School Health Education in Dearborn

—*A Growing Program*—

By FRANK H. JENNE, M.P.H.

FOUR YEARS AGO the school health program in Dearborn, Mich., was primarily service-centered. Since then it has become education-centered, and it continues to grow in that direction.

The same general division of functions between the school and city health departments that existed in 1950 before a study was made is maintained today, except that the schools have vacated the treatment field. Each department has its own nursing staff. The school nurses are responsible for health education and health counseling in the schools, and for followup on school screening programs. The city is responsible for communicable disease control. The city health department provides environmental health service to the schools. It also serves as a channel for the school health department to the specialized services of the State health department. The entire relationship is maintained by frequent conferences between the directors of the two departments and through the Dearborn Community Health Council and the School Health Advisory Council.

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In recent years the Dearborn Community Health Council has been making a determined effort to strengthen the city health department's staff and facilities. An advisory public health commission has been established as a result of this activity and several new city nursing positions have been created. The health council's eventual goals include a laboratory, health educator, and a suitable health center for the city department, and a board of health with legal authority.

It was in 1950 that the School Health Advisory Council of Dearborn, including the board of education, school staff members, and parent and community representatives, studied the old program with a group of consultants from the University of Michigan School of Public Health. The study laid for the schools this philosophical footing for the new approach:

"The modern concept of education requires that we accept responsibility for the development of the whole child. Certainly, then, this includes the physical well-being of all children. Since we are an educational institution, our health program should be aimed primarily toward (*a*) providing that health knowledge which will result in desirable health attitudes and behavior, (*b*) providing a proper foundation for intelligent choices on the part of the individual so far as his own personal health is concerned, (*c*) discovering physical defects, and (*d*) exerting every effort to see that the remediable defects are corrected.

"The school is expected to assume responsi-

bility for the health instructional program and the development of desirable health attitudes and behavior. The school, cooperatively with the parents and family physician and dentist, is responsible also for the detection of physical defects.

"In the matter of treatment, however, it is the policy of the Dearborn city school district that this should be left to the family physician and dentist always keeping in mind that there will be a fringe of medically indigent families for whom treatment assistance must be secured."

The school health department's activity programs—roundup, screening, health appraisal, and topical fluoride—rest solidly on this footing as educational projects. Conversely, the health education program is largely one of activities. Parent as well as pupil participation results in carryover to the home, community support for the program, and material assistance in reducing the workload of the school nurses and teachers. Description of various phases of school health in Dearborn in light of these concepts will indicate the present status in the growth of the program.

Kindergarten Roundup

Roundups are held in the spring for pupils entering kindergarten in the fall and in the first semester for those entering in the second semester. The most successful programs from the standpoint of attendance are those to which parents receive a personal invitation from a parent worker. In one school in a growing neighborhood parent block workers ring doorbells of newly occupied homes and in this way obtain the attendance of parents not known through the school census. Often, this call represents the first contact in a new community and results in the recruitment of new parent-teacher organization members before they become involved in other social or civic activities.

The most successful roundups from the standpoint of program are those that are planned by the building roundup committee with guidance from the principal and nurse, and at which the parent roundup chairman, rather than the principal, presides.

The purpose of the roundup is to provide a happy introduction to all phases of the school program and to assist parents in preparing children for school. The principal, school nurse, visiting teacher (who is a trained social caseworker), and kindergarten teacher each has a part in the program. The nurse distributes and explains the personal health history form to be filled out by the parent and the health appraisal forms to be filled out by the family physician and dentist. She provides some general information about school health policies and the health needs of the school child. The social hour following the program gives her an opportunity to answer some personal questions and begin to get acquainted with the new parents.

Later, when the mother comes for her enrollment interview with the teacher, she has a "get-acquainted" interview with the school nurse or with the city health department district nurse who conducts the interviews in one building while the school nurse is busy in another. In the interview the nurse may obtain pertinent health information about the child which the parent or physicians have neglected to mention on the health form. She may also find parents who have neglected to have a health appraisal done and encourage them to do so. She may steer them to a community facility such as the city physician if that is indicated.

In this way, 95 percent of the entering kindergarteners had medical health appraisals in 1953–54. Ninety-three percent had complete immunizations. Eighty percent had a dental health appraisal, and 23 percent had topical fluoride applications before coming to school.

The number of fluoride applications approximately doubled, as a result of the city health department's 1953 summer fluoride program for preschool children. The school health department loaned its equipment and helped plan the project. Stations were set up in schools. Unfortunately, the program was not continued in 1954. It may be possible to give the service again in 1955 and enlist the support of the schools' parent health workers in increasing participation.

