



Assessing Elementary Health Education: Instrument Development for School District Readiness and Delivery

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ABSTRACT

Background: Although the connection between health behaviors and Health Education is well established, elementary Health Education (EHE) readiness and delivery has been challenging to assess. **Purpose:** This research was intended to develop and test a valid and reliable instrument to assess school district readiness for and delivery of EHE. The transtheoretical model was the foundation for creating the Elementary Health Education District Assessment Tool (EHE-DAT). **Methods:** Development occurred in 3 phases: review, pilot study, and case study. Validity was established through quantitative and qualitative jury review, a focus group, and administrator interview. For reliability, the EHE-DAT was piloted in a local school district ($n = 31$) and case study of a second district ($n = 161$). **Results:** The EHE-DAT was found to be reliable and valid. All scales and subscales were determined to have high levels of internal consistency (coefficient $\alpha = .739$ to $.927$). **Discussion:** States and professional organizations could apply the EHE-DAT on a wider scale. The EHE-DAT is customizable for states or grade levels where EHE requirements vary from Alabama. **Translation to Health Education Practice:** The EHE-DAT has implications for EHE practice and accountability. By determining school district engagement in readiness behaviors and practices, it provides a starting point for bridging the gap between state standards and EHE delivery.

ARTICLE HISTORY

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Background

Health Education is the sequence of intentional learning experiences designed for improving individual and community health through improved knowledge and attitudes.¹ Research indicates that Health Education can reduce the prevalence of health risk behaviors related to chronic disease.² Specifically, health behaviors such as nutrition, physical activity, tobacco prevention, and other lifestyle choices that reduce chronic disease risk in adulthood are positively impacted by Health Education during childhood.³ Access to elementary Health Education is a powerful venue for bettering the health of children.⁴ Health Education strongly influences health promotion and the prevention of chronic disease in students.⁵ Ultimately, Health Education and health behavior can increase years of healthy life and quality of life while breaking the cycle of poverty.⁶

An increase in the delivery of elementary Health Education (EHE) is an objective of Healthy People 2020.⁷ Although the majority of states mandate EHE, only approximately 37% of school districts report specific time allotments for the subject.⁸ Political pressures, district and superintendent agendas, policy gaps, and

standards and accountability issues are pivotal in the wide variation of quality and frequency of EHE delivery.

Even though elementary schools may be required to include Health Education, accountability is lacking. The amount of time and number of days on which EHE is provided differs according to district and state. This leads to wide variation in the quality and frequency of health instruction. In Alabama, Health Education provided by teachers certified in elementary education is required in kindergarten through eighth grade.⁹ Additionally, Alabama guidelines suggest that there should be 60 minutes of health instruction per week separate from physical education. Because the State Department of Education in Alabama is not a regulatory agency, health is only included on compliance reviews as it relates to the school nurse.

Researchers and educators alike call for a transformative process that results in needed systemic change in education.¹⁰ The Transtheoretical Model (TTM) asserts that change occurs over time in 5 sequential readiness stages:

1. Precontemplation—not intending to act in the next 6 months.
2. Contemplation—intending to act within the next 6 months.
3. Preparation—intending to act in the next 30 days.
4. Action—made behavior changes less than 6 months ago.
5. Maintenance—made behavior changes more than 6 months ago.¹¹

These distinct stages or levels of readiness are further defined by differing beliefs, attitudes, and information receptiveness.¹² The TTM also includes the core constructs of self-efficacy (confidence) and decisional balance (pros and cons of changing), which are strong predictors of behavior change.¹³

Organizations, such as school districts, have the potential to be powerful agents of change. Empirical evidence consistently supports the application of the TTM to facilitate organizational change in a wide variety of organizational settings.^{13,14} According to the TTM, success may depend on the organization's readiness to change.¹⁵ Utilization of the TTM is able to have an unprecedented effect on employees by using individual responses based on organizational readiness to minimize resistance and maximize the probability of successful change.¹³

Research has not been identified that applies the TTM to school district change in EHE. Additionally, no instruments or studies were found that address readiness for EHE. These gaps support the need for the development of a tool to assess school district readiness and delivery of EHE. Organizational readiness for the current study will be determined by the collective responses of the teachers and administrators within the school district. This grouping of employees to represent the organization as a whole is consistent with current literature applying the TTM to organizational readiness.^{13,14}

Purpose

The purpose of this mixed methods research was to develop and test a valid and reliable instrument to assess school district readiness for and delivery of EHE in Alabama. The development of the instrument occurred in 3 phases: qualitative and quantitative review, school district pilot study, and subsequent school district case study.

