Health Education: Incomplete Commitment

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Executive Summary

Health education has been taught in most North Carolina schools for over 25 years. In the early 1950s, the state had both a comprehensive school health curriculum guide and a state school health committee. But during the past quarter century, a time when the importance of health education has received increased nationwide attention, the program in North Carolina has languished and lost relevance. The curriculum has not been revised since the 1950s; the committee fell into disuse and was eventually dissolved. A 1973 survey conducted by the Auxiliary of the North Carolina Medical Society concluded that "inconsistency and fragmentation describe health education in North Carolina's schools."

In 1977, the Division of Health Safety and Physical Education within the State Department of Public Instruction (DPI) developed a ten-year plan to renovate health education in North Carolina. Representative T. Clyde Auman (D-Moore) subsequently introduced to the legislature House Bill 540, "An Act to Establish a State-wide School Health Education Program Over a Ten-Year Period of Time." The bill, based upon the Division's plan, was ratified in 1978. It stated that "the development and administration [of a comprehensive school health education program] shall be the responsibility of each local educational administrative unit in the State, a local school health education coordinator for each county, the State Department of Public Instruction, and a State School Health Education Advisory Committee."

But the realization of this legislative intent has been hampered by limited funding and an apparent lack of commitment on the part of both the General Assembly and the Department of Public Instruction. Health education has had low priority in recent expansion budget requests by the State Board of Education and expansion of the program has never been included in the recommended budget of the Advisory Budget Commission. Legislative funding for health education has had to come through special appropriations bills sponsored by Rep. Auman. This money has gone primarily to hire health education coordinators, not for such other vital necessities as curriculum development. Only 16 coordinators have been hired since the passage of House Bill 540.

Although there is as yet no program to match the ambitions of House Bill 540, the administration of health education in North Carolina does adhere to some stated guidelines. At the state level, Norman Leafe directs DPI's Division of Health Safety and Physical Education. Health education consultants within the Division work to develop and implement health education policies for the state, while the 16 health education coordinators hired so far supervise school health education at the local level. Among other things, these coordinators conduct in-service training sessions for teachers and develop a local health education curriculum for each school district served. They work in conjunction with their local health education advisory council, which is composed of community members. Each district with a coordinator is required to establish such a council.

This organizational structure is sound, but it reveals little about the actual status of health education in North Carolina's schools. According to a survey conducted by the North Carolina Center for Public Policy Research in 1979:

1) 89 percent of the school units employed no teachers certified in health education;
2) 87 percent of the school units did not employ a person whose sole responsibility was the coordination of health education, and 33 percent of these school units had not designated *anyone* to coordinate health education;
3) 83 percent had no local health education advisory council;
4) 66 percent had no specific, written objectives for health education at each grade level;
5) 56 percent did not have an adequate number of curriculum guides, pamphlets, audio-visual aids and other resource materials;
6) 39 percent had no planned, sequential health education program; the programs of many others were based on broadly drawn objectives and not on specific curricula;
7) 26 percent had provided no in-service training in health education for their teachers;

8) 19 percent did not have an adequate number of health textbooks; and,
9) 6 percent received no assistance from community agencies and organizations.

The survey and research prompted by its results have revealed weaknesses in North Carolina's health education:

health education in areas without coordinators is likely to continue to be inconsistent and fragmented;

health education may still be perceived as the sibling of physical education and not as being important in its own right;

there is no statewide, comprehensive curriculum guide for the subject; and

there is no evaluation program to determine health education's effectiveness.

One of the great strengths of the health education policy already formulated for this state is that it provides enough flexibility for local voices to be heard and for local priorities to be addressed. The local advisory councils provide direct community participation, which is of importance in resolving differences of opinion about the handling of controversial subjects such as family life (sex education) and values clarification.

The development of a comprehensive curriculum guide appeared to receive the monetary impetus it needed in the spring of 1979. The Kate B. Reynolds Health Care Trust of Winston-Salem made a $50,000 grant to DPI in response to a proposal drafted by the Division of Health Safety and Physical Education. The proposal requested money to facilitate the development of the comprehensive program called for by House Bill 540 and of the comprehensive curriculum guide needed as part of this program.

For more than a year, however, DPI was unable to make use of these funds. Shortly after the grant was made, the Department was informed that it

would have to submit a revised proposal before the money could be used. Confusion over this restriction was widespread both inside and outside the Department. After more than a year of sporadic efforts on the revision, DPI submitted a revised proposal detailing a two year project to develop a health education "blueprint" for the state. The trustees of the Reynolds Health Care Trust approved funding for the first year of the plan. Funding for the project's second year will be dependent on the trustees' review of the first-year's efforts.

The future substance of health education in North Carolina will be largely dependent on the blueprint developed over the next two years. Until this program is developed and implemented, major improvements in the quality of health education within the state's schools are unlikely to occur.

Based on the analysis of health education programs and needs which follows, this report recommends that, in developing the health education blueprint, DPI preserve the strengths of the current policy — its organizational structure and accountability and its flexibility — while addressing directly the areas of weakness. It is further recommended that DPI and the State Health Education Advisory Committee appoint a committee to study the feasibility of employing more certified health instructors in the state's schools. Finally, it is recommended that a second committee be appointed by the Department of Public Instruction and the State Health Education Advisory Committee to develop guidelines to strengthen the role of the local health education advisory councils.

CHAPTER ONE

"...To Establish a State-wide School Health Education Program Over a Ten-Year Period"

Health education has been a part of most public school curricula in North Carolina and other states for over 25 years. Until recently, the subject was considered by many educators to be only an adjunct of physical education or biology. But the extraordinary rise of health care costs over the past several years has led to a new emphasis from many medical and health professionals on health education. It is now often viewed as a vital weapon in the battle against many pressing health problems.

The cost of health care in the United States is staggeringly high.[1] National health expenditures rose from $12 billion in 1950 to $139.5 billion in 1976 — an elevenfold increase that far outpaced the rate of inflation over the same time period. In 1977, 8.8 percent of the country's gross national product (GNP) — the largest chunk ever — was accounted for by health expenditures. North Carolina has in no way been sheltered from this national trend: health expenditures jumped 254 percent in the ten-year period from 1966 to 1975, rising from $994 million to $2.5 billion. Current projections forecast health costs totaling $4.6 billion for the state in 1982.

These figures are ominous, and the trend they document shows no signs of abating. "Health costs are expected to rise sharply in the foreseeable future," the *1979 North Carolina State Health Plan* cautioned. Along with personal expenditures, the government's expenditures on health care also continue to increase. As a result, the detrimental effects of increased health costs

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[1]The following statistics are taken from the *1979 North Carolina State Health Plan,* p.338. (Under P.L. 93-641, the National Health Planning and Resources Development Act of 1974, each state is directed to assess its health needs and priorities. The *1979 North Carolina State Health Plan,* developed by the North Carolina Health Coordinating Council, is the state's first such effort.)

afflict not only individuals but society as a whole: "the rising expenditure is infringing upon the achievement of other public objectives.... The consequences of increased health costs are indeed felt by all major segments of society in the form of reduced profits, lower wages, higher taxes, reduced levels of insurance coverage and (for the uninsured and the inadequately insured individual) low access and poor quality health services, or high personal expenses."[2]

Many of the nation's most prevalent and expensive health problems are largely preventable: heart disease, diabetes, hypertension, venereal disease, certain cancers, and other maladies. Style of living is intimately related to physical well-being. Many Americans are unaware of potentially health-sustaining practices; others are knowledgeable but simply unwilling to sacrifice their accustomed life-style for more healthy — but often more restricting — habits. Health educators feel that by informing people about the consequences of their practices, the onset of many preventable diseases may be averted. "The American citizen is both the major force in driving up the cost of medical care and the major block to improvement of health care," says the School Health and Health Education Committee of the North Carolina chapter of the American Academy of Pediatrics. Providing better health education — in the schools and in the community at large — is seen as an important step towards helping the American citizen improve his health and health practices.

The argument in support of improving health education, especially for school children, is logical. Nothing is more essential to a person than his own body; nothing, it would seem apparent, is more important to a person than learning how to preserve his physical and mental well-being. Children need to learn about their bodies, their minds, and the environment in which they live, just as

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[2]*Ibid.*, pp. 338-9.

they need to learn to read, to write, and to add and subtract. "I don't know anything in the whole school picture that's more important than health education — it's just fundamental," says Emma Carr Bivens, former director of the Office of Health Education in the Department of Human Resources.

The importance of teaching children about practices that can improve their health and consequently enrich their lives is steadily becoming more evident. Medical knowledge has expanded so rapidly in the past generation that many parents of school-age children are simply unaware of some important new findings. Even such seemingly rudimentary practices as brushing one's teeth correctly and eating a balanced diet are not always widely employed, often because of lack of familiarity with recent medical advances. By teaching children about their bodies and about how to care for them, health education can pursue several goals: 1) children can improve their own health practices and become more receptive to health improvement innovations in the future, thus enhancing not only their own lives but those of their children as well, and 2) children can share newly acquired knowledge with their parents, perhaps improving the lives of their parents. Consequently, a strong health education program can influence not just one generation but three.

Health educators, increasingly echoed by other health officials and policymakers, have championed the viewpoint that a public informed about and motivated to protect its health can prove to be a major factor in restraining health care cost increases. The subject of health and health education has become a familiar policy issue. The federal government has encouraged modification of existing health programs. The 1970 White House Conference on Children urged that a major commitment be made to a "systematic health and safety education plan extending from childhood through adulthood, replacing our present fragmented approach." Federal concern also resulted in passage of the 1974 National Health Planning and Resources Development Act and the 1976 National Consumer Health Information and Health Promotion Act. These statutes encouraged the use of health education and of other innovative strategies to promote an improved health environment for all persons.

