals from health services in the community.

Community Involvement in the Classroom and School

Community involvement is not only a challenge for each participant, but it is also an endeavor in which they are all engaged. Teachers are at a greater comfort level in their role

as health instructors when community members participate as guest speakers. From the participants' interviews, two levels of community involvement emerge. First, there is an instructional level, where teachers involve community members in their health classes in events such as guest speaking. Second, there is a community-involvement level that is related to the way the school infrastructure deals with health program issues, such as how community agencies interact with specific students.

In many cases, teachers have not been socialized or supported to develop and implement health programs through a team effort. Rhonda points out that she felt completely isolated and unsupported in the health domain.

> *The other thing to do with our board [is that] we do not have a health consultant and so we have not been in touch anymore. It used to be that there was a little bit of check-up and not just about what was going on. They were there if you needed resources.*

The premise of community involvement is to allow specialized and appropriate people to have a role in contributing to health in the school. Not only is the job overwhelming for a teacher, but it is also beyond their specialty. In a second interview with Bev this became more clear. She describes a meeting with a social worker that is not necessarily, in her view, a legitimate part a teacher's job description. Even though the conversation is related to students' health, she feels that if she is representing any role, it would be as a homeroom teacher and not as the CSH teacher. Communicating with community agencies as an advocate for a particular student, seems to be an auxiliary role to a homeroom teacher's job. Superficially, the participants suggest that having to deal with, for example a social worker, about a particular child is considered an isolated incident in response to a particular situation. Increasingly, however, the participants became aware that the frequency of these seemingly

'isolated' situations suggest this additional responsibility is more of a norm than an anomaly. Since each problem and situation is somewhat unique, it may be perceived as an isolated incident, the underlying problems are essentially the same and teachers are frequently required to assume an advocacy role.

Linda, Rhonda, and Bev may not define "connecting with community agencies" as being outside the instructional role of a teacher; however, the need for "forced teaming" with other agencies appears to be increasingly commonplace. Linda describes, "I don't know how many times I have gone to the office and called Stan (division psychologist) because I should not be dealing with this, this is way out of my league." The participants acknowledge and agree that increasing interagency communication and facilitating greater community involvement would enhance student health, but doing so evokes additional dilemmas and struggles that compound an already complex profession.

Power Struggles

All participants express a general frustration with bureaucracy when dealing with other protocols and institutions. According to Rhonda,

> *Usually we could go through the fellow that is in charge of the foster kids and he might call Social Services. There are not the resources and people, well you know what it is like, if you are waiting for the people downtown, social services to do anything.*

There is also the issue of relinquishing control, because the teacher cannot control how community involvement might impact the students. Inviting guests into a classroom is more risky and less predictable than direct teacher instruction. Bev describes her attempts to direct the type of information speakers would bring to her class, as she carefully hand picks her panel speakers. "I brought him in especially when he was really young 18, 19, 20, 21 because

he is just out of school and . . . I knew he had the perspective that I want to come across . . . ." She goes on to describe another situation that did not work out as she intended.

> *I had [invited into the classroom a group called] Young Adult Parents and we did teen pregnancy with them. I had wished that I had heard their answers before . . . some of the girls were "Well, I loved it. I have three kids and I am 17" and they made it sound quite glorious and that is not the image that I wanted to project.*

Linda notes that community involvement does not just happen even if you teach to the curriculum, "you need to make a conscious effort and a lot of people do not have the time to do it." She also describes her own desire to teach health and relinquish the classes "it is hard for me to give up it up . . . I don't want to give it up. Health is just one of those things that I keep wanting to do more things with."

Bev seems to have a good relationship with the Public Health Nurses. She has a positive tone as she describes.

> *One thing we do get help in, in some ways, I know almost all of the Public Health Nurses are very willing to come in to the school and help teach and brings supplies and we have our public health in here lots.*

Further discussions reveal that, although she feels that Public Health Nurses (PHN) are a willing and capable resource, there are some logistical problems that impede her from using them.

> *She has always offered to do it [teach] for me. I had her come in a couple of times and she can only come in like once or twice. With the public health there is less - kids didn't ask questions.*

In the end, the services of the PHN are not used much in Bev's classroom. In fact, this year Bev provided service to the PHN. The PHN was a mentor to a student nurse and she wanted the student to have a teaching experience, so the PHN asked Bev to allow the student to come to her class. Bev describes the conversation she had with the PHN.

> *The Public Health Nurse said to me, "I know that you do not use me much any more because you would rather do it yourself, but I have a student intern and she would like to teach and I would like her in your health class.*

Bev gave the student nurse a simple, somewhat menial lecture of what to do and she was satisfied with the outcome. The content needed to be covered, but the fact that it was delivered by a community person did not make it a more meaningful addition to the program. Rhonda, Linda, and Bev do not overtly express any uneasiness working with community members as much as they describe the situations that were more inconvenient and frustrating.