The current study used the TTM as a foundation for developing the Elementary Health Education District Assessment Tool (EHE-DAT). Specific TTM constructs comprising EHE-DAT sections included stage of readiness, decisional balance, self-efficacy, and the variables of

behaviors and practices. The target behavior for the school districts was to provide EHE that requires 60 minutes of weekly delivery separate from physical education by a certified teacher in elementary education.⁹

Methods

An initial draft of the EHE-DAT was written based on the Alabama Course of Study, a staging algorithm to assess school district readiness for EHE, and factors proven to impact Health Education delivery. The EHE-DAT was designed with 7 sections originating in state standards, TTM constructs, and current literature (see Table 1). Operational definitions were provided using lay terms in each section of the EHE-DAT to clarify understanding of instrument items (see Appendix A).

In the state of Alabama, 60 minutes of weekly Health Education (separate from physical education) provided by teachers certified in elementary education is required in elementary grades.⁹ This three-pronged state guideline was used to define EHE delivery within the instrument and as a foundation for EHE-DAT Section I (Current Delivery). In the state of Alabama, elementary schoolteachers are typically certified to teach all subjects in a self-contained classroom; therefore, *certified* is unspecified.

For the current study, *readiness* was defined as the intention to deliver EHE.¹⁴ Readiness (Section II) was assessed by using a staging algorithm, a set of decisional rules robust across populations and behaviors.¹¹ Customized for EHE, the algorithm reads as follows: *Given your role in the school district, are you ensuring the delivery of elementary Health Education?*

NO, and I do not intend to in the next 6 months.

NO, but I intend to in the next 6 months.

NO, but I intend to in the next 30 days.

YES, I have been, but for less than 6 months.

Multiple-choice responses for EHE readiness correspond to the TTM stages as seen in Table 2.

Decisional balance, the consideration of the pros and cons of delivering EHE, was assessed in Section III of the EHE-DAT.¹⁴ The Pros subscale and Cons subscale

Table 1. Origins of EHE-DAT sections.^a

| EHE-DAT section | Origin |
|----------------------------|------------------------|
| Section I Current Delivery | State standards |
| Section II Readiness | TTM stages of change |
| Section III Pros and Cons | TTM decisional balance |
| Section IV Confidence | TTM self-efficacy |
| Section V Beliefs | Current literature |
| Section VI Practices | Current literature |
| Section VII Demographics | Current literature |

^aEHE-DAT indicates Elementary Health Education District Assessment Tool; TTM, transtheoretical model.

Table 2. EHE-DAT section II responses and corresponding stage of change.^a

| EHE-DAT Section II response | TTM stage of change (readiness level) |
|--|---------------------------------------|
| NO, and I do not intend to in the next 6 months. | Precontemplation |
| NO, but I intend to in the next 6 months. | Contemplation |
| NO, but I intend to in the next 30 days. | Preparation |
| YES, I have been, but for less than 6 months. | Action |
| YES, I have been for more than 6 months. | Maintenance |

^aEHE-DAT indicates Elementary Health Education District Assessment Tool; TTM, transtheoretical model.

were composed of the even- and odd-numbered items, respectively. *Self-efficacy* (Section IV) was defined as confidence in one's ability to successfully deliver EHE in specific situations.¹⁴

A comprehensive literature review was conducted to identify factors relevant to the delivery of EHE such as instructional time, teacher preparation, and priorities.³ Furthermore, barriers such as limited planning time and lack of resources were considered in item creation.¹⁶ These factors provided the foundation for Section V (Beliefs) and Section VI (Practices) of the EHE-DAT. Finally, Section V (Demographics) addressed basic and EHE-related demographic information. The tool was intended to be completed by participants with pencil and paper. The collective responses of the participants defined and are referred to as the school district results. Institutional review board approval through the University of Alabama at Birmingham was granted for the pilot and subsequent study. Participants gave implied consent through the return of the completed EHE-DAT as described in a cover letter. The purpose of the study, participant rights, and voluntary involvement were also described in the cover letter. The two participating school districts for the pilot and subsequent study were selected because of district administrator interest and willingness, as well as geographical location in Alabama.

