

Public Elementary School Teachers' Perceptions of Health Education & Promotion

A Senior Honors Thesis

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## **Abstract**

**Background:** The importance of school health education has become well-known in the past two decades, however, there is limited research surrounding the perceptions and attitudes of classroom teachers and school health. The purpose of this study was to understand classroom teachers' perceptions of health education at the elementary school level, so that policy makers might have a clearer understanding of the state of health in today's classrooms.

**Methods:** Public Elementary School Teachers, located in Western New York, participated in a qualitative online survey consisting of 10 questions. The survey focused on their perceptions of health education and promotion. Participant's answers were then analyzed by researchers, using an open coding process, classifying teachers results into major themes and topics.

**Results:** The majority of teachers who responded were passionate about creating healthy classrooms, yet felt limited due to the lack of accessible resources and scope of practice. Many teachers understood the importance of school health and would attempt to incorporate aspects of health education into various moments throughout the day.

**Conclusions:** Despite a wide range of student health issues and a lack of resources, classroom teachers are passionate about creating healthy classrooms and healthy students.

**Keywords:** school health; health education; classroom; teacher; public school.

## **Introduction**

Over the past twenty years, public and preventive health education has become a hot topic issue, particularly at the Kindergarten-Twelfth grade level. As the landscape of children's health continues to shift – with rates of obesity tripling in the past 3 decades, almost 50% of children having a diagnosable mental health condition, and 2 in 5 children coming from low-income households – there has become a clear need for more rigorous and innovative health education (Centers for Disease Control and Prevention [CDC], 2018; Child Mind Institute, 2015; National Center for Children in Poverty, 2018). As a result, numerous curriculums and health education models have emerged in attempts to standardize and improve the quality of education which children receive - everything from the National Sexuality Education Standards to the latest Whole Community, Whole School, Whole Child model recommended by the Centers for Disease Control and Prevention (CDC, 2018b). While these standardized curriculums have helped to improve the overall quality of instructional material, they have failed to examine one of the most important aspects of health promotion and education, and that is the perspective of the teacher. Very little research has been done which focuses exclusively on how teachers view health promotion and preventive health within their classrooms; the research which is available on the topic, is dated, such as *Elementary School Teachers' Perspectives on Health Instruction: Implications for Health Education* from 2002, and therefore irrelevant because it implements old instructional models and technology; or is limited in its scope and focuses on only one area of health promotion, such as obesity or nutrition, therefore narrowing the understanding which it offers (Thackeray, Neiger, Bartle, Hill, & Barnes, 2002). The perspective of teachers is incredibly important in the creation of effective health curriculums because they are the ones implementing the models which are created. Without an understanding of how teachers view

health within their classrooms, the research and models which are created fail to be as comprehensive or as effective as possible.

This study examines the perspectives of Kindergarten-Fifth Grade (K-5) teachers within public school settings in an attempt to gain a better understanding of how teachers approach and view health promotion within their own classrooms. The data collected will potentially help to inform the creation of standardized curriculums and models and will most certainly provide school districts with valuable data to help drive forward their health education planning. The data will also provide local districts and regions with an understanding of the barriers which teachers face when it comes to health education and an understanding of the role which teachers play in the promotion of health.

### **Participants**

This study was conducted in Western New York, in both rural and suburban districts. Researchers initially selected thirteen different schools based on four main criteria, to ensure that a wide range of schools would be represented, this included: grade level (e.g. the school had to have grades K-5), location (e.g. rural or suburban), size (e.g. number of students), and economic factors (e.g. free/reduced price lunch rates and Title I Status). Following survey distribution, nine schools participated in total, with student population sizes ranging from 173 to 534 (National Center for Education Statistics [NCES], 2018). The average racial make-up of the nine schools was overwhelmingly white – schools were comprised, on average, of 11% Students of Color (with some schools having as low as 4% and some having closer to 28%) (NCES, 2018). With regard to economic factors, on average, 43% of students received free or reduced price lunch; with schools ranging from 11% to 87% (New York State Center for Rural Schools, 2018).

