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ABSTRACT

The purpose of this guide is to enable schools and school districts to develop, select or assess a comprehensive health enhancement curriculum that combines health and physical education into one integrated program. The evaluation instruments in this booklet were developed by the Montana Office of Public Instruction around the newly adopted requirements and guidelines. Since this assessment is based on accreditation standards in health enhancement, goals and learner outcomes for the program are provided. This booklet outlines health enhancement learner goals (primary, intermediate, and upon graduation); health enhancement program development; criteria organization; preparation for curriculum development; using the criteria; and curriculum analysis. Curriculum evaluation forms focus on: goals and objectives, content, teaching strategies, learning experiences, materials, time, evaluation, cultural equity, sex equity, district-specific criteria, moving beyond the curriculum into other areas of the school program, and a summary of curricula analyses. The document concludes with a section entitled "Healthy People 2000" that presents national health promotion and disease prevention objectives, and a list of resources. (LL)

Montana Assessment

For Health Enhancement

Foreword

The basic content and style of this booklet was developed by Jill English and Anthony Sancho of the Southwest Regional Educational Laboratory. Assistance was provided by Donna Lloyd-Kolkin and Lisa Hunter, Health and Education Communication Consultants. Additional consultation was provided by a group of health education experts from across the country. The adaptation of this booklet for use in Montana was done by Alex McNeill, Chair of the Health and Human Development Department, Montana State University, Robert W. Moon, Health Services Manager, Department of Health and Environmental Sciences, Pat Callbeck Harper, Gender Equity Specialist, Equity Division, and Spencer Sartorius, Administrator, Health Enhancement Division, Office of Public Instruction. Permission to reprint from the Southwest Regional Educational Laboratory is gratefully acknowledged.

Purpose

The purpose of this guide is to enable a district or school to develop, select or assess a comprehensive health enhancement education curriculum that is educationally sound and based on research of other programs that were proven effective.

As health enhancement instruction is **only one component of a total school health program,** this guide is not meant as a tool to evaluate a district's or school's comprehensive health **program**. An actual comprehensive health program includes more than the curriculum including school health services, school health environment, school/community health promotion efforts, school food service, counseling programs, school health promotion for faculty and staff, **as well as the health enhancement curriculum.** Refer to Office of Public Instruction booklet: ***Health Enhancement: A Design for Montana's Future.***

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Introduction

The Montana school accreditation requirements as outlined in ***Montana School Accreditation Standards and Procedures Manual***, and adopted by the Board of Public Education require "curriculum development and assessment." It further defines assessment as "local assessment used to monitor and measure the effectiveness of the instructional program."

The **Health Enhancement** portion of the accreditation requirements is relatively new to Montana and unique to the rest of the nation. Both traditional programs of "health" and "physical education" are combined into an integrated program intended to better meet the health-related needs of students into their adult lives.

Although program assessment is not **new** to the accreditation requirements, what is new is the priority and emphasis toward accountability. Assessment commonly takes numerous forms in the local school district: standardized and teacher-made written tests, skill tests, student surveys such as the Youth Risk Behavior, self-studies such as the Northwest Accreditation process, student discussion groups, curriculum adoption processes, curriculum development processes, etc.

The instrument contained in this booklet should be viewed as **one of a variety** of assessments utilized in assessing program's strengths and weaknesses and then making modifications for improvement. It is not intended to replace any procedures currently being used at the local level, but to enhance those efforts. It has been developed around the requirements and guidelines of the Montana accreditation standards.

Since this assessment is based on accreditation standards in **Health Enhancement**, the goals and learner outcomes for this program are found on the following pages. These should be kept firmly in mind as one proceeds through the booklet. In addition to specific **Health Enhancement** requirements, the accreditation standards include general requirements of all curricular areas. These include cross content and thinking skills and although not specifically enumerated on the following pages, have been "built in" to the assessment procedures contained in this booklet. Also, national initiatives and goals have been incorporated such as **Healthy People 2000** which are the health objectives for the nation for the year 2000. The health objectives which relate to the school are found at the back of the booklet. Other national, state or local initiatives may be appropriate and should not be ignored.