As a result of federal and local concerns, efforts to renovate health education programs were undertaken. The nation's schools were seen as

logical partners in this effort. By 1976, 27 states had school curricula which included various aspects of health education.

North Carolinians who turned their attention to the quality of health education in their state's schools during this time found a program in disarray. In the early 1950s, North Carolina had had both a state school health committee and a comprehensive school health curriculum guide. The curriculum guide was not revised after the 1950s and the state school health committee was short-lived. Health education continued to be taught in most schools in the state, but quality varied from school to school and even from teacher to teacher. "Inconsistency and fragmentation describe health education in North Carolina's schools," concluded a 1973 survey conducted by the Auxiliary of the North Carolina Medical Society.

The movement to renovate North Carolina's disjointed program of health education grew throughout the 1970s. The Governor's Advocacy Council on Children and Youth was established in 1971 to promote the health and well-being of North Carolina's children. The Council often suggested that addressing health problems within a school setting might help mitigate such problems. The Children's 100, a child advocacy group, helped direct attention to the fact that health could act as a major constraint upon a child's capacity to learn. Nutritional problems such as iron deficiences could severely retard a child's ability to perform well in school. As the evidence linking health problems to performance problems in school and as the general public's concern with the subject of staying healtny mounted, the movement to renovate North Carolina's school health education program gained momentum.

In 1977, the Division of Health Safety and Physical Education in the State Department of Public Instruction (DPI) formulated a ten-year plan aimed at developing a comprehensive, statewide program of health education. The plan called for the employment of a health education coordinator within each of the state's 145 school districts by the end of the ten-year period. (Fifteen coordinators were to be hired every year except for the final one in which

only ten new coordinators would be needed). The plan also called for the establishment of a paid state health education consultant's position within DPI and for a three-year allotment of $80,000 to be used in developing a comprehensive school health education guide for grades kindergarten through 12 (K-12).

Before it could be implemented, the plan required funding. DPI programs are funded each biennium by the General Assembly. In order to obtain or continue support, every program within the Department must submit a budget request to the State Board of Education. The Board of Education reviews such requests from the Department, culls out those it feels should be funded, places them in priority order, and sends them in the form of an "expansion budget" to the Advisory Budget Commission. The Commission reviews the Board's expansion budget and decides which programs to include in the budget that the Commission and the governor recommend to the General Assembly. The Commission generally cuts many of the Board's proposed programs.

The Board of Education may submit its own supplemental budget request directly to the legislature in order to seek funding for programs the Advisory Budget Commission cuts. In addition, programs may also be funded through special appropriations bills introduced by any legislator. Special appropriations are funded from the "pork barrel," state monies that remain after the main appropriations bills for operations and for capital improvements have been passed.*

In 1977, House Bill 540, "An Act to Establish a State-wide School Health Education Program Over a Ten-Year Period," was introduced by Representative T. Clyde Auman. The bill, which incorporated the essence of DPI's ten-

*For a thorough explanation of the budgetary process, see Mercer Doty, *The Advisory Budget Commission — Not as Simple as ABC,* published by the North Carolina Center for Public Policy Research, Inc. (Especially pertinent to the discussion above are pp. 20-30.)

year health education plan, was not ratified by the legislature until 1978. House Bill 540 was supported by the North Carolina Medical Society and its Auxiliary, the Governor's Advocacy Council on Children and Youth, the North Carolina Dental Association, the North Carolina League of Women Voters, and by other groups and individuals. It appropriated monies for the hiring of health education coordinators, called for the eventual employment of a health education coordinator in each county, funded an additional school health education consultant's position in DPI, called for the development of a curriculum in health education for kindergarten through the ninth grades (K-9), and paid the expenses of a statewide health education advisory council.* According to the legislation, "the development and administration of this program shall be the responsibility of each local educational administrative unit in the State, a local school health education coordinator for each county, the State Department of Public Instruction, and a State School Health Education Advisory Committee."

The Division of Health Safety and Physical Education plan had postulated an allocation of $354,570 for the first year of implementation. However, the General Assembly appropriated only $210,000 for the essentially identical program mandated by House Bill 540. The $210,000 came in the form of a special appropriation. Of this amount, $193,130 was designated for the employment of eight health education coordinators, $14,370 for a school health education consultant to join the staff of DPI on a permanent basis, and $1,250 for the expenses of the Advisory Committee.

This funding package was strong on personnel and weak on program. Most of the money was allocated for coordinators and very little for the

*A State Health Education Advisory Committee was established by House Bill 540 to "provide citizen input into the operations of the program; report annually to the State Board of Education on progress in accomplishing the provisions and intent of this legislation; provide advice to the department with regard to its duties under the act; and encourage development of higher education programs which would benefit health education in the public schools."

development of a curriculum guide. Without a comprehensive curriculum guide detailing statewide objectives for every grade level and suggesting teaching strategies for meeting those objectives, there could be no comprehensive, statewide health education program. While eight health education coordinators were placed in North Carolina schools as a result of House Bill 540, they had no official program to draw upon. With only $1,250 to devote to curriculum development, little could be done to alleviate this situation.

The amount funded for House Bill 540 fed the concern of some proponents of expanded health education that state officials and legislators were not wholeheartedly committed to the goal of developing a full-fledged health education program. After passing legislation which called for the development and implementation of such a program within ten years, the General Assembly seemed reluctant to appropriate the funds necessary to attain this goal. It was unclear how DPI would go about developing a comprehensive program without the funds to write a curriculum guide.

This ambivalence on the part of state officials and legislators carried over to the 1979 General Assembly. In the expansion budget request sent to the Advisory Budget Commission for the 1979-1981 biennium, the State Board of Education asked for $208,208 for health education for 1979-1980 and that amount continued plus an additional $416,416 for 1980-1981. The Board ranked the health education request 23rd on a priority list of 32. Expansion of the health education program was not included in the budget recommended by the Advisory Budget Commission.

As a result of the Commission's decision, Rep. Auman introduced House Bill 974 to the legislature. Auman's bill called for appropriating the full amount requested by the State Board of Education for health education in its expansion budget. Health education was also included in the supplemental budget submitted by the Board to the legislature. This time the Board ranked it 28th on a list of 36 items. Health education was not funded in the legislature's main appropriations bill. However, House Bill 974 was ratified. It received an appropriation of $200,000 for each year of the biennium — significantly less than the sums requested by the Board of Education.

With the $200,000 appropriated for 1979, an additional eight coordinators were hired, bringing to 16 their total number. Demand for more coordinators is

high. In the first year of funding under House Bill 540, DPI received requests from 69 school units for coordinators; during the program's second year, there were 81 requests. Without significant increases in appropriations from the General Assembly, however, it will be impossible to hire coordinators at a faster rate.

More important than the lack of coordinators is the lack of the program which the coordinators are ostensibly to implement. The General Assembly has not allocated sufficient funds to allow for the development of key elements in this program. The Division of Health Safety and Physical Education has been operating, in effect, under an amorphous blend of its ten-year plan and the General Assembly's funding allotment. There is no official, comprehensive statewide program of health education in North Carolina at this time.

By the end of the 1979 appropriations process, it seemed that not only was the General Assembly only partially committed to the program it had mandated a year earlier but that the State Board of Education was equally hesitant. Many people involved in the program felt that the low priority accorded health education by the Board doomed its opportunity for full funding. They believed that its low priority foreclosed the subject's chances of being included in the Advisory Budget Commission's recommended budget and consequently forced health education to battle with numerous other projects for pork barrel funding.

However, according to Jerome Melton, Deputy Superintendent of Public Instruction, it is the fact that an item makes it onto the priority list in the first place that is important. Dr. Melton says that DPI fights equally for funding for all items on the priority list. But historically those items listed by the Board of Education as top priorities fare better in the appropriations process than do less highly ranked items. In the 1979-1981 expansion budget, for example, the top ten ranked items received 51 percent of the allocations requested for them; items 11-20 received 22 percent; items 21-30, 18 percent.

In North Carolina, the budget recommended by the governor and the Advisory Budget Commission in large part shapes the appropriations decisions

of the General Assembly. For a new program — or for an old program seeking funding increases — to win the approval of the Advisory Budget Commission requires a good deal of lobbying on the part of a department head, the governor, or members of the Advisory Budget Commission.

> With the enthusiastic support of the department head and the acquiescence of the governor, the project may successfully "ride the coattails" of the rest of the governor's budget...If the governor is a strong supporter of the project it is virtually assured of getting to the legislature in the recommended budget, and stands a good chance of staying in the final appropriations bill.[3]

Governor James B. Hunt, Jr., who has championed the twin causes of children and education throughout his administration, has supported the health education program with less vigor than he has devoted to many other programs. As for the educational establishment, the 1977 *Course of Study for Elementary and Secondary Schools* adopted by the State Board of Education declared that "comprehensive health education in schools commands a high position among our educational priorities because effective programs have the potential of enhancing the quality of life, raising the level of health for the student's lifetime, and favorably influencing the learning process." The Board's ranking of health education as 23rd and 28th on its priority list does not appear to corroborate this expressed sentiment. And, according to the Legislative Research Committee on Health Education's report to the 1979 General Assembly, "Health education has been one of the most poorly taught subjects within the various schools." The report concluded that "the Department of Public Instruction has not been aggressive over the years in pursuing health education" and suggested "that the Department should harness the considerable interest in health education and get on with making this subject area second to none."