Screening: Vision and Hearing

The first activity after kindergarten interviews in the fall is vision screening. This is

carried out by the teachers with parent help under the guidance of the nurse. Units in eye health are taught and include such pupil activities as children measuring the light on their desks and preparing posters on eye health. The screening method used is the Snellen "E" chart with plus sphere lenses. Rechecks are made by the nurse before referral. The procedure was worked out with the help of the Michigan State Department of Health consultant and local ophthalmologists. Vision screening is scheduled for the junior primary through grade 6, and again in grades 8 and 10 and the first year of college. In college, the vision screening tests are carried out by a student committee with the guidance of the nurse.

Hearing screening follows much the same organizational and educational pattern as vision screening, except that it is performed by an audiometrist. Pamphlet materials and guides to visual aids for teacher use provided by the State health department are distributed by the nurse to teachers in grades 3, 6, 9, and 12 before the screening begins.

Sodium Fluoride Applications

Preparation for the sodium fluoride program begins with a building committee which may include the teachers, student representatives, parents, the principal, and the nurse. It is the committee's job not only to sell the program to parents and children but also to set up activities that will result in improved dental health practices.

Pupils make posters advertising the fluoride program and display them in the building. The program is often explained to parents at meetings as well as through letters. Second graders write and produce puppet shows and give toothbrushing demonstrations with the large tooth-and-brush models at meetings attended by their parents. After the show, tasty and attractive but healthful refreshments are served. The dental hygienist may be invited in to help a grade 5 class with its project. Eighth graders may collect specimens for lactobacillus counts and send them to the Michigan Department of Health laboratory. In general, the activities of the younger pupils are at the level of drama and imitation, and such children delight in the mastery of the process of toothbrushing. Older pupils are more interested in the technical and scientific aspects of dental health.

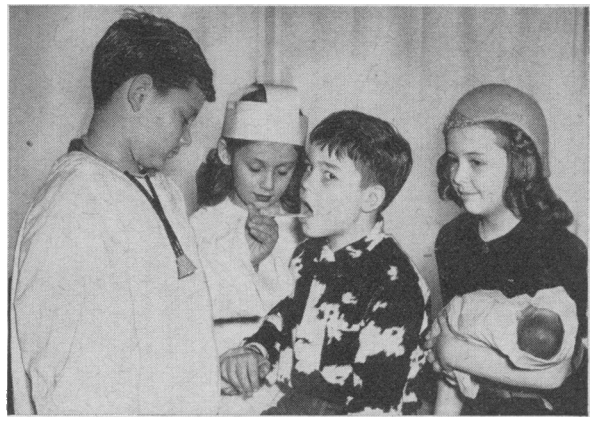

Figure 1. "Mother" brings "child" to "family doctor" for a health appraisal.

The topical fluoride program has become well known to many parents since its beginning in 1950. Several parent groups have therefore held programs on water fluoridation with speakers supplied by the local dental society.

Slightly more than 90 percent of the pupils in the eligible grades accept the fluoride applications. Eighth grade pupils sign the request form themselves, in addition to obtaining their parents' signatures. This gives them a chance to exercise some responsibility for their own health. The school nurse refers indigent children to the city health department dental clinic for needed care.

Health Appraisal

One of the specific objectives of Dearborn's health education program is to establish the attitude that periodic medical and dental checkups are an important part of healthful living. After the first health appraisal upon entering kindergarten—or the school system for the first time—additional examinations by the family doctor and dentist are asked for in grades 3, 7, and 10, and the first year of college.

Educational preparation for this event at the lower grades includes the use of visual aids, the nurse or a neighborhood physician as a resource person, and role-playing, by the pupils, of examination procedures (fig. 1). At the high

school level, students prepare and present panel discussions on health appraisal in their English classes. In junior high school, an instructional unit is given by the physical education teacher. This unit seeks first to motivate the student to have an appraisal. It also discusses the physician-patient relationship, the problem of selecting a physician, and quackery. Correlated activities are also carried out by the art, science, homemaking, and "block of time" (English and social studies) teachers.

Orientation programs for pupils entering high school (grade 10) and their parents were developed this past year. They follow to some extent the objectives and pattern of the kindergarten roundup. This activity gives the nurse an opportunity to explain the health appraisal to parents who are no longer active in parent-teacher associations and other school activities. In fact, the orientation programs resulted in considerable parent interest in developing increased parent participation at the secondary level.

The health appraisal program recognizes the fact that junior and senior high school students take increased responsibility for their own health care and that the college freshman is almost solely responsible. In practice, medical appraisals are obtained by 60 to 75 percent of the pupils in grades 3 and 7. This jumps to 97 percent in grade 10 and 90 percent in first year of college. Thirty to forty percent have dental appraisals. One reason for the high 10th grade participation is the reluctance of physical education teachers to permit strenuous activity without the protection of a health appraisal report.