Model Learner Goals

(as identified in ***Montana School Accreditation Standards and Procedures Manual***)

Health Enhancement Learner Goals: Primary

(In accordance with ARM 10.55.603 and ARM 10.55.1001)

(1) By the end of the primary level, the student shall have had the opportunity to:

(a) Demonstrate a variety of perceptual, motor, and rhythm skills, including but not limited to throwing, catching, kicking, striking, balancing, creative movement and folk dance, and skills related to lead-up games.

(b) Demonstrate an appropriate level of physical fitness in cardiorespiratory function, body composition, and musculoskeletal performance.

(c) Develop positive interpersonal relationships and self-concepts.

(2) By the end of the primary level, the student shall have had the opportunity to identify:

(a) Components of wellness and describe how decision making affects personal health practices.

(b) Roles, responsibilities, contributions, and life cycles in a family structure.

(c) The difference between use and abuse of drugs and their effects on an individual's total development.

(d) Safety hazards, causes of accidents, and preventive measures for disease control.

(e) Human body parts and systems, emphasizing individual uniqueness.

(f) Ways in which advertising influences personal health choices.

(g) Food combinations that provide a healthy and balanced diet.

(h) Potential sources of pollution and pollutions' harmful effects.

(i) Resources which help promote and maintain community health. (Eff. 7/11/89)

Health Enhancement Learner Goals: Intermediate

(In accordance with ARM 10.55.603 and ARM 10.55.1001)

(1) By the end of the intermediate level, the student shall have had the opportunity to demonstrate:

(a) A variety of physical skills that influence individual physical development, including but not limited to skills practice and lead-up games, rhythms and dance, and individual, dual, or team sports.

(b) An appropriate level of physical fitness in cardiorespiratory function, body composition, and musculoskeletal function.

(c) Positive interpersonal relationships and self-concept.

(d) An understanding of the importance of regular and sustained physical activity throughout life.

(e) An ability to identify roles, responsibilities, contributions, and life cycles in a family structure.

(2) By the end of the intermediate level, the student shall have had the opportunity to understand:

(a) Substance use and abuse and their effects on the individual and society.

(b) Health problems, including diseases and their etiology, the identification of symptoms of a variety of health problems, and prevention of health problems and injuries.

(c) The functions and maintenance of body systems, including knowledge of the reproductive system.

(d) The need for and use of consumer health services and products.

(e) Basic nutrition and its application.

(f) Cultural, environmental, social, and ethical issues which affect health lifestyles.

(g) Interrelationships between physical health and mental well-being. (Eff. 7/11/89)

Health Enhancement Learner Goals: Upon Graduation

(In accordance with ARM 10.55.603 and ARM 10.55.1001)

(1) Upon graduation, the student shall have had the opportunity to:

(a) Demonstrate a variety of physical skills used in physical activity, including but not limited to dance, individual, dual or team sports, and lifetime leisure and recreational activities.

(b) Demonstrate an appropriate level of physical fitness in cardiorespiratory function, body composition, and musculoskeletal function.

(c) Understand the importance of a positive self-concept and interpersonal relationships for total health.

(d) Understand the role of lifelong physical activity and the principles of safe and effective exercise, be able to plan a personal fitness program.

(e) Understand roles, responsibilities, contributions, and life cycles in family structures.

(f) Understand the risks of using drugs, alcohol, and tobacco.

(g) Understand attitudes and behaviors for preventing and controlling disease and accidents.

(h) Understand human reproduction and the emotional and ethical components of human sexuality.

(i) Be able to evaluate and select health services, practices, and products.

(j) Understand the relationship of sound nutrition to total health.

(k) Understand the consequences of personal and community decisions that affect the economy and the cost, availability, and quality of health care.

(l) Understand the relationship of sound mental health practices to total health.

(m) Identify careers in health and physical activity and their roles and responsibilities. (Eff. 7/11/89)

Health Enhancement Program Development

(In accordance with ARM 10.55.603 and ARM 10.55.1001)

(1) The health enhancement curriculum shall be developed and evaluated according to the standards for all program areas.

(2) Areas of the health enhancement curriculum integrated into other subject areas are ancillary to the main health enhancement program, which shall be provided by a health enhancement specialist (K-12) or by a classroom teacher in the elementary grades.

(3) Interscholastic sports and intramural programs shall not be used as a substitute for a health enhancement course.