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[3] Mercer Doty, *The Advisory Budget Commission — Not as Simple as ABC*, the North Carolina Center for Public Policy Research, Inc., 1980, p. 31.

Expansion of the health education program has yet to appear in the Advisory Budget Commission's recommended budget, leading to the conclusion that any lobbying efforts before the Commission in its behalf have been unsuccessful. The program has been forced to rely on funding from special appropriations bills sponsored by Rep. Auman. There has been little money to develop a specific program that the health education coordinators could implement.

DPI is faced with the task of securing funds for all its many programs. In order to accomplish this, the Department must utilize a variety of methods, including relying upon special appropriations bills. The rankings of the State Board of Education, the enthusiasm of the governor, and the enthusiasm of the Department of Public Instruction's leadership all influence the appropriations process. Many people familiar with the health education effort concur in the Legislative Research Committee's judgment that DPI has been remiss in its support of the subject. They believe that funding chances will not be significantly improved unless and until DPI becomes a more active advocate of health education. An assessment of whether or not DPI deserves vilification for its health education policies (or lack thereof) must begin with an examination of the current status of health education in North Carolina.

CHAPTER TWO

Health Education in North Carolina's Public Schools

The state's comprehensive health education program has yet to be fully developed, but North Carolina does have what might be termed a health education policy in lieu of a program. Under Director Norman Leafe, health education consultants in DPI's Division of Health Safety and Physical Education supervise the development and implementation of the program mandated by House Bill 540. They are responsible for coordinating, at the state level, health education in North Carolina. As part of their job, they train county health education coordinators, who in turn have the responsibility of directing school health education at the local level.

The coordinator's function is not to serve as health instructor for a particular county. Rather, each coordinator implements a local health education program by working with the individuals who will be teaching health in the public schools, many of whom have little background in the subject area.

In the elementary grades health, like most other subjects, usually is taught by the classroom teacher. In grades 7-9 health, again like most other subjects, usually is taught by a "health teacher." To help familiarize teachers with the subject, most of the health education coordinators regularly conduct in-service training sessions. Such sessions are designed to educate the teachers in the area of health, suggest teaching objectives for the subject, and offer teaching strategies for health instruction. In the many school systems without a coordinator, in-service training is conducted by DPI personnel, or in some instances, by representatives of community health organizations.

Each coordinator must develop an individual health education program to be implemented by the schools in his district. At this time, such local programs must be devised without the aid of a statewide curriculum guide. Community participation is assured, however, because each school unit requesting a coordinator must sign an agreement to establish a local health education advisory council.

There are no state guidelines for these local councils (the State Health Education Advisory Committee is required to report annually to the State Board of Education on the status of health education in the state's schools). Each locality defines the role its council will play in the development and implementation of a local health education program. Whether or not the council will report annually to the local board of education, how many times it will be required to meet during the year, and the nature of its membership are all questions to be answered at the local level.

In the many school systems without coordinators, health education is still largely subject to the discretion of the local board of education. In order to gain a more complete picture of the status of health education in North Carolina's schools, the North Carolina Center for Public Policy Research conducted, in the spring of 1979, the survey included in the Appendix to this report. The results from this survey indicate that North Carolina is indeed a long way from implementing a comprehensive program of health education in its schools. The survey found that*:

1) 89 percent of the school units employed no teachers certified in health education;
2) 87 percent of the school units did not employ a person whose sole responsibility was the coordination of health education, and 33 percent of these school units had not designated *anyone* to coordinate health education;
3) 83 percent had no local health education advisory council;
4) 66 percent had no specific, written objectives for health education at each grade level;
5) 56 percent did not have an adequate number of curriculum guides, pamphlets, audio-visual aids and other resource materials;
6) 39 percent had no planned, sequential health education program; the programs of many others were based on broadly drawn objectives and

*For full survey results, see the Appendix.

not on specific curricula;

7) 26 percent had provided no in-service training in health education for their teachers;
8) 19 percent did not have an adequate number of health textbooks; and,
9) 6 percent received no assistance from community agencies and organizations.

The policy under which DPI's Division of Health Safety and Physical Education is operating is sound in organization. It creates a chain of responsibility stretching from the schoolteacher to the health education coordinator to the local health education advisory council and the local board of education, to the health education consultants to the Director of the Division of Health Safety and Physical Education and on to the highest levels of DPI. This chain assures accountability and yet is flexible enough to allow for local health education programs to be in touch with the needs of a particular community. But the results of the survey and subsequent research prompted by those results indicate that health education in North Carolina suffers from four main weaknesses:

the lack of someone with time and training to coordinate health education for those school units without health coordinators of their own;

what might be termed an identity crisis in which health education is still often coupled in theory and in practice with physicial education;

the lack of a comprehensive curriculum guide; and,

the lack of an effective and established method for evaluating health education.

Coordination

DPI has asked those school units without coordinators to appoint a school employee to serve as a liaison between the Division of Health Safety and Physical Education and the school unit. Schools which have made such appointments have designated individuals who must take on their liaison duties in addition to other responsibilities.

The Division of Health Safety and Physical Education informs these people about available resources for health education in their school units. But these individuals must attend to other responsibilities in addition to health. They are not certified health educators, and they cannot devote the undivided attention to health education that a coordinator can. It is not unlikely, under these circumstances, that inconsistent and fragmented health education will continue to prevail within those school systems lacking professional coordinators.

Identity Crisis

Health educators feel it is essential that health maintain an educational identity separate from that of physical education. "The goal is the same in health and physical education — to create healthy individuals — but the problem is that the way to conduct the class is completely different," says Peggy Blake, DPI health education consultant. Physical education and health education curricula have different content, methodology, and problems, but this dichotomy has not been fully appreciated until recently in the North Carolina teacher certification process. Prior to 1972, one could earn a joint physical education/health education certification, but not a certification for health education alone. Since 1972, North Carolina has offered a certification in health education, and five institutions currently have such programs.* Over the last four

* Appalachian State University, East Carolina University, North Carolina Central University, University of North Carolina at Greensboro, Western Carolina University.

years, 125 students have graduated from these programs, and 178 more are expected to graduate by 1982.

But there are very few individuals certified in health education teaching in any of North Carolina's public schools. The survey conducted by the North Carolina Center for Public Policy Research in 1979 found that only 14 persons certified in health education were employed in the 105 responding school units. This finding is not confined to the elementary schools. There are very few trained health educators teaching at any level in the North Carolina public schools. According to Mrs. Martha Martinat, chairperson of the State School Health Education Advisory Committee, the overwhelming majority of health education courses in North Carolina's secondary schools continue to be taught by instructors holding joint physical education/health education certifications. Often these "health educators" are athletic coaches in addition to their other duties and have little time to devote to the demands of teaching health education. Consequently, health instruction at the secondary school level may not be handled as well as it could be.

In the spring of 1979, the State Board of Education modified its health/physical education requirement for grades 9-12. One unit of health is still required in order to graduate high school, but now the student has the option of taking that unit at any point during these four grades (previously, the unit was taken in the ninth grade). Problems may result from this modification. There are significant differences in maturity levels between ninth and twelfth graders, and the subject matter of health education courses probably cannot adequately accommodate these differences without losing relevance for each age group. Trained, full-time health educators could at least handle such situations better than essentially untrained, part-time instructors. But there are few trained health educators teaching at the high school level (or at any level in the North Carolina public schools).

Lack of Curriculum Guide

With such a shortage of employed teachers trained in health education, North Carolina desperately needs a comprehensive, statewide curriculum guide. In an independent survey conducted in the mid-1970s, 94 percent of the state's school superintendents and principals indicated they felt it was imperative that a health education curriculum guide for teachers be developed on a statewide basis. In 1980, North Carolina teachers still cannot refer to a comprehensive health education curriculum guide that includes specific objectives for each grade level as well as instructional strategies for meeting those objectives. The General Assembly has never appropriated sufficient funds for the development of such a guide, and until recently, DPI had failed to obtain funds from any other source to support such a project (see Chapter 5).

A curriculum guide would provide the foundation for the comprehensive program of health education called for by House Bill 540. It would provide teachers with ideas not only about what to teach but about how to teach the subject. Without such a guide, students are dependent upon teachers who are both unfamiliar with the material and unschooled in the appropriate methods for teaching the subject.

DPI does distribute to local units two publications designed to aid health instructors: *Course of Study for Elementary and Secondary Schools K-12* and *A Framework for Health Education Grades K-12. Course of Study* provides only a conceptual background for teaching health education. It contains no specific suggestions for classroom activities and lists no materials for teachers to use. *A Framework* is described in a foreword by State Superintendent of Public Instruction A. Craig Phillips as "a resource for health education program planning, not a program itself." It is a curriculum outline, not a curriculum. "Most teachers are left on their own to determine the extent, sequence, and methods of teaching health and to relate health texts to the *Course of Study,*" says the *Factsheet on School Health Education in North Carolina,* written by DPI's Division of Health Safety and Physical Education. Since most of these teachers have no background in health, the absence of a comprehensive curriculum guide appears to be quite costly. In-service alone is not enough: training sessions are too brief to cover topics, objectives, and teaching strategies for an entire year.

Since the curriculum guide would serve as the point of reference for all those teaching health in the public schools, it must be carefully written. It must be flexible enough to allow local communities to address their own most pressing health problems while still meeting statewide objectives for each grade level. It must also suggest the most effective methods for teaching the subject material. During the summer of 1979, members of DPI gathered in Greensboro with the health coordinators and some faculty members of the University of North Carolina at Greensboro and attempted to write — in two weeks — a curriculum guide. The product of their efforts has been field-tested. It still must be revised and rewritten based upon the results of these field tests and approved in final form by DPI before it can be distributed.