The teachers selected for this research study were general and special education teachers in Kindergarten – Grade 5; health education, physical education, art, music, and other teachers or associated school personnel (e.g. guidance counselors) were not included in the study. Teachers were contacted via e-mail and could choose to participate in the study by responding to an online survey. In total, there were 33 responses from nine different schools, representing a wide range of teacher experiences. On average, teachers had been involved in education for 16 years, with ranges from 4 years in the classroom to 34 years. The participants were mostly female, with 29 of the participants identifying as female and 3 identifying as male. In terms of grade breakdown, 20 of the participants were involved in grades K-2 classrooms and 12 were involved in grades 3-5 classrooms.

### **Instruments**

Participants who chose to take part in the study completed a ten-question survey using The College at Brockport’s *Qualtrics* survey software (Figure 1). The survey was conducted online to increase the accessibility and scope of the research study. The survey, which included 4 classification questions (in order to categorize participants) and 6 education-related questions, asked teachers to describe their experiences with health education and promotion.

#### Survey Questions (Figure 1)

##### *Demographic Questions:*

1. Please enter the name of the school in which you work.
2. Please select the grade range in which you work. (Answers: Grades K-2 or 3-5)
3. Please enter the number of years you have been working as a K-5 educator.
4. Please select your gender (Answers: Male, Female, Transgender/Non-Binary).

##### *Education-Related Questions:*

1. What role do you believe you play in helping your students lead healthy lives?
2. Describe the most significant health issues impacting your students.
3. What do you do, if anything, in your classroom to promote a healthy lifestyle?
4. Do you incorporate healthy living into other lesson areas (e.g. reading, math, writing, etc.)?  
If so, how?
5. What are the most difficult factors pertaining to health education in your classroom?
6. What would help you to better incorporate health education into your classroom?

### **Procedure**

Researchers began the process by creating survey questions inspired by the Center for Disease Control and Prevention's *School Health Policies and Practices Study (2014)*, the National Health Education Standards, and the Whole School, Whole Community, Whole Child Health Education Model (CDC 2014; CDC 2016; CDC 2018b). Researchers also used journal articles, such as *Elementary School Teachers' Perspectives on Health Instruction: Implications for Health Education (CHANGE)*. These resources were used to create questions which would address the issues of health education and promotion within the classroom.

Following the creation of the survey, researchers submitted the research proposal to the Institutional Review Board, and upon approval created the survey using the research software *Qualtrics*. Researchers then used school websites of selected districts to retrieve teacher contact information (i.e. teacher emails). Participants were then grouped by district and contacted via e-mail. Participants were provided with information regarding the research study and a link to the online survey. Every participant who chose to take part in the survey received a statement regarding informed consent and confidentiality. The survey was estimated to take approximately 10 to 20 minutes and could be completed from the participant's home or school computer. In

return for taking the survey, participants could elect to enter into a raffle, where the prizes consisted of \$5-\$25 Target gift cards.

### **Data Analysis**

Following the completion of survey distribution, the researchers used an open coding process to determine and identify themes within results. Each researcher reviewed and rated the survey results, independently, to identify the major themes for each of the six education-related questions. Researchers also took note of important quotes and phrasing used by participants to be included as evidence of the most frequent methods of instruction and barriers which participants faced in the classroom. Following this review, the researchers compared their findings, noting similarities amongst themes and quotations. Using this data, researchers created five main categories/themes in relation to the topic, along with a series of subtopics for each theme. Researchers also conducted a brief quantitative review, using the four demographic-based questions to garner simple information about participants' identity and background.

### **Results**

There were a number of themes which emerged across the surveys, reflecting five key ideas: Student Issues, Teacher Role, Methods of Instruction, Barriers to Instruction, and Teacher Wants. Within each key idea or theme, there were a number of different subtopics which emerged, as seen below.