(4) Recess shall not be used to fulfill health enhancement requirements.

(5) When required as part of the basic education program, all students shall have daily health enhancement activity.

(6) The school district shall encourage its teaching staff to exemplify health lifestyles.

(7) A telephone or communication device and basic first aid materials shall be located in close proximity to the instructional physical activity area. (Eff. 7/11/89)

Criteria Organization

The following criteria for a comprehensive health enhancement education curriculum are based on educational theory, research of effective health education programs, and the practical application of those programs. The criteria are expressed in terms of the optimum and are organized into the following categories: goals and objectives; content; teaching strategies; learning experiences; materials; time; evaluation; cultural equity; sex equity; district-specific criteria; and beyond the curriculum.

Preparation for Curriculum Development

The first step in developing or selecting a comprehensive school health enhancement curriculum is to form a district team. Suggested members for this team include:

- health enhancement specialist;
- curriculum specialist;
- teacher;
- school/district administrator;
- school counselor;
- principal;
- parent;
- school nurse;
- student;
- representative from a community health agency, such as the local health department; and
- representative from a local voluntary health agency.

In lieu of having a single parent or community member whose views may not accurately reflect the majority's on a team, a separate representative parent/community advisory committee may be established to review and comment on the work of the curriculum committee. Other representatives relevant to your community (e.g., religious leaders and youth organization leaders) also may be appropriate team members.

After receiving thorough orientation and guidance, the team needs to accomplish the following tasks:

1. *Develop realistic, attainable goals for the curriculum.* One of the main reasons many past prevention efforts failed is because goals were so ambitious that they were virtually impossible to achieve. In addition, it is unrealistic to expect that a school-based curriculum alone would be able to affect students' health behaviors without the support of other school and community programs, as well as parental support. The goals that the curriculum itself may attain must be within reason, given the school's resources and level of commitment for it to be successful.

2. *Carefully review the criteria.* To ensure that the criteria in this workbook are applicable to an individual district, the team needs to review them prior to curriculum development or analysis.

3. *Decide on additional criteria the team thinks are important.* There may be criteria other than those given in this guide the team may want to consider. These criteria will be specific to district, school, or state guidelines, such as emphasis on health enhancement issues prominent in the population or the use of local health-related resources.

4. *Determine how the curriculum will fit into the overall comprehensive health program.* A comprehensive school health program includes far more than curriculum, such as nutrition services, counseling, staff development, and health services. Determine how the curriculum can support the total health program. Find out what other federally or state-funded programs are already in place that may be using curriculum. Assess the current and projected district priorities for health enhancement education.

5. *Find out what curricula are being used by other districts.* Sharing and consultation with other districts can be valuable in locating resources, identifying and resolving potential problems, and creating an idea network.

6. *Review the state requirements as outlined in the* ***Montana School Accreditation Standards and Procedures Manual.*** Check with your school administrator for this reference. Specific requirements for **Health Enhancement** should be understood and general requirements of all programs should be studied.

Once these tasks are completed, the team is ready to begin the process.

Using the Criteria

This workbook may be used (a) to guide a district in the development of their own curricula, (b) as a tool to systematically analyze curricula being considered for adoption, and (c) to assess the existing health enhancement curriculum for strengths and weaknesses.

There are several basic criteria not included in this guide. These include the following: (a) materials are current and valid; (b) materials are durable and safe; and (c) content is accurate and reflects current knowledge of the field. It is absolutely essential that these gateway criteria be met when developing or selecting any health enhancement curriculum.

Curriculum Development

Many school districts are interested in developing a health enhancement curriculum specifically for their own district. The criteria in this workbook may be extremely useful in guiding a district to develop a curriculum that is based on research of effective programs with substantial potential to influence actual behavior change in its students.

Curriculum Analysis

There are many existing health education curricula that districts may want to use in lieu of developing their own. This guide may be used to analyze systematically such curricula to select the most appropriate one for the school. Since the quality of curricula may vary by grade level, it is suggested that the criteria be used to evaluate one curriculum at each grade level rather than using the one form to evaluate all the grades within a curriculum.