Lack of Evaluation

It is difficult to document the cost-effectiveness of massive health education programs. For this reason, cost-benefit studies of health education are restricted in scope. Some limited studies have shown that specific health education programs have changed children's behavior for the better over the short run, but there are formidable obstacles to conducting comprehensive studies of the long-term effectiveness of school health education programs: it would be necessary to construct highly individualized, intensive studies to understand how other factors in the personal lives and environments of the study's subjects relate to the knowledge, attitudes, and behavior resulting from health education.

In order to achieve the objective of creating a more healthy society, health education must be more than simply health information. Knowledge alone will not guarantee positive health habits — people constantly engage in practiçes they know to be detrimental to their bodies. For example, people with high blood pressure often continue to eat the "wrong" foods. To help motivate the student to adopt health generating habits, health educators must teach "thinking and decision-making skills," says DPI health education consultant Peggy Blake.

Because the goal of school health education is to inform the student about his health and to motivate him to protect it, each component of the health education curriculum must be analyzed in terms of its effectiveness in meeting this goal. There is no school health education evaluation program in North Carolina, nor has money been allocated for the development of one. Such a program will not be crucial until the comprehensive health education program itself is developed and implemented. But an evaluative component must be a part of the overall health education program. Otherwise, documentation of health education's effectiveness and the implementation of logical revisions based on a systematic analysis of health education's components will probably not be possible.

CHAPTER THREE

Family Life and Health Education

One of the great strengths of the health education policy as formulated by the Division of Health Safety and Physical Education is its flexibility. This flexibility allows each coordinator's program to meet certain statewide course requirements while still addressing particular community needs, priorities, and desires. This allows the program to deal effectively with such controversial subjects as "values clarification" and sex education.

Motivating the student to adopt positive health habits is one of the primary objectives of health education. In order to accomplish this, DPI's health education consultants have urged teachers to help the students apply their health knowledge to everyday situations. Consequently, the teaching of health may include exercises in decision-making, values clarification, and simply "coping" as it seeks to extend the student's awareness of health and health-related decisions to an environment beyond that of the immediate classroom.

Values clarification exercises place the student in various hypothetical situations in which he must make choices that will supposedly reveal to him more about the fundamental values he holds and uses, consciously or unconsciously, in arriving at decisions. The values clarification approach works from the premise that young people, although influenced by parents, peers, teachers, public figures, churches, the media and other forces, must ultimately decide on their own whose advice to follow. Values clarification exercises are designed, according to their proponents, to help the young person develop his decision-making skills so that he will be better able to cope with a complex world.

Professors Louis Raths, Sidney Simon, and other developers of the values clarification approach insist that they are not interested in the *content*

of a person's values, only in the actual *process* of valuing.[4] Thus, they claim that the values clarification approach focuses on the process of making a decision and on helping the student understand more about this process. The actual end-product of the decision is not of critical importance in this schema.

But opponents of the use of values clarification claim that it is a technique designed to undermine family and community standards. They claim further that values clarification oversteps the proper role of the school: "We're dumping too many of our own problems on the schools," says State Representative Mary Pegg (R - Forsyth). "Parents should have these responsibilities. We're gearing our schools to the needs of minorities... Homes that have responsibility are being undermined by homes that don't have it." Opponents see values clarification as a means of instilling a particular ideology in a child. Dr. Pierre LeMaster, a Fayetteville physician, warns that one day "Johnny may not only be unable to read and write but Johnny may be manipulated to accept what an educational elite has decided he must learn."

But, according to *A Framework for Health Education Grades K-12*,

> Unless students have clear ideas of what is important to themselves (values), their behavior will be based on what is pleasant or enjoyable right now. Unfortunately, a life style based only on immediate pleasures is not conducive to health. Values clarification is a process of encouraging students to reflect on and test their own values. Values clarification should not be confused with the teaching of one specific set of values.

A suggested values clarification exercise is outlined in *A Framework:*

> Topic Concept: Teeth have many uses.
>
> Process Concept: Values can be identified.

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[4]Sidney Simon, Leland Howe, Howard Kirschenbaum, *Values Clarification: A Handbook of Practical Strategies for Teachers and Students*, Hart Publishing Company, 1972, p. 19.

Behavioral Objectives: Student will be able to identify personal values in relation to the uses of his teeth.

Activity: Divide the class into groups of four. Ask each group to identify five things they would be unable to do if they had no teeth. Each individual rank orders the five identified items in order of importance to himself.

Proponents believe the purpose of these exercises is not the imposition of an ideology but the encouragement of responsible behavior. This is to be accomplished by increasing the student's awareness of his behavior and of the forces which guide his choices of action. "We're not trying to change people's values at all, we're trying to get them to look at responsibility," says George Shackleford, DPI health education consultant.

Opponents disagree. With so many forces already pulling at the family, Mary Pegg says, "any examination [of values] will lead to conflict." Pegg feels that, primarily due to peer pressure, this conflict will be resolved to the detriment of the family and family values.

A Framework cites the process concepts that values clarification exercises are designed to impart:

Values can be identified.

Value issues and conflicts can be identified.

Each person has a right to his or her own values.

People often have different values.

Values can change throughout life.

Values can be prioritized.

Acting on one's values is usually more rewarding than ignoring one's own values.

Everyone is subject to many different external influences on his or her values.

The clarification of values is not inherently bad. The recitation of the Pledge of Allegiance clarifies patriotic values to a certain extent, and yet it is rarely argued that this recitation is a damaging process. The key question in the values clarification debate is whether values clarification is an exercise that deliberately imposes a particular set of values upon the student or whether (in the case of health education) it is a useful teaching technique that can motivate the student to accept more responsibility for his own health.

Values clarification is an exercise designed to be used in almost any curriculum. Teachers who have used values clarification often speak favorably of the technique. Other than such verbal data, however, there is little to substantiate or refute the effectiveness of values clarification as an educational tool, and little also to prove whether it is harmful or beneficial to the student.

Much opposition to the use of values clarification has been based upon the premise that it abrogates the rights of parents by instilling a particular ideology in the student. But, parental rights are protected by the Hatch Amendment to the 1978 reauthorization of the Elementary and Secondary Education Act, which provides that

> (b) No student shall be required, as part of any applicable program, to submit to psychiatric examination, testing, or treatment, or psychological examination, testing, or treatment, in which the primary purpose is to reveal information concerning:
> (1) political affiliations
> (2) mental or psychological problems potentially embarrassing to the student or his family;
> (3) sex behavior and attitudes;
> (4) illegal, anti-social, self-incriminating and demeaning behavior;
> (5) critical appraisals of other individuals with whom respondents have close family relationships;
> (6) legally recognized privileged and analogous relationships, such as those of lawyers, physicians and ministers or
> (7) income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program), without the prior consent of the student (if the student is an adult or emancipated minor) or in the case

> of unemancipated minor, without the prior written consent of the parent.[5]

Even without the Hatch Amendment, the health education policy protects parents' rights. Since the local curriculum is developed by the health education coordinator in conjunction with the local health education advisory council, parents can influence the final version of the curriculum.

By encouraging a student to examine his value structure, to think about actions he might adopt in a particular situation, and to anticipate consequences of particular actions, values clarification can encourage the student to be more aware of his personal behavior. This heightened awareness may lead to the adoption of positive health behaviors, one of the primary goals of health education. Values clarification may also help define and strengthen the values the student holds by forcing an examination and a greater appreciation of those values. But there is no reliable proof that values clarification will accomplish these results. Controversy attends any decision to employ values clarification techniques in the classroom, and this is especially true in health education classes. The issue requires consideration and debate at the local level, and local advisory councils offer a forum where such discussions can take place.

The issue of values clarification is not completely divorced from the equally controversial issue of sex education. Sex education, in the sense of growth and development and of family life, is part of the subject matter of health education. Values clarification is a technique that can be used in conducting sex education classes. The extent and breadth of coverage that should be accorded the topic of family life, and the grade levels at which it should be addressed, are key questions in the sex education controversy.

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[5] Title 20, U.S. Code, Section 1232(h).

"We need a strong family life component in our program," says Martha Martinat. "We need to show children that they have a strong responsibility within their family and to relate the family unit to the health of the child in a very broad sense." Accordingly, the topic of family life tends to be integrated into the health education curriculum from the earliest grades. But at some point the family life sequence and the growth and development sequence will begin to discuss aspects of human sexuality. There are widespread differences of opinion as to what constitutes the appropriate content of such material.

North Carolina has no law mandating that "sex education" be taught, but the subject is included in some form in most public school curricula. Although DPI has both a policy statement and a suggested bibliography to which teachers can refer in order to teach the subject, it has been the responsibility of the local school districts to develop their own curricula in sex education. Some school districts, like Forsyth County, forbid teaching about contraception in the school. Other districts do not. Contraception is often discussed frankly in high school classes.

Dr. LeMaster believes "there is no place whatsoever for sex education in schools. There is a place for biology, but not this 'how to and what if' teaching." Many of North Carolina's conservative and fundamentalist organizations agree. Reverend Kent Kelly of the Churches for Life and Liberty (originally the Organized Christian Schools of North Carolina) says that, "as a general rule, they [sex education classes] promote what most people consider an amoral position — what we consider an immoral position." Kelly feels that sex education cannot be properly taught unless it is taught in conjunction with a religious moral code. Since this cannot be done in the public schools (as a result of the separation of church and state), he believes that sex education should not be a part of a public curriculum.*

* Religious organizations do not necessarily oppose sex education. Many do not feel the need to adopt official positions on the subject. The North Carolina Council of Churches, an organization representing 17 denominations, has not discussed sex education as a pertinent issue and has not adopted a position on sex education, nor is sex education scheduled as a topic on the Council's agenda for the coming year. Collins Kilburn, executive director of the Council, says that, "personally, I'm inclined to believe that sex education classes can do some good."