Tim, however, is clearly dealing with the several tensions that erupted as a result of community members and agencies trying to work together. As described earlier, Tim and several other teachers were seconded by their respective divisions to produce a binder filled with units that would be available to all teachers in their three school divisions. One set of units was developed by a woman who worked at the Community Wellness Center and was not a teacher. Tim stated,

> *I get the feeling that some schools, they do not want her in there. I think what has happened is, if someone would have come back and said, "Who is this lady talking "sex ed." with my son or whatever?" That has come up a bit. When this [the units] came out, I got a couple of phone calls to say, "Have you looked at it?" I got into it and I started looking at some of the topics and ooohh! I said "Wow!" I did not know it well enough, so I dug out the curriculum guide and I phoned the director of the Community Wellness Center. She said, "Let's have a look at the curriculum objectives set out by Sask Ed." Actually, she followed it. I think some would have a very tough time talking all about pregnancy with their Grade 7s. They are looking at the curriculum guide thinking, I am not supposed to teach this until Grade 9. I think that is what happened. Some of the Grade 7 teachers thought "whooo" should I be teaching this yet? But if you look at the objectives . . .?*

The curriculum objectives are quite broad and somewhat ambiguous and, even though this unit did not go beyond the scope of the curriculum, the writer, who is not a teacher, was called into question.

This unit writing project is at the center of another controversy involving community participation. Tim and his colleagues were responsible for the Grade 8 portion of this project. One of the units they were developing was related to eating disorders. Somehow, the local PHN was advised this unit was being developed and called to inquire about the process and wanted to be involved.

> *I guess it was kind of funny on the phone because I guess what she said to Frieda was she would like to APPROVE our materials. Somebody had made the call about what they could offer us in terms of resources and she was wanting to APPROVE our materials, that we would be teaching in OUR classrooms??? You see public health comes into our classrooms so we were thinking they just wanted to know what we were doing. She actually asked for a copy of it and she did not get one.*

Tim tells another story about a new student that got into a violent rage on his first day of school. After a few phone calls, Tim learned that this boy had severe behavioural problems which were not relayed to the school by either the former school or the parents. The next dilemma was to determine whether the boy's teachers should be privy to confidential information about his behaviour. Tim seems somewhat resentful and perplexed that there is not a standard and explicit protocol to direct him concerning what information is appropriate to disclose.

> *How much can I tell my staff? On one hand, we could call a meeting right away and say this is . . . . The Grade 1 teacher was down there and she said, "I have not seen a kid go like that for awhile." So the other administrator and I said, "People have to know."*

The "shoe was on the other foot" in a reverse situation one day for Tim. A police officer, not known by Tim, came to the school to get one of the student's address. After checking to be sure this was appropriate, Tim gave the officer the information he required. The conversation that ensued, disclosed a great deal of personal information about this student that the school was not aware of. Tim was uncertain and uncomfortable that the

officer may have crossed a professional boundary and disclosed too much information. It also caused Tim to wonder what he should do with this information, "it was almost like I had better go and tell the classroom teacher." It bothered Tim that he did not know the correct protocol for either the police officer or himself and he sought more information from other administrators and legal advisors. In the end, he learned that what the police officer had said was not inappropriate and that, in supplying the school with information for the purposes of health prevention, his actions were appropriate and acceptable.

VALUING THE PATIENT

CSH is suffering from several cardiac ailments, but the participants found ways to live with these conditions. Engaged in the process of change, the participants have, at times, been overwhelmed and confused. Throughout the turmoil and chaos, they have begun to create a comfortable health education niche of their own. While their condition is constantly changing, the present snapshot is indicative of how they are currently finding satisfaction in their role as a CSH teacher.

One of the areas that each participant cultivated is strengthening the link between the students' needs and the instructional content and strategies they incorporate into their health courses. Having strong pedagogical relationships with the students contributes to the direction and the intensity of the health instruction. Reciprocally thoughtful health instruction contributes to developing strong pedagogical relations. This symbiotic relationship between health instruction and students' needs is a microversion of how health instruction (theory) is strengthened through practice and how practice is informed through theory.

Unable to neglect the obvious needs of students in crisis, participants are forced to stay grounded in their students' daily lives. This sense of reality reinforces their commitment to health education and energizes their sense of moral obligation to strive to improve health conditions for their students. While trying to change conditions for children, they are also bound by a self-imposed sense that the change must occur within the financial and structural restraints they perceive as confining. Certainly, there are financial and structural barriers to CSH, but there has been very limited testing to see what the barriers really are and how confining they might be. In some situations, for example, where administration inquired about initiating a Liaison Committee or when they initiated health-related speakers, the participants did not always capitalize on potential opportunities. There are several examples that suggest when the participants feel strongly that they need some type of support, whether financial or other, adjustments are made and their demands are met. Believing that the coffers are empty and that other supportive features are unlikely, the participants are not very demanding. There does not appear to be a strong sense of apathy but a sense of tolerance and of coping in situations that have chronic and systemic problems.