To begin, each team member should rate each curriculum independently. The curriculum should be analyzed according to the degree that it meets the criterion: completely, to some degree, not at all. In addition, if the curriculum does meet the criterion to some degree, the percentage to which it is met should be rated as: 75 percent, 50 percent, or 25 percent. These percentages should be used simply as guidelines, not actual calculations. The score for each criterion should be circled, based on the analysis. There is space next to the rating of each criterion for comments and notes as to what is lacking or is exceptionally good.

After that task is completed, the committee should meet to discuss any significant individual discrepancies, coming to a consensus about any necessary revisions.

The total score for each category is tallied and transferred to page 21 for easier analysis of all curricula reviewed. *It is strongly recommended that curricula not be selected based on the total score.* Each set of criteria has not been given an equal value in the overall scoring and needs to be prioritized according to district and school needs and priorities. A main purpose of this document is to assist districts in the systematic analysis of curricula so that curricula may be given a fair and thorough analysis of all components. Curricula may be selected using one of the following processes:

1. Select one curriculum from an array of curricula.

2. Select one curriculum based on its own merits, without comparing it to others.

3. Develop a list of acceptable curricula from which policymakers may select.

Goals and Objectives

Goals are the long-range results toward which the curriculum is directed—or the development of positive health behaviors in this case. Objectives are a listing of what the students will be able to do at the conclusion of the curricular program as a means of attaining the overall goals.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. The goals and objectives are *realistically* attainable.	4	3	2	1	0	
2. Goals and objectives are related to the district's identified needs.	4	3	2	1	0	
3. Objectives are well-defined and measurable.	4	3	2	1	0	
4. Both long-term and short-term objectives are included.	4	3	2	1	0	
5. Objectives include a strong focus on a positive approach to health promotion.	4	3	2	1	0	
6. Program includes a balance of cognitive, affective, and behavioral objectives.	4	3	2	1	0	
7. Objectives reflect an appropriate and comprehensive scope and sequence for grade level.	4	3	2	1	0	
8. Goals and objectives relate to health enhancement and other accreditation requirements.	4	3	2	1	0	

TOTAL SCORE _____ OF 32

Content

The content refers to the subject matter included in the curriculum.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. Curriculum contains appropriate continuity, scope, and sequence throughout the grade level.	4	3	2	1	0	
2. Content is based on identified health needs.	4	3	2	1	0	
3. Content may also be integrated into a variety of other subject matter as a means of reinforcing the health education course.	4	3	2	1	0	
4. Content addresses the perspectives of various ethnic and cultural groups.	4	3	2	1	0	
5. Provides reinforcement of other curricular areas including language arts.	4	3	2	1	0	
6. Content reflects Healthy People 2000 as well as other national goals.	4	3	2	1	0	
7. Curriculum content is based upon the model learner outcomes as identified in the accreditation standards: • growth and development • mental/emotional health • family life • safety and first aid • consumer health • drug use and abuse • community health • environmental health • disease prevention • nutrition • basic movement • physical skills • physical fitness	4	3	2	1	0	

TOTAL SCORE _____ OF 28

Teaching Strategies

Teaching strategies are the activities or strategies used *by the teacher* to facilitate student learning.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. The curriculum uses a variety of instructional methodologies for effective health enhancement programs, such as: • inquiry • simulation • small group activities/ cooperative learning • role playing • whole group process • group investigation; and • field trips	4	3	2	1	0	
2. The instructional strategies take into account the cultural and ethnic values, customs and practices of the community.	4	3	2	1	0	
3. The curriculum uses teaching strategies that teachers and students will find interesting and rewarding.	4	3	2	1	0	
4. The instructional strategies are appropriate for the grade level.	4	3	2	1	0	
5. The strategies are based on student age, ability and aptitude.	4	3	2	1	0	
6. The strategies consider ways that integrate other curricular areas.	4	3	2	1	0	
7. The strategies allow student's practice in: • thinking & problem solving • identifying & defining problem • ability to gather, analyze & present information • logical, creative, innovative thinking • decision making & reasoning	4	3	2	1	0	

TOTAL SCORE _____ OF 28

Learning Experiences

Learning experiences help students achieve the curricular goals and objectives.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. The curricular learning experiences foster: • social action • decision making • skill rehearsal • critical analysis • values identification • goal setting	4	3	2	1	0	
2. The curriculum provides a variety of both in-school and out-of-school learning experiences taking advantage of community resources.	4	3	2	1	0	
3. Homework assignments provide opportunities for parent involvement.	4	3	2	1	0	
4. Activities foster higher-order thinking among students.	4	3	2	1	0	