Yet the topic of teenage sexuality demands attention. Statistics indicate that sexual intercourse between teenagers is increasing, that teenage pregnancies are often unwanted, and that the costs of teenage motherhood are often borne by all of society[6]:

in 1976, North Carolina ranked fifth in the nation in the proportion of births to mothers under 19;

from 1971 to 1976, there was a 30 percent increase in premarital sex among 15 to 19 year old women;

a North Carolina study found that not one of the 510 babies born in 1975 to females under 15 was wanted and that 10,810 babies born to females 15-19 were unwanted;

from 1976 to 1979, the number of teenage mothers in North Carolina receiving payments under the Aid to Families with Dependent Children program skyrocketed from 205 to 4,664.

Efforts to deal with the increasing prevalence of premarital sex and its attendant consequences have often focused on the role that a program of sex education in the schools can play. According to DPI's policy statement on sex education*, "(b)etter understanding and acceptance of one's individual sexuality, interpersonal relationships, family roles, and reproductive responsibility are important reasons for carrying out programs of sex education. In addition, the problems that result from the sharp rise in venereal disease, the

* This statement was written in 1973. Although House Bill 540 has altered the method in which a sex education curriculum will be formulated (it will now come under the purview of the health coordinator), DPI's policy statement on sex education has not been revised as a result of the legislation. The official attitude of DPI towards sex education remains essentially the same today as it was in 1973.

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[6] These statistics are taken from the report by the Governor's Advocacy Council on Children and Youth, *Teenage Pregnancy in North Carolina: Better Choices for a Better Future,* June, 1980.

increase of unwanted pregnancies and illegitimate births, abortion, divorce, and the persistence of inadequate perceptions about sex all indicate the need for sex education. Also, students continue to express a need for clear simple answers to their questions about sex."

Yet many critics doubt that sex education alleviates these problems. In fact, sex education has been both excoriated for promoting promiscuity and praised for providing access to information that young people desperately need if they are to deal responsibly with the changing role of sex in our society. The key questions as to the efficacy of sex education in the classroom must be those of responsibility and responsiveness:

> Can a responsible curriculum be designed with parental participation and community support?
>
> Can such a curriculum promote sexual responsibility?
>
> Is the curriculum a response to the desire of the community to have sex education in the schools?

Viola Christians, co-chairperson of the Concerned Parents Committee, a North Carolina organization concerned with "educating" parents and teachers about what the committee feels are harmful trends and practices in the educational system, does not believe that family life education has been handled responsibly in the past. She feels that, as a parent, she has not had the opportunity to be either informed about or to issue her consent on programs of sex education conducted in the schools. Rather, she has had to inform herself on the matter. She also feels that DPI's bibliography does not include enough good materials to aid a teacher in a responsible presentation of sex education. Ms. Christians feels that "99 percent of the materials [on the bibliography list] are junk" due to the scope of their coverage, the perspective from which they are written, and the grade levels for which they are recommended. "Our kids don't need to be turned into 'sexperts' when they are 13-years-old," she says, nor do they need to be taught with "four letter words."

Until a statewide health education program is developed and implemented in every North Carolina school unit, sex education, like health education in general, will be largely subject to the discretion of local school administrators. Each local school unit can institute a sex education program as it sees fit. In such a system, it is possible for parental concerns to have no official outlet.

In the school units that do have health education coordinators as a result of House Bill 540 and subsequent funding, it is the health education coordinator who is responsible for designing the health (and hence, sex) education curriculum for the school district. DPI's health consultants emphasize to the coordinator that this should be done in conjunction with the community. The coordinator should also seek the approval of the local board of education before implementing the curriculum. To date, the coordinators have been careful to adhere to such guidelines.

Several coordinators who were contacted for the purpose of this report said that, in general, the vast majority of people in the communities agree that family life should be taught in the schools and they consequently have sought to weave some degree of family life components into their programs. Working with his local council and other community representatives, each coordinator has sought to determine just what the family life curriculum should include. DPI's Division of Health Safety and Physical Education has yet to receive any complaints from the communities on these family life curricula. "As long as community members feel they're included, there'll be no problem," reports Jimmy Hines, Cleveland County health coordinator. David Moore, coordinator for Moore County, adds that "we don't feel it's our sole responsibility to deal with this material — parents and religious people are vital sources of information in the community on this subject." The coordinators have tapped the community's religious and secular resources in shaping their programs and report that they will continue to do so in the future. (In Montgomery County, coordinator Janice Andreasen found that the community and the school system had — on their own initiative — designed and implemented a sex education curriculum before her tenure began. The curriculum

was written through a joint effort on the part of the K-8 teachers, school administrators and community personnel; there are teacher guidelines and student booklets for each grade level. Andreasen said that there were no problems in getting the curriculum passed by the local board of education, and that the program itself has been highly successful, both in the eyes of the school personnel and the general community.)

Does sex education promote sexual responsibility on the part of teenagers? According to DPI's policy statement, the "overall objective of sex education is to build a society in which each person's sexuality is permitted to develop to maturity as a positive force." If sex education is to promote sexual responsibility of this sort, it must make the student appreciate the consequences of his behavior. As in the case of health practices in general, information alone will not accomplish this task. Knowledge about contraceptives, while needed, apparently will not guarantee their usage. In study data reported by James R. Faulkenberry and Murray L. Vincent,[7] 38 percent of the surveyed South Carolina college students indicated that they had used no contraceptives during their first intercourse; 19 percent had used no contraceptives during their most recent intercourse. Whereas 20 percent indicated that lack of knowledge about contraception was a reason for their negligence during their first sexual experiences, only 4 percent cited it as a reason for not using contraception during their most recent intercourse. Although information is needed, the real problem will be to make young people realize the consequences to their own lives of an unwanted pregnancy and to motivate them to act accordingly. This is where values clarification exercises may prove especially helpful.

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[7] James R. Faulkenberry and Murray L. Vincent, "Adolescent Sexual Behavior," *Health Education*, May/June 1979, pp. 5-7.

Many people fear that values clarification and sex education are attempts to indoctrinate public school children with a humanistic ideology (often referred to as a "secular religion"). Humanists are "nontheists" who "reject those features of traditional religious morality that deny humans a full appreciation of their own potentialities and responsibilities."[8] They believe that, by working together at their full potentialities, men and women can create a world government dedicated to the preservation of global peace. They also believe that ethics are "autonomous and situational, needing not theological or ideological sanction...Human life has meaning because we create and develop our futures."[9] (emphasis in original) As for sexuality,

> we believe that intolerant attitudes, often cultivated by orthodox religions and puritanical cultures, unduly repress sexual conduct. The right to birth control, abortion, and divorce should be recognized. While we do not approve of exploitive, denigrating forms of sexual expression, neither do we wish to prohibit, by law or social sanction, sexual behavior between consenting adults. The many varieties of sexual exploration should not in themselves be considered "evil." Without countenancing mindless permissiveness or unbridled promiscuity, a civilized society should be a *tolerant* one. Short of harming others or compelling them to do likewise, individuals should be permitted to express their sexual proclivities and pursue their life-styles as they desire. We wish to cultivate the development of a responsible attitude toward sexuality, in which humans are not exploited as sexual objects, and in which intimacy, sensitivity, respect, and honesty in interpersonal relations are encouraged.[10] (emphasis in original)

Some of the leading advocates today of values clarification and sex education are members of the humanist movement. Many conservatives fear that humanists are trying to inculcate an anti-God, anti-family, anti-United States ideology into public school students and that values clarification and

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[8] "Humanist Manifesto II," *The Humanist*, September/October 1973, p. 5.

[9] *Ibid*, p. 6.

[10] *Ibid.*, p. 6.

sex education are a part of this effort.[11]

But humanists are not alone in their support of values clarification and sex education. Various agencies across the state of North Carolina have called for responsible sex education in the schools to help alleviate the problem of unwanted pregnancy. The North Carolina Personnel and Guidance Association has encouraged such teaching. The Governor's Advocacy Council on Children and Youth (GACCY) in its report on adolescent sexuality, recommended that comprehensive family life programs be run from grades K-12. GACCY recommended that these programs be based upon broad community input and that they emphasize a sense of responsibility for one's sexual activities. Both groups have also endorsed the idea that the school cannot act alone in this regard: the community must also establish programs designed to encourage sexual responsibility.

Research into the question of whether or not sex education promotes sexual responsibility has been inconsistent and inconclusive. Yet, even without firm validation data, communities have indicated a desire for sex education in their schools. The report on adolescent sexuality by the Governor's Advocacy Council found that 85 percent of teenagers and 95 percent of community leaders surveyed favored family life education in the schools. Such percentages indicate that community support for sex education is strong. (The case of Montgomery County and its sex education initiative also lend credence to such a conclusion.)

Under the current health education policy, North Carolina is developing a strong system of accountability that offers parents an opportunity to ensure

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[11] See Frances Hill, "Is Humanism Molesting Your Child?", published by the Pro-Family Forum, Fort Worth, Texas, and other Pro-Family Forum publications.

See also Jo-Ann Abrigg, "In the Name of Education," speech delivered at the annual conference of the Eagle Forum, St. Louis, October 10, 1976 (published by the Committee for Positive Education, Warren, Ohio).

that their children will receive a curriculum in sex education and in health in general that will present balanced coverage to all viewpoints and that will encourage responsibility. If the program developed under House Bill 540 continues to emphasize the importance of local councils and to utilize the councils in the curriculum process, North Carolina's schools will develop health education curricula through community effort.