RECOMMENDATIONS

Based on the findings in this study, the following recommendations are made.

Teachers

1. Health teachers should continue to understand and remain committed to CSH by attending in-services, participating in research, and marketing CSH.
2. Teachers need to participate in policy development that relates to health issues in their school divisions.

3. Teachers should increase the extent to which parents are involved in CSH programs.
4. All teachers need to be involved with CSH, but health specialists need to take leadership positions in CSH instruction.
5. Teachers should explore ways to build relationships that foster an expanded notion of community involvement.

School Divisions and School Administration

1. School divisions and school administrators should focus on improving the understanding and commitment to CSH by providing in-services and engaging in marketing CSH.
2. Administrators should advocate for an expanded integration of Health Services (community involvement) in schools. In doing this, arrangements must be made to facilitate relationship building and communication among teachers, administrators and community members.
3. Teacher resources should be readily available and accessible for teachers to plan, implement, and evaluate CSH programs.
4. There should be a CSH Coordinator that manages and coordinates the four CSH components and assists with implementation and evaluation of CSH programs.
5. School divisions need to provide protocol, structure, and encouragement for teachers to contribute to policy development that is related to Healthy Environments.
6. School administrators need to acknowledge the connection between school health and health instruction, and work towards having them complement each other, rather than work in isolation.

7. There needs to be an acknowledgement that teachers are experiencing a sense of exhaustion.

Government and Universities

1. The Saskatchewan government needs to support the integration of Health Services (community involvement) in schools. In doing this, considerations must be made to facilitate relationship building in all stakeholders. For example, funding could be available for projects that clearly represent greater interagency cooperation between health-service agencies and schools.
2. A variety of accommodations could be made at the governmental level that would ease the sense of exhaustion teachers are experiencing (ie. increase funding for greater preparation time and lower pupil teacher ratio).
3. There needs to be funding for greater access to health services dedicated to primary health care (e.g., Public Health Nurses or Resource Officers).
4. Universities must provide greater opportunities for all preservice teachers, regardless of their major, to become confident and qualified to implement CSH.

RECOMMENDATIONS FOR FUTURE RESEARCH

Wignall (1998) describes the difficulty that interpretive researchers experience in concluding their work, because the emergent nature of their work leads to another focus of interest. The following areas for further research are suggested.

1. Variations of this study, using other participants with various health education interests and experiences.

2. Explore what being a teacher of CSH means to school administrators or Directors of Education.
3. Investigate the ways that teachers overcome and develop coping strategies to meet the challenges of CSH.
4. Determine a profile of the type of person that embodies a CSH teacher.
5. Explore the role of the teacher in relation to specific components of CSH, such as interagency participation, parental involvement, or policy development.
6. Investigate how teachers perpetuate the status quo in health education.
7. Collect stories of CSH teachers implementing CSH and determine how those stories empower them.
8. Determine how administrators' attitudes and the behaviour affect the beliefs and actions of CSH teachers.
9. Explore what power relationships exist in being a teacher of CSH.

CLOSING STATEMENTS

Improving health through education is probably not as difficult as open heart surgery, but it is also not as quick to fix. The role of the cardiac-care nurse is to be Panacea and heal the sick: the role of a teacher is to be Hygeia and prevent sickness. Like nurses, teachers work with a variety of team members to accomplish their goals. Both Panacea and Hygeia and their team members are necessary elements in a healthy society; however, the philosophical underpinnings of health care in modern history have been mainly influenced by a belief system which resembles a "Panacea influence" and is dominated by the notion that preventative activities are frivolous. As discussed in Chapter 1, vaccination for current

health problems does not come in a handy, fast-acting serum. It seems unacceptable to continue to function in a paradigm that relies on secondary and tertiary interventions when what is needed most, especially for adolescents, is primary health intervention. Typically, we do not want to wait years to see a significant results; nevertheless, in the case of adolescent health concerns, there is no alternative.

The participants in this study share common characteristics in that they all are deeply concerned with their students' health and are working very hard as leaders in their field to improve the conditions for children. They have attempted to create coping mechanisms to combat the barriers they are facing, but they seem to be losing that battle on some fronts as they are physically and mentally experiencing burnout. As individuals, they have created programs in which they take great pride and have assisted individual students with health-related concerns, but they are working in a system and a society that is not structured with an emphasis on healthful living for primary prevention. In fact, much of the school infrastructure impedes growth in this area. Common barriers such as insufficient money, time and resources, as outlined in Butler's (1993) study, were confirmed by the participants. The barriers that the literature does not address relate to the philosophies and structures in society and schools that are beyond the control of a teacher's practice. For example, CSH demands strong links to the community and with parents. Presently, not all schools seem to be sincere in their attempts to create an infrastructure where parents are more involved and in a less traditional way.