TOTAL SCORE _____ OF 16

Instructional strategies and learning experiences should take into consideration means of addressing the needs of youth considered "at risk." This could include strategies to reduce "risk factors" or enhance "protective factors." Although the term "at risk" may mean a variety of things, it could be defined as those students to be considered at risk of poor academic performance, dropping out of school, a victim of abuse, a drug/alcohol user or has such friends, has attempted suicide, has been in trouble with law enforcement, has mental health problems, or is economically disadvantaged.

Materials

The materials are items that are a part of the curricular package used by teachers or students.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. The curriculum utilizes a variety of materials to facilitate learning such as manipulatives, apparati, media, books, charts, and learning stations.	4	3	2	1	0	
2. Materials are appropriate for the academic levels of the target population and adaptable to differing student needs.	4	3	2	1	0	
3. Materials are relevant to the program objectives.	4	3	2	1	0	
4. Materials may easily be used by teachers, containing clear format and direction.	4	3	2	1	0	
5. Materials are aesthetically pleasing, high quality, and likely to excite the interest of teachers and students.	4	3	2	1	0	
6. The structure of the curriculum allows the materials to be easily updated.	4	3	2	1	0	
7. References and support materials are provided for teachers.	4	3	2	1	0	
8. The curriculum relies on much more than a text to organize classroom instruction.	4	3	2	1	0	
9. Materials are reasonably available to the instructor.	4	3	2	1	0	

TOTAL SCORE _____ OF 36

Time

Time refers to the amount of time devoted to implementing the curriculum.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. The curriculum is of adequate time and intensity to meet all objectives.	4	3	2	1	0	
2. The amount of time allotted for each lesson fits the scheduling needs of the instructor/school.	4	3	2	1	0	
3. Daily health enhancement is provided at the elementary level.*	4	3	2	1	0	
4. A minimum of 1/2 unit is provided at each grade level in junior high/middle school (grades 7 and 8).**	4	3	2	1	0	
5. A minimum of 1 unit over a two-year period is required at the high school level.**	4	3	2	1	0	
6. The curriculum includes adequate time for review, mastery, reinforcement, and extension.	4	3	2	1	0	

TOTAL SCORE _____ OF 24

*Current research indicates that a minimum of 50 hours of instructional time is necessary to effect knowledge, attitude and behavior in health-related programs.

**One-half (1/2) unit is defined as at least 112 1/2 minutes per week or 4,050 minutes per school year of instruction.

Evaluation

The evaluation includes student assessments administered during the curriculum's implementation.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. The curriculum provides teachers with a means of assessing student attainment of objectives.*	4	3	2	1	0	
2. Student assessments are clearly linked to all curricular objectives.	4	3	2	1	0	
3. Student assessment is included for knowledge, attitude, behavior, and skills.	4	3	2	1	0	
4. Process evaluation is included so results may be used for curricular revisions.	4	3	2	1	0	

TOTAL SCORE _____ OF 16

*Including cognitive, affective and psychomotor.

Cultural Equity

Materials reflect cultural equity when there is a balance in the positive representation of diverse cultural and racial groups.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. Materials contain no demeaning labels or stereotypes of racial/cultural minorities.	4	3	2	1	0	
2. Materials display a variety of diverse ethnic groups in active roles.	4	3	2	1	0	
3. Materials display minorities in a variety of professions.	4	3	2	1	0	
4. Materials present minority contributions and achievements.	4	3	2	1	0	
5. Materials depict differences in cultures and customs as valuable to all.	4	3	2	1	0	
6. Materials contain equal representation of minorities in mental and physical activities.	4	3	2	1	0	
7. Materials show wide socio-economic ranges for different minority groups.	4	3	2	1	0	
8. Materials reflect a balance of both traditional and non-traditional family compositions.	4	3	2	1	0	