Such a curriculum development process offers parents many safeguards. Parents can voice objections to particular aspects of the health education curriculum (for example, values clarification). Parents can also help assure that a sex education curriculum will give balanced coverage to both traditional and non-traditional attitudes. The curriculum can be designed to require parental permission for student participation or to require periodic "information" sessions to apprise parents of the content of classroom instruction. The development of a curriculum through the local councils allows for a process of community consensus to determine just what the curriculum should be.

Parents' rights are also protected by the Hatch Amendment, a safeguard against the sort of inculcation in the name of education that critics of values clarification and sex education most fear. "Parents have a right to know in advance to what materials their children are exposed and a right to participate in the selection of those materials," writes Phyllis Schlafly.[12]

The health education policy protects these rights. If offers all sectors of the population an opportunity to work together to develop a curriculum that is acceptable to the community. Values clarification and sex education are indeed controversial topics, and research into their possible benefits or defects is inconclusive. Consequently, they are areas that should be handled thoughtfully and carefully. The local health education advisory council provides the necessary forum for deliberative action on these topics.

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[12]*The Phyllis Schlafly Report,* November, 1979, Volume 13, No. 4, Section 2, p. 2.

CHAPTER FOUR

New Generation Spillover?

The controversy surrounding North Carolina's New Generation Act is part of the past decade's increasingly vocal outcry against governmental interference in family life. The New Generation Act, ratified in 1979, has been attacked by its opponents as the implementing legislation for the North Carolina Child Health Plan (CHP). Might adverse reaction to the New Generation-CHP spill over onto health education? The possibility does exist and, consequently, a brief examination of these subjects is necessary.

The New Generation Act passed virtually unnoticed during the 1979 legislative session. In fact, all 50 members of the Senate originally co-sponsored the bill. Essentially, the act establishes a statewide interagency committee, appointed and led by the governor, to coordinate existing services for children and families. The act also suggests that similar committees be formed at the county level.

It was a bill that Governor Hunt reportedly saw as the "most important thing for me this session."[13] The act seemed to herald increased efficiency and organization on behalf of the children of North Carolina. But, in short order, opposition mobilized to the New Generation Act. Opponents claimed it placed too much power in the hands of the governor and that it was actually the implementing legislation for the North Carolina Child Health Plan.

The Child Health Plan, developed over the course of two years by a joint task force from the State Department of Human Resources and the North Carolina Pediatric Society, was released in March of 1979, at about the same time the New Generation Act was being reviewed by the General Assembly.

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[13] *Winston-Salem Journal*, April 26, 1979.

The task force had been formed in order to construct a model plan for health service delivery systems that would meet the needs of children. The plan that evolved from the task force's work in large part precipitated the New Generation controversy. After its release, attacks upon the New Generation Act began in earnest.

The Plan recommended that each child have access to a "health care home" that would "provide or arrange for the services needed to maximize health as well as minimize illness. Relatively few of our children enjoy the benefits of an adequate health care home. In some cases, the barriers are related to finances or lack of health provider resources. In others, parents fail to understand the advantages of maintaining the continued relationship."[14] The Plan also identified special health needs of various sectors of the population and recommended the provision of numerous health services, including education and counseling in parenting, obstetric and gynecological consultation, problem pregnancy services, and health education. In addition, the Plan argued that "family planning services, including pregnancy testing, sex education and contraceptives should be available to all sexually active persons regardless of age."

Critics attacked the Plan as a "socialistic" attempt to usurp the role of the family in child-rearing. They noted its often dictatorial language:

> The child and his family will accept one principal source of primary health care...The child and his parents will arrange for examination, education, and counselling... (page 19)

They bridled at the Plan's suggestion that "parent attitude toward controversial subjects" can act as a barrier to effectively reducing the number of pregnancies to minors. And for a variety of reasons, they linked the CHP to the New Generation Act.

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[14] Child Health Plan, p. v.

The cover of the CHP identifies it as "A Child Health Plan for Raising a New Generation." The first page of the Plan is a letter "To the Citizens of North Carolina" from Governor Hunt "endors[ing] this as North Carolina's action plan for providing health services to children in this state. I hope that in the future all child health planning will be carried out within the framework of this plan to insure continuation and expansion of this effort."

The New Generation Committee is authorized to "modify policy, programs, procedures and regulations that serve as barriers to the effective delivery of services to families and children." The CHP also refers to "barriers to service" and enumerates some of them, such as parental attitudes. These similarities serve as the main threads critics see as linking the New Generation and the Child Health Plan together.

Governor Hunt and other state officials deny any such linkage, emphasizing that the New Generation is state policy, whereas the Child Health Plan is not. The Governor has modified his "endorsement" of the CHP, saying that he agrees with its major goal of improving health services for children but not necessarily with all the policies recommended by it. As for the words "New Generation" in the title of the CHP, Dr. Thomas Frothingham, co-chairperson of the CHP task force, says that the words were added because "we thought it would please the Governor and get his endorsement."

The Child Health Plan explains that its purpose is to act as a model for North Carolina counties as they attempt to develop their own plans to improve child health:

> ...the Task Force's efforts are designed to provide stimulus and guidance to local planning — not to dictate priorities or methodology. County planning groups are urged to use this plan in the way that best meets their needs — or rather, the needs of their children. (page 2)
>
> The Task Force does not advocate a single organizational model for the health care home. Rather, we recommend the particular combination of private, public, and joint ventures that best meets the needs of all the children of a community. (page 19)

> [The Task Force guidelines] are not intended to dictate local priorities or constrain local initiative. Rather, the intent is to provide a basic framework and to encourage full participation by all concerned. (page 39)

The CHP is replete with such references to the importance of local initiatives in developing health planning efforts. "The whole point of the Child Health Plan is to defend ourselves against state policy — to protect ourselves from the tyranny of the state imposing things on us," says Dr. Frothingham. "I don't think half the people protesting the Child Health Plan have read it — I don't see how they could have."

The Child Health Plan is designed as a model for *local* communities to utilize; the New Generation Committee is a statewide organization, designed to examine statewide child services. The similarity between the two is not in their functions, but in their goals: both represent attempts to better address the needs of the children and families of North Carolina. The Child Health Plan "attempted to identify the support needed by the family in nurturing a healthy child."[15] The New Generation makes it "the policy of the State to promote and encourage programs and practices to support and strengthen families in North Carolina..."

Despite the denials and refutations, the New Generation-CHP linkage still persists in the minds of many. More than anything else, critics perceive them as being linked by a socialistic, anti-family ideology. Opponents claim that, while the goal of improving child health care is laudable, the methods advanced by the New Generation and the Child Health Plan for achieving this goal are not. These methods are perceived as being anti-family and as placing too much power in the hands of the state. "The family alone cannot meet all of the essential needs of each new generation of children," states a provision of the New Generation Act. The Act also declares that "the family is the most effective institution through which to meet the needs of children...

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[15] *Ibid.*, p. v.

the wide range of programs and agencies serving the needs of children requires that steps be taken to coordinate their efforts." Critics focus on the former statement, supporters on the latter.

The New Generation controversy quickly became an issue in 1980 political campaigns. Former Governor Bob Scott, in his bid for the Democratic gubernatorial nomination, called for the repeal of the New Generation bill. I. Beverly Lake, Republican candidate for the gubernatorial seat, indicated he would make the bill an issue. He sees it as epitomizing exactly what Republicans have traditionally abhorred: expensive, ever-expanding government and increased governmental intervention into the private lives of its citizens.[16] "We [the Republicans] intend to make it an issue and so has Governor Scott. That really puts it on a bipartisan level," commented Senator Anne Bagnal (R-Forsyth).[17]

Although their goals are similar, the functions of the New Generation Act and the Child Health Plan are entirely different. The controversy surrounding them tends to obscure exactly what they are and what they are supposed to accomplish. In the minds of many, they are inextricably linked — if not in function, at least in ideology. Might such an ideological linkage in turn be extended from the New Generation-Child Health Plan to the germinating health education program?

The CHP was written to provide a model for a comprehensive system of community health service delivery. School health education was endorsed as one component of such a community program. But the actual comprehensive health education program for the state is being developed by the Department of Public Instruction, not by the CHP task force.

As to a connection between the New Generation Act and the health education program, Florry Glasser, policy advisor to the Governor, "can't imagine how anybody would relate the two." The New Generation Committee meetings have explored ways that could increase interagency cooperation

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[16]Raleigh *News and Observer*, Dec. 10, 1979.

[17] *Greensboro Daily News*, Nov. 30, 1979.

and coordination of child services without requiring additional appropriations. According to participants, the health education program has never been mentioned at these meetings.

DPI personnel refute any connection between health education and either the New Generation or the Child Health Plan. "Some small portion of a vocal minority may be interested in trying to make some kind of connection," says Bob Frye, health education consultant for DPI. "But our program was established long before them [the CHP and the New Generation Act] and there's no connection. They haven't had any impact on our policies."

But, many opponents of the New Generation Act see the health education policy as a manifestation of the same "anti-family" ideology they feel pervades the New Generation Act and the Child Health Plan. Dr. LeMaster believes the health education policy is part of the same ideology that brought North Carolina the CHP and the New Generation, an ideology that is "by and large, anti-traditional, anti-parent, anti-American...the government is taking on a pseudo-parent position." And Mary Pegg also feels that the health education program is one more manifestation of governmental intervention in local prerogatives.