The health appraisal includes a personal health history filled out by the pupil and his parent. Instead of a checklist of procedures, the physician's portion of the form contains questions designed to reveal conditions of which the school should be aware and to bring out specific recommendations for necessary modification of the child's school activities.

Health appraisals for indigent children are regarded as a community rather than a school responsibility. It is the nurse's job to see that school children from indigent families are introduced to the community health resources they need.

Educational Activities

A statement "What Do You Believe About Health Education?" was developed by the school health department staff and instruction personnel (see p. 61). The statement was designed to crystallize a school health philosophy in Dearborn. How this philosphy is carried out varies from year to year and from school to school because of the concept of student-staff planning.

At one building, for example, students must cross a major highway to reach their play area. Despite heavy truck traffic there is no stop light. To reinforce their demand for action, students counted the number of cars and trucks passing the school—some 800 per hour. Staff, parents, and pupils worked on the problem, which was complicated by a question of which of several government units was responsible. Once this problem is solved, attention will be turned to others which can provide worthwhile learning experiences and achieve worthwhile objectives.

In other schools an inadequate breakfast at home is a perennial problem. This is something that requires home-student cooperation. Fourth grade youngsters almost traditionally tackle this problem by putting on a breakfast or luncheon in the school lunchroom for their parents (fig. 2). Usually the menu includes several choices to demonstrate different kinds of good breakfasts. A skit, written and presented by the children, dramatizes the kind of breakfasts they would like to have each day,

Figure 2. Parents join children in eating a "good" school lunch.

Statement on School Health Education

Do You Believe that . . .

▶health education is a continuous experience in healthful living throughout the entire day?

▶health education is a part of every phase of the student's experience in school and out, but improvement of living at school should be our first concern?

▶health instruction should make the maximum use of the health implications inherent in all subject areas?

▶health instruction should recognize personal and group problems of health and actually come to grips with the problems?

▶health instruction should build upon and reinforce the health understandings, habits, and attitudes developed in preceding grades?

▶the health status of students should be given consideration when determining the type of educational program in which they will participate?

▶to establish effective health habits, attitudes, and practices the school must provide a healthful environment?

▶health instruction is an integral part of all of the student's experiences?

▶health instruction is the responsibility of every member of the total staff?

▶health education should result in healthful living, and that correction of defects and mastery of health facts do not necessarily insure healthful living?

▶health instruction extends beyond the course of study and the coverage of material in a basic text?

▶the health program can best be evaluated in terms of behavioral changes?

▶improved behavior is more certain to result when health instruction has been given through the problem-solving approach where students and staff plan and work together?

including some pointed bits of business about the conduct of adults at the breakfast table.

Other schools have tackled the first aid problem. The usual result is a first aid kit and manual written by and for each school and each room. This activity has perhaps helped as much as anything else to establish the school nurse as the school health consultant rather than a finger-wrapper.

The bicycle safety situation became a real problem in one school, especially with conflicting advice from parents and teachers about street versus sidewalk riding and left-side-of-the-street versus right. Parents, staff, and children met with a policeman and other safety experts and wrote their own bike-safety manual. This mimeographed pamphlet got the message across much more effectively than an expensively printed manual prepared by experts could have done because it was written by those who use it.

Halloween treats of candy—often sticky, unwrapped, and insanitary—got the attention of one school. The result: an attractive leaflet, written and illustrated by the children, listing the kinds of treats they would like to have.

These are but a few examples of the kinds of health education activities in Dearborn schools. Some of them are classroom activities. Others are sponsored by health and safety committees of the student councils. All of them require planning that involves students, teachers, and the nurse and may also involve parents and representatives of community agencies.

The Basic Text

At first the concept of health education as extending "beyond the course of study and the coverage of material in a basic text" was interpreted as the "beyond" only without "a basic text." Of late, as teachers have seen health instruction needs that remain unmet and as they have seen some of the excellent new texts available, an increasing number of requests for text books have come to the director's office.

During 1952–53, the system's elementary health curriculum committee developed screening criteria to be applied to the several health text series available. One of these criteria calls for a text that will stimulate activities of the sort described in this paper and will not substitute for them a simple reading program. Following the preliminary screening, classroom

pilot studies were made in 1953–54 to determine which series will finally be adopted for use. Carefully screened audiovisual aids and other materials are already available to teachers for enrichment of health teaching and include free materials suggested and furnished by the city health department.

In 1951 a committee was appointed to prepare an improved junior high school health and physical education curriculum. A handbook was prepared and texts selected after 2 years of work and study in which consultants from outside the system participated. Now, after 1 year of use, teachers and principals have submitted their comments on the strengths and weaknesses of the course. Their suggestions are being reviewed by the committee and recommendations for further improvement will be made.