TOTAL SCORE _____ OF 32

Sex Equity

Sex equity refers to a balance of gender roles, depicted in traditional and nontraditional settings, inclusive of language, illustrations and classroom techniques that affirm full participation of females and males.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. Materials contain equal illustrations of and portrayals of males and females in occupations/activities.	4	3	2	1	0	
2. Materials maintain a balance of traditional and nontraditional male and female roles.	4	3	2	1	0	
3. Materials contain neutral language (e.g., people, persons, men and women, they, etc.).	4	3	2	1	0	
4. Materials portray both sexes in parenting activities with families.	4	3	2	1	0	
5. Materials contain no demeaning labels or sex role stereotypes.	4	3	2	1	0	
6. Materials show equal representation of males/ females in mental and physical activities.	4	3	2	1	0	
7. Special speakers and instructors are equally male and female.	4	3	2	1	0	
8. Participants are not segregated by sex except when allowable by law (or "except in contact sports or human sexuality instruction").	4	3	2	1	0	

TOTAL SCORE _____ OF 32

District-Specific Criteria

District-specific criteria include any additional requirements an individual district may want to make, including the incorporation of any state or local requirements for health instruction.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1.						
2.						
3.						
4.						
5.						
6.						

TOTAL SCORE _____

Beyond the Curriculum

The Health Enhancement Program is intended to reach beyond the curriculum itself and into other areas of the school program. These "beyond the curriculum" activities can enhance the curricular offering.

Criteria	Degree to which criterion is met					Needs/Comments
	Completely	To some degree			Not at all	
		75%	50%	25%		
1. There is a district wellness program and/or employees' assistance program in place.	4	3	2	1	0	
2. Health Enhancement staff works cooperatively and collaboratively with other school health-related personnel such as Home Ec, Counselor, Drug-Free Schools, etc.	4	3	2	1	0	
3. There is a district program for students considered "at risk," including dropout prevention.	4	3	2	1	0	
4. There is a school nurse.	4	3	2	1	0	
5. There is a "tobacco free" district policy.	4	3	2	1	0	
6. There are routine safety inspections of the school building and campus.	4	3	2	1	0	
7. Staff belongs and actively works in its professional association.	4	3	2	1	0	
8. Fire/earthquake drills are conducted as required.	4	3	2	1	0	
9. Staff works to give students: • a sense of responsibility, • a sense of "belonging," • a positive role model.	4	3	2	1	0	

TOTAL SCORE _____ OF 36

Summary of Curricula Analyses

Summary of Curricula Analyses		Goals and Objectives (32)	Content (28)	Teaching Strategies (28)	Learning Experiences(16)	Materials (36)	Time (24)	Evaluation (16)	Cultural Equity (32)	Sex Equity (32)	District-Specific Criteria	Beyond the Curriculum (36)	TOTAL
Curriculum Title	**Grade**												

Strengths:

Weaknesses:

Recommendations:

HEALTHY PEOPLE 2000

National Health Promotion and Disease Prevention Objectives

School-Related Objectives

1.8 Increase to at least 50 percent the proportion of children and adolescents in 1st through 12th grade who participate in daily school physical education. (Baseline: 36 percent in 1984-86.)

1.9 Increase to at least 50 percent the proportion of school physical education class time that students spend being physically active, preferably engaged in lifetime physical activities. (Baseline: Students spent an estimated 27 percent of class time being physically active in 1984.)

2.16 Increase to at least 90 percent the proportion of restaurants and institutional food service operations that offer identifiable low-fat, low-calorie food choices, consistent with the Dietary Guidelines for Americans. (Baseline: About 70 percent of fast food and family restaurant chains with 350 or more units had at least one low-fat, low-calorie item on their menu in 1989.)

2.19 Increase to at least 75 percent the proportion of the nation's schools that provide nutrition education from preschool through 12th grade, preferably as part of quality school health education. (Baseline data available in 1991.)

3.10 Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of quality school health education. (Baseline: 17 percent of school districts totally banned smoking on school premises or at school functions in 1988; antismoking education was provided by 78 percent of school districts at the high school level, 81 percent at the middle school level, and 75 percent at the elementary school level in 1988.)