Allensworth and Kolbe (1987) outline eight essential elements for CSH. The participants engaged in these practices, in varying degrees, but would have shouldered a tremendous amount of responsibility to create a new paradigm of education if they pursued

CSH to the fullest. Clearly, the intent of CSH is for the ideals to be supported through a community approach, but teachers are bearing a disproportionate amount of the responsibility. Even in terms of CSH education where the teachers are the primary stakeholders, there are many expectations and very little support. The literature and current research offer very little information to help teachers address pertinent issues related to implementing CSH. The power struggles between helping professionals are a significant concern related to implementing greater community involvement. Moreover, little is known about how to help teachers and other professionals work amicably together to improve conditions for children. Program effectiveness is at the center of most of the research related to CSH programs. Very little has been written about the relationships and the people who embody the practice which informs CSH theory.

The participants outlined other concerns, such as their lack of involvement with policies. They could have an important role in this area, if they knew more clearly what the role should be. The study illuminated other concerns not addressed in the literature, such as the discrepancies between the teacher role in CSH education in the classroom and a CSH approach in a school program. This two-tiered understanding of CSH as a school approach and CSH education as a course needs further study, as it affects the way teachers understand their role.

In Saskatchewan classrooms, crucial health concerns present themselves on a daily basis. Kolbe (1993) states that it is a critical time for students because many children are engaging in high-risk behaviour that puts their health in jeopardy. Conditions that do arise, are most often preventable, and it is unacceptable that greater conviction for primary health programs has not been emphasized in a more comprehensive way.

The participants in this study are visionaries: insightful and hopeful as they discussed what being a teacher of CSH has meant to them. They must be commended for their motivation to pursue a CSH approach in a world that is not CSH friendly. They truly believe that children who are exposed to good health education in their school career will be empowered to make better lifestyle and healthy choices over their lifetime.

Emotion runs high in cardiac care. Every day nurses save lives and I think teachers do too.

REFERENCES

Allegrante, J. (1998). School-site health promotion for faculty and staff: A key component of the coordinated school health program. *Journal of School Health, 68*(5), 190-195.

Allensworth, D. (1994). The research base for innovative practices in school health education at the secondary level. *Journal of School Health, 64*(5), 181-187.

Allensworth, D., & Kolbe, L. (1987). Exploring an expanded concept. *Journal of School Health, 57*(10), 409-411.

Altrichter, H., Posch, P., & Somekh, B. (1993). *Teachers investigate their work. An introduction to the methods of action research.* New York: Routledge.

American Cancer Society. (1992). *National action plan for Comprehensive School Health education.* Atlanta, GA: Author.

American Cancer Society. (1995). *American Cancer Society's approach to youth education.* Atlanta, GA: Author.

Anderson, A., Kalnins, I., Raphael, D., CAHPERD, CASH, & Health Canada. (1999). *Partners for health – Schools, communities and young people working together.* Health Canada.

Anderson, A., & Piran, N. (1999). Health promoting school. *The Journal of Canadian Association for Health, Physical Education, Recreation and Dance, 65*(1), 10-15.

Anderson, A., & Thorsen, E. (1997). Preservice teacher education in health education: An Ontario survey. *Avante, 3*(3), 1-13.

Andrews. R.. & Hearne. J. (1984). Effects of primary grade health curriculum project on students and parents smoking attitudes and behavior. *Journal of School Health. 54*(1). 18-20.

Auter. J. (1993). Closing session comments: Making it work. *The Journal of School Health. 63*(1). 38-39.

Black. S. (1997). Picture of health. *The American School Board Journal. 184.* 42-44.

Botvin. G.. Baker. E.. Dusenbury. L.. Tortu. S.. & Botvin. E. (1990). Preventing adolescent drug abuse through a multimodal cognitive-behavioural approach: Results of a 3-year study. *Journal of Consulting and Clinical Psychology. 58.* 437-446.

Brindis. C. (1993). Health policy reform and Comprehensive School Health education: The need for an effective partnership. *The Journal of School Health. 63*(1). 33-37.

Brown. J.. Grubb. S.. Wicker. T.. & O'Tuel. F. (1985). Health variables and school achievement. *Journal of School Health. 55*(1). 21-23.

Butler. S. (1993). Chief state school officers rank barriers to implement Comprehensive School Health education. *The Journal of School Health. 63*(3). 130-132.

Cameron. H. (1991). Comprehensive School Health education: Are curriculum policies leading the way? *Education-Canada. 31.* 4-9.

Canadian Association for School Health. (1991). *Consensus statement on CSH.* http://www.schoolfile.com/cash/consensus.htm.

Chance. G. (1994). *Message from the chairperson. The Health of Canada's Children* (2nd ed.). Ottawa. ON: Canadian Institute of Child Health.

Clandinin. D.J. (1986). *Classroom practice: Teacher images in action.* London: Falmer Press.