#### ***Student Issues***

There were a number of health issues which teachers indicated as being major or prevalent within their classrooms. These issues could be divided into two main categories – issues of health affecting the student directly and issues of health within a student's greater environment.

In terms of direct issues, the most common issue teachers cited were poor nutritional choices. Teachers claimed that students had limited knowledge of healthy food choices, specifically confusing “junk food” as a healthy food choice. Another major issue cited by teachers was the lack of physical activity or a “sedentary lifestyle,” and increased use of “screen time.” Teachers said their students did not engage in enough exercise and claimed they spent “too much time playing video games,” or “thinking video games is physical activity.” Many teachers also noted that students did not appear motivated to engage in physical activity. Other common issues teachers mentioned included viruses/contagious disease, stating that “stomach bug, colds, and flu are significant health concerns;” and a lack of sleep, as a result of “students staying up too late.” Teachers also reported mental and social health as being an issue which students faced, citing “ADHD, OCD, depression, anger, and other mental health issues,” as playing a role in the health of their students.

In terms of environmental-related issues, the number one issue cited by teachers was poverty and the lack of access to healthy options as a result. Seven teachers cited poverty, saying it affected “healthy eating, sleeping, and exercising” as well as limited “access to healthy choices – healthcare or food.” Teachers also named “stressful events at home,” “domestic violence and substance abuse at home,” and “smoking in the home” as significant environmental factors affecting a student’s health. In turn, Teachers also discussed their inability to affect some of these “at-home” issues, stating, “It’s hard to know boundaries and have an impact at home ... where healthy habits aren’t practiced.”

### ***Teacher Role***

Across the board, teachers were certain that their number one role in health education and promotion was through active role modeling and demonstration of healthy behaviors and

activities. Many teachers claimed that they modeled a “healthy lifestyle” for their students, taking note that it was part of their job to “help them identify and understand healthy choices.” One teacher noted that they could help to “influence healthy decisions.” Teachers identified nutrition as a key modeling point, often engaging in the practice of eating healthy food in front of their students and/or talking about healthy snacks with their students to help encourage healthy food choices. Teachers also mentioned exercise and physical activity as a major modeling point. Within the K-2 grade levels, the use of daily “movement breaks” were common; teachers would show/engage the students in physical activity between subjects. Within the 3-5 grade levels, teachers cited recess as a chance to model movement, with one teacher “exercising with students 2 days a week.” Beyond nutrition and physical activity, many K-2 teachers also mentioned modeling disease-prevention techniques, specifically “washing hands” and “covering coughs.”

In terms of their greater role within the classroom, many teachers cited that they had a big impact on the social-emotional growth of their students, playing a role in students “feeling good about who they are,” and acknowledging that they serve as a “trusted adult to students.” Some teachers cited teaching “self-regulation” techniques and helping “redirect choices,” when students did not make healthy decisions. There was only one teacher who felt they did not have an impact on their student’s health, citing the lack of time dedicated to health education, stating that there was “little to no direct instruction,” and so the impact they had in the classroom was limited.

### ***Methods of Instruction***

Teachers engaged in a number of different practices related to health education and the promotion of a healthy classroom; however, very few of these methods involved actual lessons related to health education and promotion. The most common method of health promotion within

the classroom involved movement breaks or “brain breaks,” to encourage children to participate in physical activity. Teachers also cited outdoor recess as a major tool of health promotion within the classroom, noting weather as a limiting factor to this approach. Disease prevention, specifically washing hands and covering coughs, was often promoted within the classroom, with teachers offering regular reminders to students. Teachers also encouraged healthy snacks, with some classrooms not allowing unhealthy snacks or “traditional birthday treats,” in an effort to increase healthy eating.

Another common method, specifically when dealing with social-emotional health, involved the use of “mindful breathing” and “mindfulness yoga.” This was especially common in grades K-2, where a number of teachers cited encouraging students to engage in practices of deep breathing or yoga-like activities. Others mentioned creating a “welcoming environment for positive emotional health,” and promoting “positive thinking” to ensure that students feel comfortable and safe within the classroom setting.