4.9 Increase the proportion of high school seniors who perceive social disapproval associated with the heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, as follows:

Behavior	Baseline 1989	Target 2000
Heavy use of alcohol	56.4%	70%
Occasional use of marijuana	71.1%	85%
Trying cocaine once or twice	88.9%	95%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

4.10 Increase the proportion of high school seniors who associate risk of physical or psychological harm with the heavy use of alcohol, regular use of marijuana, and experimentation with cocaine, as follows:

Behavior	Baseline 1989	Target 2000
Heavy use of alcohol	44%	70%
Occasional use of marijuana	77.5%	90%
Trying cocaine once or twice	54.9%	80%

4.11 Reduce to no more than 3 percent the proportion of male high school seniors who use anabolic steroids. (Baseline: 4.7 percent in 1989.)

4.13 Provide to children in all school districts and private schools primary and secondary school educational programs on alcohol and other drugs, preferably as a part of quality school health education. (Baseline: 63 percent provided some instruction, 39 percent provided counseling, and 23 percent referred students for clinical assessments in 1987.)

5.8 Increase to at least 85 percent the proportion of people aged 10 through 18 who have discussed human sexuality, including values surrounding sexuality, with their parents and/or have received information through another parentally-endorsed source, such as youth, school, or religious programs. (Baseline: 66 percent of people aged 13 through 18 have discussed sexuality with their parents reported in 1986.)

7.16 Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of quality school health education. (Baseline data available in 1991.)

8.2 Increase the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health. (Baseline: 79 percent of people aged 20 through 21 had graduated from high school with a regular diploma in 1989.)

8.3 Achieve for all disadvantaged children and children with disabilities access to high quality and developmentally appropriate preschool programs that help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health. (Baseline: 47 percent of eligible children aged 4 were afforded the opportunity to enroll in Head Start in 1990.)

8.4 Increase to at least 75 percent the proportion of the nation's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade quality school health education. (Baseline data available in 1991.)

8.5 Increase to at least 50 percent the proportion of postsecondary institutions with institutionwide health promotion programs for students, faculty, and staff. (Baseline: At least 20 percent of higher education institutions offered health promotion activities for students in 1989-90.)

9.18 Provide academic instruction on injury prevention and control, preferably as part of quality school health education, in at least 50 percent of public school systems (grade K through 12). (Baseline data available in 1991.)

9.19 Extend requirement of the use of effective head, face, eye and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury. (Baseline: Only National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988.)

13.12 Increase to at least 90 percent the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and followup for necessary diagnostic, preventive, and treatment services. (Baseline: 66 percent of children aged 5 visited a dentist during the previous year in 1986.)

13.16 Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury. (Baseline: Only National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988.)

18.10 Increase to at least 95 percent the proportion of schools that have age-appropriate HIV education curricula for students in 4th through 12th grade, preferably as part of quality school health education. (Baseline: 66 percent of school districts required HIV education and 5 percent of school districts required HIV education in each year for 7th through 12th grade in 1989.)

19.12 Include instruction in sexually transmitted disease transmission prevention in the curricula of all middle and secondary schools, preferably as part of quality school health education. (Baseline: 95 percent of schools reported offering at least one class on sexually transmitted diseases as part of their standard curricula in 1988.)

NOTE: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.

20.11 Increase immunization levels as follows:

Basic immunization series among children under age 2: at least 90 percent. (Baseline: 70-80 percent estimated in 1989.)

Basic immunization series among children in licensed child care facilities and kindergarten through postsecondary education institutions: at least 95 percent. (Baseline: for licensed child care, 94 percent; 97 percent for children entering school for the 1987-88 school year; and for postsecondary institutions, baseline data available in 1992.)

Pneumococcal pneumonia and influenza immunization among institutionalized chronically ill or older people: at least 80 percent. (Baseline: data available in 1992.)

Pneumococcal pneumonia and influenza immunization among noninstitutionalized, high-risk populations, as defined by the Immunization Practice Advisory Committee: at least 60 percent. (Baseline: 10 percent estimated for pneumococcal vaccine and 20 percent for influenza vaccine in 1985.)

Hepatitis B immunization among high-risk populations, including infants of surface antigen-positive mothers to at least 90 percent; occupationally exposed workers to at least 90 percent; IV-drug users in drug treatment programs to at least 50 percent; and homosexual men to at least 50 percent. (Baseline data available in 1992.)

20.13 Expand immunization laws for schools. preschools, and day care settings to all states for all antigens. (Baseline: 0 States in 1990.)