Cogdon, A., & Belzer, E. (1991, Spring). Dartmouth's Health Promotion Study. *Health Promotion*, 6-13.

Connell, D., Turner, R., & Mason, E. (1985). Summary of findings of school health education evaluation: Health promotions effect, implementation and costs. *Journal of School Health, 55*(8), 316-321.

Connelly, F.M., & Clandinin, D.J. (1990). *Personal experience methods: Handbook of Qualitative Research.* San Francisco: Jossey-Bass.

Cortese, P. (1993). Accomplishments in Comprehensive School Health education. *The Journal of School Health, 63*(1), 21-23.

Davis, R., Gonser, H., Kirkpatrick, M., Lavery, S., & Owen, S. (1985). Comprehensive School Health education: A practical definition. *Journal of School Health, 55*(8), 334-9.

Davis, T., & Allensworth, D. (1994). Program management: A necessary component for the Comprehensive School Health program. *The Journal of School Health, 64*(9), 400-404.

DeFriese, G., Crossland, C., & MacPhail-Wilcox, B. (1990). Implementing Comprehensive School Health programs: Prospects for change in American schools. *The Journal of School Health, 60*(4), 182-187.

DeGraw, C. (1994). A community-based school health system: Parameters for developing a comprehensive student health promotion program. *Journal of School Health, 64*(5), 192-195.

Detert, R., Bradly, C., & Schindler, J. (1996). The Wisconsin elementary health education pilot project: Introduction and overview. *Journal of Health Education, 27*, 68-72.

Dryfoos, J. (1990). *Adolescents at risk: Prevalence and prevention.* New York: Oxford University Press.

Dryfoos, J. (2000). The mind-body-building equation. *Educational Leadership, 80*(5), 14-17.

English, J. (1994). Innovative practices in comprehensive health education program in elementary schools. *Journal of School Health, 64*(5), 188-191.

Epstein, J. (1987). What principals should know about parent involvement. *Principal, 66*(3), 6-9.

Gallop Organization. (1994). *Values and opinions of Comprehensive School Health education in U.S. public schools: Adolescents, parents, and school district administrators.* Atlanta, GA: American Cancer Society:

Gallop Poll. (1992). *Comprehensive School Health.* www.oise.utoronto.ca/~jsathakos/schools/comprehe.htm.

Gibson-Laemel, R. (1987, Oct./Nov.). Teacher initiatives that lead to quality health education programs. *Health Education*, 41-43.

Glesne, C., & Peshkin, A. (1992). *Becoming qualitative researchers.* White Plains, NY: Longman.

Gold, R., Parcel, G., Walberg, H., Luepker, R., Portnoy., B., & Stone, E. (1991). Summary and conclusions of the teenage health teaching modules evaluation: The expert work group perspective. *Journal of School Health, 61*(1), 39-42.

Grebow, P., Greene, B., Harvey, J., & Head, C. (2000). Shaping health policies. *Educational Leadership, 57*(6), 63-66.

Grunbaum, J., Gingiss, P., Orpinas, P., Batey, L., & Parcel, G. (1995). A comprehensive approach to school health program needs assessments. *Journal of School Health, 65*(2), 54-9.

Hardy, L. (1999). To your health. *The American School Board Journal, 186*(8), 34-35.

Hausman, A., & Ruzek, S. (1995). Implementation of Comprehensive School Health education in elementary schools: Focus on teacher concerns. *The Journal of School Health, 65*(3), 81-86.

Healthy School. (1996). *Healthy everyone's responsibility – A resource guide.* Eastern Ontario Health Unit.

Healthy Schools Update. (1994, Spring). Victoria, BC: British Columbia Ministry of Health and Ministry Responsible for Seniors.

Jackson, S. (1994). Comprehensive School Health education programs: Innovative practices and issues in standard setting. *Journal of School Health, 64*(5), 311-315.

Johnson, J., & Deshpande, C. (2000). Health education and physical education: Disciplines preparing student as productive, healthy citizens for the challenges of the 21st century. *Journal of School Health, 70*(2), 66-68.

Kane, W. (1993). *Step by step to Comprehensive School Health: The program planning guide.* Santa Cruz, CA: ETR Associates.

Kann, L., Kinchen, S., Williams, B., Ross, J., Lowry, R., Hill, C., Grunbaum, J., Blumson, P., Collins, J., & Kolbe, L. (1998). Youth risk behaviour surveillance – United States 1997. *Journal of School Health, 68*(9), 355-364.

Kazemipur, A., & Halli, A. (2000). *The new poverty in Canada – Ethnic groups and ghetto neighbourhoods.* Toronto, ON: Thompson Educational Publishing.

Kelder, S., Perry, C., & Klepp, K. (1993). Community-wide youth exercise education: Long-term outcomes of the Minnesota Heart Health Program. *Journal of School Health, 63 (4)*, 218-223.