A limited number of teachers mentioned the use of actual lessons to engage in health promotion, citing lessons involving learning “how the body works and ways to keep it healthy,” and specific “health units” which covered various topics of health. One teacher mentioned that the majority of the health curriculum was taught in physical education, not in the regular classroom.

For the most part, teachers did not incorporate health education into other areas of learning (such as English Language Arts or Math), citing limited time and the pressure to meet standards in core subjects. When healthy living was incorporated into other subjects, however, it was overwhelmingly used in reading and writing lessons. Teachers might use books or passages in reading related to health, one cited the use of “themed emergent readers for guided reading

and sentence stories for writing prompts.” Others talked about making connections in math classes through the use of surveys or graphing related to healthy living; some teachers also mentioned the incorporation of healthy living into science topics, learning about the body and its functions.

### ***Barriers to Instruction***

The number one barrier teachers reported in teaching health education and promotion was the lack of time. Nearly every single participant mentioned that there was “not enough time to fit it all in,” and that the “restraints of time” limited their ability to teach health topics in their classroom. Many teachers also commented on the lack of mandated health instruction, responding that the majority of the emphasis is placed on “reading, writing, and math” and that such core subjects and the “demands of testing” dominated the school day schedule. Another major barrier to instruction was the lack of “money for resources,” and the lack of having access to easy and current resources for health promotion lessons and education.

Beyond the classroom, a number of teachers also mentioned outside factors, such as family and home life, as limiting their ability to teach effective health education. Some participants stated that “healthy habits were not practiced at home,” and that “kids weren’t able to incorporate healthy habits at home;” while others had to deal with unhealthy home environments. Finally, some teachers expressed uncertainty around when they might be “overstepping” and not sharing “appropriate information” with their students. When dealing with parents, teachers also experienced hesitation, one participant in particular, said, “It can be a tricky subject to bring up with parents as they can get defensive.”

### ***Teacher Wants***

There were a number of things which teachers stated would help them to better incorporate health education into their classroom – the most requested being more time in the school day or a “dedicated time in the schedule” for health education; some also cited a “longer school day” to allow for more health education incorporation. The second most requested tool were easily accessible classroom materials or “materials that were readily available with little prep.” Teachers also suggested the use of “digital tools” or “quick videos of important topics,” along with “ideas for bite sized lessons to fit into the limited time frame designated for health education.” Finally, some teachers requested “PD workshops and easy guides” or access to a “health educator to come in and teach lessons.”

### **Discussion**

It is clear, based on the findings, that teachers are passionate about creating healthy classrooms and experiences for their students, however, there also appears to be a major lack of resources and accessible information when it comes to the adequate instruction and incorporation of health education within the classroom. Teachers are faced with an absence of dedicated school health education time, limited curriculum and information, and feelings of detachment between home and school life. Additionally, it is clear that students in elementary school are facing significant health issues – obesity, lack of nutritious foods, lack of physical activity, social and emotional challenges – and that these issues do not discriminate based on the demographics of the school. Regardless of the percentage of students receiving free/reduced price lunch, teachers reported similar issues across the board, with poverty and substance abuse being just as common at high-income schools as those with lower-income levels. Furthermore, the most common health issues seen in this study are not surprising – their prevalence is backed up by statistics from

major organizations like the Centers for Disease Control and Prevention and the Child Mind Institute.

Teachers were very clear about their part in the classroom as role models of healthy behavior, often indicating that they would demonstrate and incorporate visibly eating healthy snacks, taking part in physical activity, and encouraging students to make healthy choices during the school day. It is important to note, however, that very few teachers mentioned actual health education instruction. The vast majority of classroom teachers never used a lesson plan with clear objectives or a specific health-related curriculum. Despite their dedication to serving as role models of health, teachers faced significant barriers when it came to fulfilling this role, most distinctly their limited ability to influence a child's health outside of the classroom. Teachers often stated that they did not want to overstep their role, fearing backlash from either the administration or the families of students. This correlates directly to previous research, which founds that teachers often felt like their "hands were tied," when it came to making certain decisions regarding health and their students (Patino-Fernandez, Hernandez, Villa, & Delamater, 2013).