Worksite-related Objectives for Schools

3.12 Enact in 50 states comprehensive laws on clean indoor air that prohibit or strictly limit smoking in the workplace and enclosed public places (including health care facilities, schools, and public transportation). (Baseline: 42 states and DC had laws restricting smoking in public places; 32 states restricted smoking in public workplaces; but only 13 states had comprehensive laws regulating smoking in private as well as public worksites and at least 4 public places, including restaurants, as of 1988.)

4.14 Extend adoption of alcohol and drug policies for the work environment to at least 60 percent of worksites with 50 or more employees. (Baseline data available in 1991.)

6.11 Increase to at least 40 percent the proportion of worksites employing 50 or more people that provide programs to reduce employee stress. (Baseline: 26.6 percent in 1985.)

8.6 Increase to at least 85 percent the proportion of workplaces with 50 or more employees that offer health promotion activities for their employees, preferably as part of a comprehensive employee health promotion program. (Baseline: 65 percent of worksites with 50 or more employees offered at least one health promotion activity in 1985; 63 percent of medium and large companies had a wellness program in 1987.)

10.6 Increase to at least 75 percent the proportion of worksites with 50 or more employees that mandate employee use of occupant protection systems, such as seatbelts, during all work-related motor vehicle travel. (Baseline data available in 1991.)

10.12 Increase to at least 70 percent the proportion of worksites with 50 or more employees that have implemented programs on worker health and safety. (Baseline data available in 1991.)

10.13 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer back injury prevention and rehabilitation programs. (Baseline: 28.6 percent offered back care activities in 1985.)

15.16 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer high blood pressure and/or cholesterol education and control activities to their employees. (Baseline: 16.5 percent offered high blood pressure activities and 16.8 percent offered nutrition education activities in 1985.)

17.19 Increase to at least 75 percent the proportion of worksites with 50 or more employees that have a voluntarily established policy or program for the hiring of people with disabilities. (Baseline: 37 percent of medium and large companies in 1986.)

NOTE: Voluntarily established policies and programs for the hiring of people with disabilities are encouraged for worksites of all sizes. This objective is limited to worksites with 50 or more employees for tracking purposes.

Resources

From the Office of Public Instruction:

1. **Health Enhancement: A Design for Montana's Future**
2. **Montana in Action: Physical Education Curriculum Guide Grades K-12**
3. **Montana Health Education Curriculum Planning Guide**
4. **1991 Montana Youth Risk Behavior Survey**
5. **Montana AIDS Curriculum Planning Guidelines**
6. **Montana Supplemental Curriculum Materials for K-12 HIV/AIDS Education**
7. **Together: Guidelines for Drug and Alcohol Programs**
8. **Drug-Free Schools and Communities: Program Planning Guidelines and Community Inventory**
9. **The Curriculum Process Guide: Developing Curriculum for the 1990s**

Others:

1. Centers for Disease Control. (January 29, 1988/Vol. 37/No. S-2) Morbidity and Mortality Weekly Report Supplement: **Guidelines for Effective School Health Education to Prevent the Spread of AIDS.**

2. **NASPE Physical Education Outcomes**. Available from the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD), 1900 Association Drive, Reston, VA.

3. American Medical Association. **Adolescent Health Care: Use Costs and Problems of Access.**

4. U.S. Department of Education, Office of Educational Research and Improvement. **Youth Indicators 1991: Trends in the Well-Being of American Youth.**

5. U.S. Department of Education. **America 2000: An Education Strategy.**

6. National Association of State Boards of Education. **Code Blue: Uniting for Healthier Youth.**

7. American Association of School Administrators. **Promoting Health Education in Schools—Problems and Solutions.**

8. Metropolitan Life Foundation. **Health, You've Got to be Taught: An Evaluation of Comprehensive Health Education in American Public Schools.**

9. *Journal of School Health.* October 1985 and December 1987.

10. Department of Health and Human Services. **Healthy People 2000.**

11. *Health Education*, November/December 1990, **Evaluating Your Curriculum: Does it Pass the Jeans Test?** by Paula H. Hildebrand and David M. White.

12. *Educational Leadership* (Vol. 49, No. 2). Entire issue focuses on **Integrating the Curriculum**, published by Association for Supervision and Curriculum Development, 1250 N. Pitt St., Alexandria, VA 22314-1403 (703) 549-9110.

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