Phase I: Qualitative and quantitative review

Once the draft was written, content validity was established by carefully selecting a jury of experts, performing one qualitative review, performing one quantitative review, and revising the instrument according to feedback. Jury selection criteria were based on job position, experience, and availability. Specifically, this included 10 individuals with expertise and experience in education, Health Education, or instrumentation; a willingness to serve on the jury; and the ability to complete the task in the researcher's time frame. Six of the jurors were full or associate professors in their fields of Health Education, Educational Research, and Educational Leadership at the University of Alabama in Birmingham. Two jurors were professors at the University of Alabama ranked as full or associate

professor in Health Science. Finally, one juror was a retired public school administrator and one juror was a retired public elementary schoolteacher. A minimum of 5 jurors was needed to meet the minimum requirements for the content validity ratio.¹⁷

Jury review

Formal review of the EHE-DAT was completed by the jury of 10 experts through one round of qualitative review and one round of quantitative review with revisions made according to feedback. The qualitative portion was based on McKenzie et al's table of specifications for qualitative review.¹⁷ It included appropriateness, completeness, and clarity of the instrument title, directions, content areas, and instrument items. Each component of the instrument was analyzed and consensus was determined. For the quantitative review of the EHE-DAT, jurors rated each item's appropriateness by indicating whether the item was essential, useful but not essential, or not necessary.

Focus group

After jurors performed both qualitative and quantitative review, a focus group with 6 elementary schoolteachers from a variety of elementary schools and an interview with an elementary administrator were conducted in a local school district. They provided further open-ended feedback on clarity, readability, and relevance for the revised version of the instrument.

Phase II: Pilot study

Reliability

To assess reliability, the EHE-DAT was piloted with 31 elementary schoolteachers and administrators in Alabama outside of the school district involved in the subsequent case study. Data were self-reported by the participants and collectively used to represent school district readiness for and delivery of EHE. Two types of reliability were assessed: test-retest reliability and internal consistency reliability. The instrument was administered to the pilot group on 2 occasions, one week apart in order to establish evidence of stability through test-retest reliability. The relevant scales and subscales

included in these analyses were Current Delivery, Readiness, Decisional Balance (Pros and Cons), Self-efficacy, Beliefs, Practices, and Demographics.

Phase III: Case study

The case study was delimited to the self-reporting of elementary schoolteachers, school administrators, and district administrators in the selected Alabama school district. As with the pilot study, responses were used collectively to determine school district readiness for and the delivery of EHE. To be clear, the school district was not the same as used in the pilot study. EHE-DAT administration took place during the school district's annual in-service meeting. This proved to be an ideal time for data collection because school district faculty and administrators were required to attend. Completion of the EHE-DAT took approximately 10 minutes.

Results

Phase I: Qualitative and quantitative review

Based on juror responses, a revision to the Likert-scale choices for the Confidence section of the EHE-DAT was made. Originally, the choices ranged from *not at all important* to *extremely important*. Revised choices were worded *not at all confident* to *extremely confident*. The wording was changed for consistency with the Confidence section.

Content validity

Content validity is determined by “demonstrating that the items in the test appropriately sample the content domain.”^{18(p565)} A content validity ratio (CVR) was calculated for each instrument item using quantitative responses from the jury of experts. The following formula was employed for CVR calculation:

$$CVR = \frac{(n_e^1 - N/2)}{N/2}$$

Table 3. Test–retest reliability of the scales and subscales of the EHE-DAT.^a

| EHE-DAT scale/ subscales | Number of items | Pearson's correlation coefficient |
|-----------------------------|--------------------|--------------------------------------|
| Current Delivery | 3 | 0.860 |
| Readiness | 1 | 0.978 |
| Decisional Balance | 3 | 0.802 |
| Pros | 3 | 0.841 |
| Cons | | |
| Self-efficacy | 6 | 0.808 |
| Beliefs | 6 | 0.759 |
| Practices | 6 | 0.815 |

^aEHE-DAT indicates Elementary Health Education District Assessment Tool.

where n_e is the number of jurors essential and N is the total number of jurors.¹⁸

The resulting ratio indicates a “linear transformation of a proportional level of agreement on how many experts within a panel rate an item essential.”^{19(p79)} According to Lawshe, based on the jury size of 10, the minimum CVR value for instrument items to be significant at the $P < .05$ level was 0.62 (one-tailed test).¹⁸ Thirty-one items did not meet the minimum CVR value of 0.62. Those items were removed from the instrument.