Killip, D., Lovick, S., Goldman, L., & Allensworth, D. (1987). Integrated school and community programs. *Journal of School Health, 57*(10), 437- 443.

Kirby, D. (1990). Comprehensive School Health and the larger community: Issues and a possible scenario. *The Journal of School Health, 60*(4), 170-177.

Kirby, D. (1992). School-based programs to reduce sexual risk-taking behaviour. *Journal of School Health, 62*, 280-287.

Kolbe, L. (1985). Why school health education? An empirical point of view. *Health Education, 16*(2), 116-119.

Kolbe, L. (1986, Oct./Nov.). *Increasing the impact of school health promotion programs: Emerging research perspectives.* (Oberteuffer Symposium).

Kolbe, L. (1993). An essential strategy to improve health and education of Americans. *Preventive Medicine, 22*, 544-560.

Kolbe, L. (1993). Developing a plan of action to institutionalize Comprehensive School Health education programs in the United States. *The Journal of School Health, 63*(1), 12-13.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* London: Sage.

Lavin, A. (1993). Comprehensive School Health education: Barriers and opportunities. *The Journal of School Health, 63*(1), 24-7.

Lavin, A., Shapiro, G., & Weile, K. (1992). Creating an agenda for school based health promotion – A review of 25 selected reports. *Journal of School Health, 62*(6), 212-223.

Lawton, M. (1999). Health kid, healthy learners: Coordinated school health programs embrace the mind-body connection for student. *Middle Ground: The Magazine of Middle Education, 3*(1), 10-16.

Learning Through Health Partnerships. (1997, Oct. 6). *Comprehensive School Health: Learning through health initiative: Report on Evaluation of Comprehensive School Health.* Calgary, AB: Calgary Regional Health Authority.

Luckman, J., & Sorenson, K. (1987). *Medical surgical nursing.* Toronto, ON: W.B. Saunder.

Luepker, R.V., Perry, C., McKinlay, S., Nader, P., Parcel, G., Stone, E., Webber, L., Elder, J., Feldman, H., Johnson, C., Kelder, S., & Wu, M. (1996). Outcomes of a field trial to improve children's dietary patterns and physical activity: The Child and Adolescent Trial for Cardiovascular Health (CATCH). *Journal of the American Medical Association, 275*, 768-776.

Macrina, D., Creswell, W., Forouzesh, M., & Stone, D. (1986, April/May). A continuing professional education profile of the association for the advancement of health education. *Health Education*, 46-48.

Marx, E. (1999). Health and learning: A coordinated approach. *Principal, 79*(1), 6-9.

Marx, E., & Northrop, D. (1995). *Educating for health: A guide to implementing a comprehensive approach to school health education.* Newton, MA. Education Development Center.

Marx, E., & Northrop, D. (2000). Partnerships to keep students healthy. *Educational Leadership, 57*(6), 22-24.

Marx, E., Wooley S., & Northrop, D. (1998). *Health is academic: A guide to coordinated school health programs.* New York. Teachers College Press.

Mason, J. (1989). Forging working partnerships for school health education. *Journal of School Health, 59*(1), 18-20.

McCall, D. (1999). Comprehensive School Health: Help for teachers from the community. *The Canadian Association for Health, Physical Education Recreation and Dance Journal, 65*(1), 4-9.

McGinnis, J. (1981). Health problems of children and youth: A challenge for schools. *Health Education Quarterly, 8*, 11-14.

Metropolitan Life. (1988). *An evaluation of comprehensive health education in American public schools. Health you've got to be taught.* New York: Louis Harris & Associates.

Mutter, G., Ashworth, C., & Cameron, H. (1990). Canada: Perspective in school health. *Journal of School Health, 60*(7), 308-312.

National Commission of the Role of the School and the Community in Improving Adolescent Health. (1990). *Code blue: Uniting for healthier youth.* National Association of State Boards of Education.

National Professional School Health Education Organization. (1984). Comprehensive School Health education. *Journal of School Health, 54*(8), 312-14.

Novello, A., DeGraw, C., & Kleinman, D. (1992). Healthy children ready to learn: An essential collaboration between health and education. *Public Health Reports, 107*(1), 3-15.

Oetter, D. (1987, Oct./Nov.). Comprehensive School Health education: Overcoming barriers. Oberteuffer Symposium. *Health Education*, 39-40.

O'Rourke, T. (1985). Why school health education? The economic point of view. *Health Education, 16*(2), 121-124.

O'Rourke, T. (1996). A Comprehensive School Health program to improve health education. *Education, 116*, 490-494.

Osorio, J., Marx, E., & Bauer, L. (2000). Finding the funds for health resources. *Educational Leadership, 80*(5), 30-32.

Pentz, M. (1986). Community organization and school liaisons: How to get programs started. *Journal of School Health, 56*(9), 382-388.