Objections to the "ideology" of the New Generation Act and the Child Health Plan center upon the contention that they both represent instances of the government imposing its will upon the people. "Quality child care is a goal no one can argue with," said Rep. Pegg and Sen. Bagnal in their joint press conference on the New Generation Act. What they objected to were the methods advanced for achieving this goal, methods they see as designed to grant the government primacy over the family.

It is ironic that some critics have attacked health education as one more policy attempt to usurp the role of the family when the state's health education policy contains so many constraints on the government's power to disrupt parental influence in the program. The health education policy is designed in large degree to facilitate family participation through the local councils. The councils offer each community an opportunity to improve the quality of child health through a curriculum that is in large part developed and approved by the community itself, a process that should appeal to those who fear "anti-family" interference with parental authority by state government.

CHAPTER FIVE

The Program?

DPI has yet to present the General Assembly with the comprehensive, statewide health education plan called for by House Bill 540. A curriculum guide is a key element that must be finished before a comprehensive health education program can be implemented. Until such a document is written and distributed, individual teachers will have no certified guide to statewide objectives for each grade level of health education.

Because the General Assembly has allocated health education funds almost exclusively for health education coordinators, work on a curriculum guide has progressed slowly. In the spring of 1979, it appeared that the pace of this work might pick up considerably. The Division of Health Safety and Physical Education drafted a proposal to use $50,000 to convene a panel of nationally recognized authorities with whom the Board of Education, DPI and the State Health Education Advisory Committee could consult in developing the program called for by House Bill 540, to evaluate existing health education programs and to assess the school health education needs of North Carolina, and to initiate the development of a comprehensive curriculum guide. This proposal was submitted to the Program on Access to Health Care, which functions as a consultant to a three-foundation consortium (the Kate B. Reynolds Health Care Trust, the Z. Smith Reynolds Foundation and the Duke Endowment). The Program on Access to Health Care works with potential sponsors on the development of their proposals and then monitors the implementation of approved proposals.

DPI's proposal was funded by the trustees of the Kate B. Reynolds Health Care Trust. But, before the money could be used by DPI, the Department was informed by Bill Henderson, then Director of the Program on Access to Health Care, that it had to revise its original proposal. For more than a year, DPI and the Program on Access to Health Care were unable to agree on a revision acceptable to both parties. The exact reasons for the lengthy delay are unclear. According to Bill Henderson, the problem was that

DPI never followed through on its proposal and never submitted to Henderson a budget detailing how the $50,000 would be spent. "No consensus developed within the Department [about] just how they'd go about using the grant money," explained Henderson, who further said that the budget included in DPI's proposal was inadequate, because it did not identify with enough specificity the people to be hired and the program to be implemented.

Several members of the State School Health Education Advisory Committee and DPI were bewildered by the snafu. They believed the original proposal was more than adequate, and they feared that the "revision" was an attempt by the Program on Access to Health Care to redirect the project away from curriculum development and towards school health services. Months passed without any new proposal, and speculation arose among members of the Advisory Committee that not only were there problems with the Program on Access to Health Care but that factions within the Department of Public Instruction were acting to subvert the whole project.

There is a noticeable split within DPI over the question of health education. By the nature of the DPI bureaucracy, advocacy of a particular program is bound to be strongest at the staff level where people are most intimately involved in a program's implementation. At the higher levels of command, administrative matters and often competing educational policies take precedence over specific issues. This situation is compounded in the case of health education by the fact that there are often disagreements among the members of the staff, the State Health Education Advisory Committee, and the administrators as to how to best proceed with health education. This can lead to a health education policy dependent upon who can best play, circumvent, or control the bureaucratic channels of DPI. This split, along with several other factors both internal and external to DPI played a role in the grant delay.

After more than one year of revision and periodic negotiations, DPI submitted to the Reynolds Health Care Trust "A Plan to Implement the Reynolds Health Care Trust Fund Grant to the State Board of Education to Aid in the Implementation of a Comprehensive Public School Health Education Program in North Carolina." The new proposal spelled out its precise objectives and

the time required to meet these objectives. The entire project was to be completed over a two-year period.

The implementation plan aimed to:

> identify [the] nature, extent, and current needs of health education for grades K-12 in the North Carolina Public Schools,
>
> assess health education programs which are provided in other North Carolina agencies and other states,
>
> convene a panel of recognized school health educators to provide advice and consultation regarding the development of a health education program for North Carolina,
>
> design [a] plan for evaluating health education in the public schools for the next ten years, and
>
> develop a health education program blueprint for implementation in the North Carolina Public Schools over the next ten years.

The revised proposal specified that a project coordinator would be appointed to orchestrate this project. The proposal included a detailed budget calling for $62,164 for the first year and $61,421 for the second (final) year of the agenda.

In their May, 1980 meeting, the trustees of the Kate B. Reynolds Health Care Trust approved $12,164 (in addition to the original grant of $50,000) to be used by DPI in order to fund and run the first year of this project. After one year, the trustees will appraise the progress of the project and determine whether or not to fund its second year.

Martha Martinat, chairperson of the State Health Education Advisory Committee, had been involved in the negotiations and was aware of the trustees' decision soon after it was made, but the full Advisory Committee could not be officially notified until its next meeting on July 23rd. This was more than three weeks after Jean Thompson, the project coordinator, began her tenure on July 1. Thompson and Jerome Melton informed the Committee

of the Foundation's decision and supplied the Committee's members with copies of the "implementation plan." Dr. Melton had been scheduled to address the Committee for ten minutes. He remained at the meeting for almost two hours. Many Committee members voiced reservations about the plan; much of the opposition centered around the policy review committee called for by the proposal. Some members expressed the opinion that such a committee would perform duties delegated to the Advisory Committee by House Bill 540. Other aspects of the proposal were also unsettling to Committee members, but there was little for them to do except voice their displeasure.

The implementation plan does indeed raise several complex questions. The objective of the project "is to implement essential preparatory work that will ensure the development of an exemplary public school health education program for North Carolina." In essence, it aims to lay the groundwork for the program mandated but never sufficiently funded by the General Assembly.

The original (1979) proposal called for a panel of 8-10 experts to be convened for a five-day period to "react and provide evaluations, recommendations, and suggestions" for the future direction of health education. The revised proposal calls for a panel of recognized health educators to "provide advice and consultation regarding the development of a health education program in North Carolina." Although the proposal calls for the work of the panel to be completed within eight months, Jean Thompson has said that, if it is the decision of those working on the project that the panel's services will be needed beyond that length of time, she will seek to have their tenure extended by the State Board of Education.

House Bill 540 established the State Health Education Advisory Committee in part to "provide advice to the department with regard to its duties under this act." One of those duties is to

> supervise the development and operation of a statewide comprehensive school health education program including curriculum

> development, in-service training provision and promotion of collegiate training; learning material review; and assessment and evaluation of local programs in the same manner as for other programs... (GS 115-204.1. [f])

Considering that the objective of the implementation plan is to develop a health education blueprint with one of its main features being a comprehensive curriculum guide, it is reasonable to conclude that the State Health Education Advisory Committee should be responsible for providing advice and consultation on this project.

The implementation plan calls for "conferences with the panel to get advice and consultation regarding the health education program, program administration integration of health education with health services delivery, cooperative linkages between health consumers and providers, curriculum materials, staffing, training, and teaching health education." Only considerations about integrating health education with health services delivery and about cooperative linkage between health consumers and providers would not obviously fall under the duties of DPI as specified in House Bill 540. It hardly seems necessary to appoint a committee merely to advise on these two matters instead of arranging for the State Health Education Advisory Committee to address the issues for the duration of the grant.

At its August meeting, the State Board of Education was asked to approve the appointment of 14 people to sit on the new "North Carolina Health Education Commission." The question of whether this new committee would merely duplicate the role of the State Advisory Committee was raised by several members of the Board. Speaking for the Advisory Committee, Martha Martinat defended the expertise of the Advisory Committee's members, but added that "we need all the help we can get" in establishing a health education program for North Carolina. The conclusion of the Board was that the North Carolina Health Education Commission would act as a reinforcer rather than a duplicator in the health education effort. The appointments, to last from September 1, 1980 through September 1, 1981, were approved.

In speaking before the Board of Education on the matter, Jerome Melton said it was the opinion of DPI that the Advisory Committee was a continuing committee whose function was to advise the Board on the implementation of

health education programs in general. Dr. Melton explained to the Board that this advisory role was a "long-range" duty. However, the North Carolina Health Education Commission was an *ad hoc* group whose purpose was to "help the Board of Education develop a health education program for consideration and adoption."

Melton's analysis ignored the fact that advising on the development of a health education program was exactly what the Advisory Committee was established to do. The program developed under this current project will in all likelihood shape health education in North Carolina for the foreseeable future. It is unclear why this project is not considered to be within the "long-range" purview of the Advisory Committee. And, if the Advisory Committee is only to advise on a "long-range" basis, it is equally unclear who will draw the distinction between long-range and short-term and whether or not each short-term project will demand the appointment of a new, *ad hoc* committee.

The fact that the work to be addressed by the North Carolina Health Commission is largely within the mandate of the State Health Education Advisory Committee does not automatically diminish the new committee's value. It is composed of respected individuals with impressive credentials. They can surely contribute much to the health education program both in the next several months and in the years to come. The State Health Education Advisory Committee is represented on the Commission, and Sharon Guenther, the health education coordinator for Wilkes County schools, is also a member. It is too early to judge whether the two committees will act to reinforce or to undercut each other.