Face validity

The focus group established face validity of the EHE-DAT by giving input on the clarity, readability, and relevance. The group reached consensus that the instrument should be shortened so that the participant would not feel overwhelmed by the length. As a result, extra spaces were deleted and the EHE-DAT page length went from 4 pages to 3. One teacher suggested shortening or deleting the directions because “teachers are busy and won't read them anyway.” Another teacher concurred that she “only skimmed the top of the directions.” Consensus was reached that during the actual administration reading the directions carefully should be emphasized. The administrator who was interviewed offered no suggestions for improvement but suggested that 20 minutes allowed for EHE-DAT administration might be an overestimate.

Phase II: Pilot study

Reliability

Test–retest reliability using the Pearson reliability coefficient (r) provided evidence of stability over time. Table 3 shows the reliability coefficients for the scales and subscales of the EHE-DAT. Correlations ($n = 31$) ranged from 0.759 to 0.978 with the lowest score being the Beliefs Scale ($r = 0.759$) and the highest being the Readiness Scale ($r = 0.978$). Scores are considered reliable at 0.6.²⁰ Correlations showed that the scales and subscales were reliable and significant at the $P < .01$ level.

The first administration provided data to assess internal consistency reliability. A scale is considered reliable if items that comprise the scale are internally consistent.²⁰ Internal consistency reliability of the EHE-DAT was assessed by Cronbach's alpha (α) for relevant scales and subscales of the instrument based on the participant responses from week 1. These scales and subscales included Current Delivery, Pros, Cons, Self-efficacy, Beliefs, and Practices (see Table 4).

Table 4. Pilot study internal consistency reliability of EHE-DAT scales and subscales.^a

| EHE-DAT scale/ subscale | Number of items | Cronbach's alpha | Cronbach's alpha after deleting 2 items |
|----------------------------|--------------------|---------------------|--|
| Currently Delivery | 3 | .762 | |
| Decisional | 3 | .852 | |
| Balance | 3 | .752 | |
| Pros | | | |
| Cons | | | |
| Self-efficacy | 6 | .897 | |
| Beliefs | 6 | .671 | .701 |
| Practices | 6 | .818 | |

^aEHE-DAT indicates Elementary Health Education District Assessment Tool.

Internal consistency

Recommended good to excellent levels of internal consistency are 0.70 and higher.²¹ Table 4 shows the internal consistency reliability ($n = 31$) for the sections and subsections of the EHE-DAT. Coefficient α increased from .671 to .701 for the Beliefs Scale after 2 items were deleted due to low item-total correlations. (See Appendix A for final version.)

Phase III: Case study

There were 174 EHE-DAT participants, but 13 surveys were incomplete and subsequently excluded from the case study. A total of 161 school district faculty and administrators completed the EHE-DAT in entirety. All respondents indicated that they held current Alabama teaching certification.

Internal consistency

As with the pilot study, internal consistency reliability of the EHE-DAT was measured by Cronbach's alpha (α) for relevant scales and subscales of the instrument based on participant responses ($n = 161$). Table 5 shows the internal consistency reliabilities for the scales and subscales of the EHE-DAT. All scales and subscales were determined to have high levels of internal consistency with coefficient α ranging from .739 to .927. Findings were similar to those of the pilot study reliability analyses.

Table 5. Case study internal consistency reliability of the EHE-DAT scales and subscales.^a

| EHE-DAT scale/subscale | Number of items | Chronbach's alpha |
|------------------------|-----------------|-------------------|
| Currently Delivery | 3 | .741 |
| Decisional Balance | 3 | .814 |
| Pros | 3 | .878 |
| Cons | | |
| Self-efficacy | 6 | .927 |
| Beliefs | 4 | .813 |
| Practices | 6 | .739 |

^aEHE-DAT indicates Elementary Health Education District Assessment Tool.