Perry, C., Kelder, S., Murry, D., & Klepp, K. (1992). Community-wide smoking prevention: Long term outcomes of the Minnesota Heart Health Program and the Class of 1989 Study. *American Journal of Public Health, 9*, 1210-1216

Perry, C., Stone, E., Parcel, G., Ellison, S., Nader, P., Webber, L., & Luepker, R. (1990). School-based cardiovascular health promotion: The Child and Adolescent Trial for Cardiovascular Health (CATCH). *Journal of School Health, 60*, 406-413.

Peshkin, A. (1993, March). The goodness of qualitative research. *Educational Researcher*, (22) 23-29.

Reason. P. (1994). *Inquiry and alienation: Participation in human inquiry.* Thousand Oaks. CA: Sage.

Report of the 1990 Joint Committee on Health Education Terminology. (1991). *Health Education. 22*(3). 173-184.

Resnicow. K.. & Allensworth. D. (1996). Conducting a Comprehensive School Health program. *The Journal of School Health. 66*(2). 59-63.

Resnicow. K.. Cherry. J.. & Cross. D. (1993). Ten unanswered questions regarding Comprehensive School Health promotion. *Journal of School Health. 63*(4). 171-175.

Roper. W. (1991). Preface to the Teenage Health Teaching Modules Evaluation. *Journal of School Health. 61*(1). 19.

Ross. J.. Luepker. R.. Nelson. G.. Savedra. P.. & Hubbard. B. (1991). Teenage health teaching modules: Impact of teacher training on implementation and student outcomes. *Journal of School Health. 61*(1). 31-34.

Rossman. G.. & Rallis. S. (1997). *Learning in the field: An introduction to qualitative research.* London: Sage.

Rothman. M.. Ehreth. J.. Palmer. C.. Collins. J.. Reblando. J.. & Luce. B. (1994). *The potential benefits and costs of a Comprehensive School Health education program* [Draft report to WHO]. Geneva. Switzerland: WHO.

Saskatchewan Middle Level Health Curriculum. (1998). Regina. SK: Saskatchewan Department of Education.

Schissel. B.. & Eisler. L. (1999). *Youth speak out: Attitudes and behaviours related to youth at risk in Saskatchewan.* Regina. SK: Saskatchewan Institute on Prevention of Handicaps.

Seffrin, J. (1990). The Comprehensive School Health curriculum: Closing the gap between state of the art and state of the practice. *The Journal of School Health, 60*(4), 51-156.

Seffrein, J. (1994). America's interest in Comprehensive School Health Education. *The Journal of School Health, 64*(10), 397-399.

Statistical Report on the Health of Canadians. (1999, Sept. 16-17). Prepared by the Federal, Provincial, and Territorial Advisory Committee on Population Health for the Meeting of the Ministers of Health. Charlottetown, PI.

Stone, E. (1990). Access. Keystones for school health promotion. *Journal of School Health, 60*(7), 298-300.

Sullivan, C., & Bogden, J. (1993). Today's education policy environment. *Journal of School Health, 63*(1), 28-32.

Symons, C., Cinelli, B., & James, T. (1997). Bridging student health risks and academic achievement through Comprehensive School Health programs. *The Journal of School Health, 67*(8), 220-227.

Tyson, D. (1999). A load off the teachers' backs - Coordinated school health programs. *Phi Delta Kappan, 80*(5), K1-8.

U.S. Public Health Service. (1999). *School health: Findings from evaluated programs* (2nd ed.). Washington, DC: U.S. Government Printing Office.

Valois, R., & Hoyle, T. (2000). Formative evaluation results from the mariner project: A coordinated health pilot program. *Journal of School Health, 70*(3), 95-103.

van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy.* London, ON: Althouse Press.

WHO. (1992). *The health promoting school.* Available:

http: www.who.int/hpr/school/goal.html

Wignall, R. (1998). Challenges for interpretivist inquiry. *The Alberta Journal of Educational Research, 3,* 302-319.

Wood, D. (1996). Learning effectiveness begins with student health education. *Education, 116*(4), 483-489.

Wooley, S., Eberst, R., & Bradly, B. (2000). Creative collaborations with health providers. *Educational Leadership, 57*(6), 25-28.

APPENDICES

APPENDIX A

Ethics Form

DATE: September 20, 2000

TO: Twyla Salm
8 Falcon Bay
Regina, SK
S4S 4L8

FROM: K. McNaughton, Ph.D.
Chair, Research Ethics Board

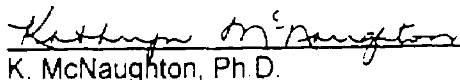
Re: The Cardiac Conditions: The Heart of Being a Teacher Implementing a Comprehensive School Health Approach.