Also of importance, is the connection between the barriers which teachers experience and the steps that they are taking to empower and educate their students on topics of health. As mentioned, many teachers felt limited when it came to the scope of their health education instruction, however, many of the topics they covered did not focus on empowering the individual child, but rather changing the child's environment. For example, many kindergarten through second grade teachers focused on nutrition (eating healthy food options), however, a Kindergartener has a limited choice of foods beyond what their families choose. In the later grades (third-fifth grade), children may have more of a say when it comes to certain

environmental factors, however, they are still limited in these decisions. So, while teachers often feel they have a finite scope of impact, their topics of instruction do not always assist in creating the most effective outcomes.

While the issues of health which students face are vast and the resources which teachers have available are limited, the importance of health education was clear to every single participant. Many teachers desire further professional development, a dedicated time to health education, accessible curricula, and a healthier classroom. This, is quite promising, as it reminds public health professionals and policy makers that despite limitations, classroom teachers are ready and willing to create healthier students and classrooms.

### **Limitations**

These findings help provide professionals with an insight into the state of health within Public School classrooms, through the eyes of a teacher. One limitation for this study includes the lack of location diversity – all of the schools participating were located in one area of the country. Additionally, the schools surveyed were all located in rural and suburban areas, with no schools from urban areas participating. This information would provide more insight into a broader range of academic settings and classrooms, allowing researchers to gain a clearer understanding of teachers' perceptions of health. As a result of the limited location diversity, many of the schools also had limited racial/ethnic diversity. In future studies, incorporating schools which are more diverse would take priority, in order to create a more accurate representation of teacher perception

### **Implications For School Health**

These findings have significant implications for public health professionals, curriculum specialists, school administrators, and policy makers. It is clear that classroom teachers believe in

health education and creating healthy classrooms, however, many feel limited due to a lack of resources. Public health professionals, along with organizations like the Centers for Disease Control and Prevention, should work to make their curriculum and resources more easily accessible. Many teachers expressed a desire for digital tools and short lesson plans, both of which currently exist through numerous organizations, however, there is a clear lack of publication and awareness. Furthermore, the creation of future curriculum should be sure to involve little to no resources/prep, in order to make them as accessible as possible. Short videos and activities, particularly between other subjects, appeared to be one of the most popular ways teachers chose to incorporate health education into their classrooms. The creation of these types of resources would most certainly help to increase the amount of instructional time within the classroom.

Curriculum should also focus on tools and topics which empower the student and allow them to make choices regarding their own health; rather than topics of health which affect the student's environment. By emphasizing health education which focuses on choices the student can make (rather than choices which involve the family), educators can increase their scope of impact, and lessen feelings of disconnect between home and school.

Very few teachers integrated health education into core subjects (reading, writing, and math), a tool which is an easy way to increase the amount of health education instruction which students are receiving. Similar to current guidelines regarding Arts Integration, public health professionals and educators should work to create a set of guidelines regarding Health Education Integration. This would allow an increase in health education instruction time, without detracting time from other major subjects. Additionally, when creating and planning school schedules, educational administrators and district professionals could work to incorporate mandated health

instruction into the school day. By setting aside a mandated time to engage in health instruction, teachers would be able to increase instructional time, by engaging in active curriculum-based health education.

Finally, public health and education professionals should promote and engage activities and events which connect the child's family to the school environment and health education process. Connecting with families, and engaging in health-education related activities, can help to promote environmental changes and support families in leading and living healthy lives. This could be done through regular health activity days, family workshops, and regular home-school communication regarding healthy topics. Educators and health professionals should take care to create opportunities which require a range of resources, so that all families may participate and continue to promote health within the home. Additionally, connecting children's families to the health education process, helps to reinforce for children the importance of preventive health and health education.

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