While the work of designing health education's blueprint goes on, major renovations of local health education curricula are unlikely to occur. In a June 23, 1980 memorandum, Dr. A. Craig Phillips, State Superintendent of Public Instruction, wrote all local superintendents that, "In the meantime, I would urge you to consider carefully before beginning any new health education project or study within your unit." Since innovations on the part of local units conceivably could be revoked within a short period by the new program, it seems that for the immediate future, health education in North Carolina's schools will continue to suffer from a variety of infirmities. Inconsistency and fragmentation will probably continue to be the rule until a comprehensive, statewide health education program is developed and implemented.

Conclusions

School health education is a subject that can improve the future health of North Carolinians, but this goal cannot be realized unless there is a strong health education curriculum in all the state's schools. The present quality of health education across the state is uneven, and there is no unified, statewide program for the subject.

In House Bill 540, ratified in 1978, the General Assembly called for the development and implementation of a comprehensive, statewide health education program for kindergarten through the ninth grade. But health education has never received the official support necessary for its expansion to be included in the Advisory Budget Commission's recommended budget. Its funding allocations as a special appropriation have not been large enough to permit key elements of the program to develop.

Although there is no official comprehensive program, health education is being taught in North Carolina under certain guidelines. The organizational structure of the current health education policy is strong, as is the policy's adaptability to local needs and priorities. But there are several deficiencies in health education in North Carolina. Of these deficiencies, the lack of a comprehensive curriculum guide is the most serious. Until such a curriculum guide is developed and distributed, teachers will not be able to plan their health lessons with the aid of a guide that details statewide objectives for each grade level.

The grant from the Kate B. Reynolds Health Care Trust offers the means for DPI to begin in earnest the work of developing an official health education "blueprint" complete with curriculum guide and evaluation program. This work will be supervised in part by the North Carolina Health Education Commission. The duties assigned to the Commission are similar to those assigned to the State Health Education Advisory Committee by House Bill 540. It is not yet clear whether the two committees will work in conjunction or in competition with each other.

As the health education policy is now administered, the local health education advisory councils provide parents with a key point of access into

the health education curriculum process at the local level. This allows for community participation in decisions concerning controversial aspects of health education. Values clarification and sex education are two such controversial features. Values clarification is a potentially useful technique for improving a student's understanding of his decision-making processes and for encouraging the student to accept responsibility for his own health. Sex education, when responsibly taught, may be a valuable tool in addressing the problems of teenage sexuality, problems which affect all members of the community. Because of their controversial natures, values clarification and sex education are topics that concerned individuals may want to discuss at the community level. The local councils offer convenient and relevant forums for such discussions.

The controversy surrounding the New Generation Act and the Child Health Plan has made sex education a "hot" issue. Many people believe there is an ideological linkage from the Child Health Plan to the New Generation Act and on to sex education/health education. There is a danger that candidates for public office this year will feel compelled to distance themselves not only from the New Generation Act but from health education as well. This might decrease health education's funding chances in the next session of the General Assembly.

The future of health education in North Carolina is uncertain. As DPI develops its program blueprint over the next two years, the quality of health education will continue to be largely dependent upon local initiative. Health education in North Carolina's public schools has suffered from an incomplete commitment. The state needs to allocate the necessary resources to develop and implement the program called for by House Bill 540. North Carolina needs leadership — from the State Board of Education, from the General Assembly, from a Governor who has made children a major theme of his administration — to marshal the state's resources for a full-fledged commitment to health education.

Recommendations

It is the recommendation of this report that:

1) In designing the health education blueprint, the strengths of the current policy — most notably its flexibility and organization — be preserved. The new program should enumerate statewide standards for health education, compose a comprehensive curriculum guide including both objectives for each grade level and suggested teaching strategies for attaining those objectives, and develop an evaluation program for determining health education's success in meeting its objectives. The North Carolina Health Education Commission and the State Health Education Advisory Committee should work in consultation with each other to insure a reinforcing, rather than a replicating or countervailing, relationship.

2) A committee of health educators, including health education coordinators, school principals, teachers, and DPI administrators, be appointed by the Department of Public Instruction and the State Health Education Advisory Committee to study the employment patterns of the graduates of North Carolina's health education teacher certification programs. The committee should make recommendations to the Department of Public Instruction on the feasibility of employing more certified health instructors in the state's schools.

3) A statewide committee of health educators (including health education coordinators), health personnel and North Carolina citizens, be appointed by the Department of Public Instruction and the State School Health Education Advisory Committee to study the work of the local health education advisory councils and to develop guidelines that will safeguard and strengthen the role of the councils in local health education curriculum development.

Appendix

The following questionnaire was sent by the North Carolina Center for Public Policy Research to each of the state's 145 school units in the spring of 1979.

Note: Please feel free to provide any additional information or documentation that will help us in getting a true picture of health education in your school system.

1. Does your school system have a health education coordinator, a person whose sole responsibility is the coordination of health education?
   YES_____ NO_____
   If no, has any one been designated as responsible for health education in your school system?
   YES_____ NO_____
   If yes, what is his or her position? _____
2. Does your school system employ any teachers who are certified in health education? (Do not include persons certified in health and physical education.)
   YES_____ NO_____
   If yes, how many? _____
3. Have any teachers participated in in-service training in health education in the past?
   YES_____ NO_____
   If yes, how many? _____
4. Does your school system have a planned, sequential health education program?
   YES_____ NO_____
   If yes, who developed the program? _____
5. Does your school system have specific, written objectives for health education at each grade level?
   YES_____ NO_____
   If yes, approximately what percentage of the teachers use the objectives? _____
   If yes, are students evaluated on these objectives?
   YES_____ NO_____
6. Does your school system have an adequate number of textbooks on health education?
   YES_____ NO_____
7. Does your school system have an adequate number of curriculum guides, pamphlets, audio-visual aids and other resources in health education?
   YES_____ NO_____
8. Do community agencies and organizations assist in health education in your schools?
   YES_____ NO_____

If yes, which agencies and organizations are involved? _____

_____

_____

_____

To what extent do the agencies and organizations participate in the health education program? _____

_____

_____

_____

_____

9. Does your school system have a local health education advisory council?
   YES_____ NO_____
10. What would you identify as the biggest problem in the teaching of health education?

Name of School Official _____

Position _____

(Neither the school official nor the school district will be identified in the Center's report.)

Responses to the preceding questionnaire were received from 105 of the 145 North Carolina units, a response rate of 72 percent. The survey results were as follows:

1. Does your school system have a health education coordinator, a person whose sole responsibility is the coordination of health education?
   Yes 13 No 90 NA (No Answer) 2
   If no, has anyone been designated as responsible for health education in your school system?
   Yes 60 No 30
   If yes, what is his or her position?
   The school units have designated individuals who have other responsibilities in addition to those of health education. Directors of instruction and supervisors were the individuals cited most frequently, but a broad range of positions was listed: counselor, director of federal programs, school nurse, director of pupil personnel services, principal, superintendent, physical education teacher.

2. Does your school system employ any teachers who are certified in health education? (Do not include persons certified in health and physical education.)
   Yes 11 No 91 NA 3
   If yes, how many?
   A total of 14 persons certified in health education is employed in these school units.

3. Have any teachers participated in in-service training in health education in the past?
   Yes 76 No 27 NA 2
   If yes, how many?
   The number of teachers who had participated in in-service training ranged from a low of one in one of the reporting school units to a high of 1,300 in another.

4. Does your school have a planned, sequential health education program?
   Yes 62 No 40 NA 3
   If yes, who developed the program?
   About half the schools answering yes reported using the course of study supplied by the State Department of Public Instruction (Course of Study for Elementary and Secondary Schools K-12 *and* A Framework for Health Education Grades K-12). *The other half cited local development of curricula, the specific local sources ranging from an individual teacher to a committee composed of teachers, administrators, and representatives of community health agencies.*

5. Does your school system have specific, written objectives for health education at each grade level?
   Yes 34 No 65 NA 6

If yes, approximately what percentage of the teachers use the objectives?
Ten of the 34 school systems reported that all of their teachers use the written objectives. Most of the remaining units quoted figures from 25 to 95 percent.
If yes, are students evaluated on these objectives?
29 of the 34 school units reported that students are evaluated on the objectives.

6. Does your school system have an adequate number of textbooks on health education?
   Yes 81 No 19 NA 5
   (Health textbooks are available from the state for grades 4 through 9. As it does in all subject areas, the State Textbook Commission chooses several series of acceptable texts, and the individual school systems choose the series they wish to use. The number of books distributed to each unit is determined by the Division of Textbooks on the basis of reports submitted by the school units.)

7. Does your school system have an adequate number of curriculum guides, pamphlets, audio-visual aids, and other resources in health education?
   Yes 44 No 55 NA 6

8. Do community agencies and organizations assist in health education in your schools?
   Yes 93 No 6 NA 6
   If yes, what agencies and organizations are involved?
   The local health department was the most frequently cited source of aid. Other sources listed included police and fire departments, rescue squads, civic clubs, organizations devoted to fighting specific diseases, community colleges, nursing homes, dentists, physicians, medical societies, hospitals, Red Cross chapters, social services departments. A number of units cited assistance provided by community health educators assigned to county health departments.
   To what extent do the agencies and organizations participate in the health education program?
   Assessments ranged from "limited" to "considerable".

9. Does your school have a local health advisory council?
   Yes 18 No 86 NA 1

10. What would you identify as the biggest problem in the teaching of health education?
    The answers indicate that one of the biggest problems local units face is the lack of trained staff to coordinate a health education program. Other problems cited repeatedly were inadequate preparation of teachers, insufficient time in the school day, and lack of materials. Also cited by many of the respondents was the current emphasis on the "basic" subjects of reading and mathematics and the concomitant lack of emphasis on other subjects like health.

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