Basically, the junior high school course involves a third of each semester devoted to health classes offered by the physical education instructor best qualified to teach health, with the remainder of the time spent in the gymnasium, pool, or on the playground. These classes include units on physical health and safety, first aid, and personality. Additional units, appropriate to the content of the course in which they are placed, are offered in "block of time" (English and social studies), general science, homemaking, and industrial arts.

Work on a senior high school health curriculum has just begun as part of a systemwide overhauling of the secondary curriculum. Students have been polled informally as to their interests and needs. Courses of study from other systems have been reviewed, and a list of specific objectives is in preparation. Each high school now has an active future nurses club of which the school nurse is faculty sponsor. Some excellent health teaching is going on but on a "hit or miss" basis.

The new curriculum will emphasize preparation for family and community responsibilities. Instructional responsibility will be shared by the various departments. Teachers will work, not from a set course of study, but from a resource guide which will suggest several alternative methods and list a variety of available resources for use in achieving each objective.

Staff Organization

The school nurse is the sparkplug of the health education and activity program within each school. The 15 nurses employed by the board of education serve 29 public schools, the junior college, and 8 parochial schools. The parochial schools are served on the same basis as the public schools, but lack the advantage of well-organized parent groups. Each nurse serves from 1,500 to 2,200 children in from 1 to 3 schools. A bachelor's degree is required for employment. The staff is remarkably stable. It has a history of only one or two resignations a year.

The successful school nurse in Dearborn shares the leadership of the health program in her school. She has active committees at work on real health problems—yet she knows better than to organize a committee just because one is suggested in the Handbook for Parent Health Workers. She has an infectious enthusiasm for her job that enables her to pile hours of work on busy principals, engineers, parents, teachers, and children and make them love it. She devotes her noon hours to informal conferences with her teachers, for her conception of a "consultant's" job is "to consult" rather than "to be consulted." She works closely with the visiting teacher and counselor, for she is conscious of the mental health implications of her work. She devotes many evenings to committee and staff meetings.

The 8 city health department nurses and their supervisor hold occasional joint meetings with the school health staff. The school and public health nurses serving the same family are encouraged to consult each other directly rather than through interdepartmental channels.

Besides the nurses, the schools employ three dental hygienists, a dentist who gives professional supervision to the fluoride program as required by law, an audiometrist, and the director.

The city health department's sanitarians make frequent inspections of the schools, with special attention to the food service and swimming pool areas. The director of school health analyzes accident reports to find correctable safety hazards.

There is no school physician. Medical advice

is provided as needed by the president of the Dearborn Medical Society, the city health officer, and the city physician.

These physicians, together with the systemwide parent health chairman and representatives of the Dearborn Dental Society, members of the board of education, teachers, principals, school administrative officers, and parochial school, school nursing, and community agencies sit on the School Health Advisory Council, which meets once a month to consider citywide school health problems.

Dearborn also has a well-organized and active community health council in which both school and city health department staffs participate.

Health and physical education policies were last revised and published in 1951. These are interpreted for the staff in the School Nursing Manual, a looseleaf publication that is under constant revision by the staff and the director. In addition, bulletins covering each phase of the systemwide program are issued each year at appropriate times through the offices of the assistant superintendents.

The school health department has a consulting and advisory, or staff, function. Line authority begins with the superintendent and extends down through the classroom teacher. Policies are developed cooperatively by the line and staff organizations and placed in effect by the line.

For example, a parent and a nurse called the attention of the director to flaws in the system of notifying parents when cases of communicable disease occur in the classroom. The problem was discussed by the School Health Advisory Council, and a committee including a principal, nurse, parent, the city health officer, a representative of the medical society, and the director of school health drew up a recommended procedure including several form letters of an informational nature to be sent to parents. The recommendation was reviewed and approved—first, by the council; then, by the superintendent and his staff, who sent out a bulletin placing the new procedure in effect.

Under this plan of operation each group concerned has a voice in the development of policy, but the authority for implementing policy remains with the line. Much confusion is thus avoided.

The devotion of the health staff and the active cooperation of the board, the administration, parents, and teachers, rather than the pattern of operation, make it possible for Dearborn's school health program to grow and flourish.

Venereal Disease Postgraduate Course

The 23d venereal disease postgraduate course will be given at Tulane Medical School from January 31 through February 4, 1955, under the cosponsorship of the division of graduate medicine and the Public Health Service. The 1-week course accredited by the American Academy of General Practice covers the latest developments in diagnosis, treatment, and management of the venereal diseases and is open to all physicians. Application for enrollment should be sent to Dr. Clifford Grulee, Jr., director of the Division of Graduate Medicine, Tulane University of Louisiana, 1430 Tulane Avenue, New Orleans, La.