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

__✓__ 1. ACCEPTABLE AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. The *Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans* requires the researcher to send the Chair of the REB annual reports and notice of project conclusion for research lasting more than one year (Section 1F). **ETHICAL CLEARANCE MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS. CLEARANCE WILL BE REVOKED UNLESS A SATISFACTORY STATUS REPORT IS RECEIVED.**

_____ 2. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). **Changes must be submitted to the REB and subsequently approved prior to beginning research. Please address the concerns raised by the reviewer(s) by means of a supplementary memo to the Chair of the REB. Do not submit a new application. Once changes are deemed acceptable, approval will be granted.**

_____ 3. UNACCEPTABLE AS SUBMITTED. **Please contact the Chair of the REB for advice on how the project proposal might be revised.**



K. McNaughton, Ph.D.

c.c. Dr. C. Kesten, supervisor

GM/mvs/ethics2 dot

APPENDIX B

Letter of Consent

FACULTY OF EDUCATION

Letter of Consent
Regarding
Comprehensive School Health: A Contemporary Vaccination

Health Canada (1999) states that despite the theoretical support for schools to promote optimal health education programs and the ample guidelines for implementation of such programs, Comprehensive School Health (CSH), tends to be developed more conceptually than practically. Current literature outlines definitions, frameworks and strategies but there are few nationally documented CSH studies and very little is known about how teachers actualize the CSH ideals and how it affects the way they teach and understand CSH education. Understanding the teacher's perspective of CSH may serve to improve our ability to overcome some of the obstacles related to CSH education and perhaps enhance society's understanding and appreciation of health education. It is clear that what is needed to fully understand the benefits and challenges of CSH is an accurate description and exploration of the lived experience of teachers currently teaching within the CSH framework. The purpose of this study is to explore the meaning of Comprehensive School Health (CSH) Education for Catalyst Teachers.

The undersigned, ______________________________, agrees to participate in the program of research entitled *Comprehensive School Health: A Contemporary Vaccination*, to be undertaken by Twyla Salm as the topic of her Master's thesis for the University of Regina, under the following terms and conditions:

1) The participant will record on audio-tape two 1.5 hour interviews describing what Comprehensive School Health has meant to them. (Potential interview questions are attached)
2) There will be two interviews, which are expected to take no more that 1.5 hours each.
3) The participant has the right to withdraw his/her assistance from this project at any time without penalty, even after signing this letter of consent.
4) The participant has the right to refuse to answer one or more of the questions without penalty and may continue to be a part of the study.
5) The participant will receive a report summary, which will come as a result of this study.
6) The participant will be entirely free to discuss issues and will not be in any way coerced into providing information that is confidential or of a sensitive nature. Even though this study's questions are not of a sensitive nature, if illegal activity is disclosed the researcher will be obliged to report this to the appropriate authorities.
7) Pseudonyms will be used to conceal the identity of the participants. The information disclosed in the interviews will be confidential.
8) Audio-tapes and transcripts will be kept under lock and key in a secure cabinet and destroyed after three years.

FACULTY OF EDUCATION

Letter of Consent
Regarding
Comprehensive School Health: A Contemporary Vaccination
(page 2)

I, ______________________________, agree to the conditions stated in this letter of consent

______________________________ ______________________

(Signature) (Date)

This project was approved by the Research Ethics Board, University of Regina. If the research subjects have any questions or concerns about their rights or treatment as subjects they may contact the Chair of the Research Ethics Board at 585-4775 or by email: ann.bishop@uregina.ca. Questions concerning the study can be directed to the researcher, Twyla Salm, or her advisor Dr. Cyril Kesten at 585-4532.

This is to certify that the participant has received a copy of the consent form.

______________________________ ______________________

(Signature) (Date)

Twyla Salm
#8 Falcon Bay
Regina, SK
S4S 4L8
Tel: 306-585-0354

APPENDIX C

Interview Questions

The interview will be guided by the main question:

What has being a teacher using CSH meant to you?

Three main sub-questions:

1. What is the role of a CSH teacher?
2. How important is this role?
3. Why are you committed to this role?

Other discussion questions that may be used in the interview

Dimension of health

1. What areas or dimensions of health have you embraced/avoided? Why?
2. What does Comprehensive School Health mean to you?
3. What insights have you had about teaching/students/health/society as you have explored CSH?

Curriculum Issues

4. How has the Middle Level Health curriculum contributed to your understanding of CSH?

Community and Outreach

5. What health services/ community agencies are available in your school? What community agencies have been a part of your health program? Why did you choose or use these resources?

6. How do you feel about eliciting community and family involvement with your program? How does your health program link to student families and communities? How would you like to change, delete, expand certain elements of this? Why did you select these particular experiences for the students?

The Teaching Package

7. How have you attempted to develop a healthy environment your classroom? Why have you focused your attention in this area?
8. What does it mean to have a healthy environment in this school/classroom?
9. What does it mean to have to be culturally sensitive in CSH?

Inservice and Assessment

10. What meaning has inservice played in contributing to your understanding of CSH?
11. What is important in assessment of CSH?