Discussion

The present research provided encouraging findings with demonstrated reliability and validity for the EHE-DAT with all scales and subscales having levels of internal consistency. The study was delimited to elementary schoolteacher and administrator self-reporting of EHE delivery and readiness. It was not intended to be predictive of or include observation of teaching practices. Future research could include assessing additional school districts in Alabama and perhaps observing teacher instruction of EHE or lesson plans examination. State professional organizations could apply the EHE-DAT on a larger scale involving multiple school districts, but caution must be exercised in generalizing the results. For data collection with a broader number of participants, an electronic version of the EHE-DAT could be developed.

Modification

The nature of the first section of the tool allows for modification of the target behavior. Thus, the EHE-DAT is customizable for use in other states or grade levels where EHE requirements vary from those in Alabama. However, even if only small changes are made to an existing instrument, the psychometric properties will change and new data should be collected through a new pilot study.²²

Timing and setting

The following recommendations are suggested to improve the timing and setting for use in school districts. First, the timing of the survey might be improved by administering the EHE-DAT in the middle or at the end of the academic year. Typically, teachers and some administrators have a month or two away from school during the summer. This absence may affect perceptions upon returning to a new academic year. However, it could be that end-of-year administration could prove to be a stressful time for teachers and administrators. Secondly, survey administration conditions may be more favorable if teachers and administrators were surveyed in separate settings. It is feasible that teacher participation and/or responses may be affected by an awareness of their principal's or district administrator's presence in the room.

Translation to Health Education Practice

Although the connection between health behaviors and EHE is well established, EHE readiness and delivery has

been challenging to assess without an appropriate instrument. This mixed methods research was intended to develop and test a valid and reliable instrument to assess school district readiness for and delivery of EHE in Alabama. Using the TTM as a framework, the EHE-DAT development aids in addressing EHE instructional practices, school district and state policy, policy accountability, readiness, and professional development. EHE-DAT data could be used to assist in school district design, implementation, and evaluation of EHE. Examples might include creating school district policy requiring adherence to the guidelines for elementary health education in the *Alabama Course of Study*, providing health curriculum and textbooks, increasing instructional and planning time for elementary schoolteachers, and ongoing Health Education professional development for elementary schoolteachers and administrators.

Customized intervention

EHE-DAT administration yields data identifying school district readiness for EHE and school district behaviors and practices that facilitate or impede EHE. This specialized data can result in a customized stage-based intervention with a potentially more powerful impact than generic interventions.¹⁰ Following a school district intervention, the EHE-DAT should be re-administered to evaluate readiness progression in the school district.

Implications

The creation of the EHE-DAT also has implications for improving EHE practice and accountability. The instrument identifies whether there is a gap between the school district's current delivery of EHE and state standards. Additionally, it determines the extent to which the school district engages in EHE readiness behaviors and practices. Results gained from EHE-DAT assessment could be used to justify funding EHE materials and professional development. Data could also be used to encourage accountability practices such as including EHE as a separate subject on report cards and requiring teachers to submit EHE lesson plans. The development and application of the current instrument provides a starting point to bridge the gap between state standards and delivery of EHE. Identifying school district readiness for and delivery of EHE is paramount given the established connection between chronic disease, health behaviors, and Health Education at the elementary level.

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Appendix A: Elementary Health Education District Assessment Tool (EHE-DAT)

This survey asks questions about elementary Health Education. Keep this definition and these criteria in mind as you answer the questions:

Health Education is the combination of planned learning experiences that are designed to help individuals and communities improve their health through increasing knowledge or influencing attitudes.

Elementary Health Education Delivery

- (1) 60 minutes weekly
- (2) Separate from physical education
- (3) Provided by a certified teacher
- (4) **Current Delivery**

Please respond to the following questions by placing an “x” in the appropriate space:

| In your experience with this school district, to what extent is elementary Health Education delivered ... | Not at all | A little | Moderately | Quite a bit | Completely |
|---|------------|----------|------------|-------------|------------|
| 60 minutes weekly? | | | | | |
| Separate from physical education? | | | | | |
| Provided by a certified teacher? | | | | | |

(5) Readiness

Keeping the entire definition and criteria in mind and given your role in the school district, are you ensuring the delivery of elementary Health Education?

- NO, and I do not intend to in the next 6 months.
- NO, but I intend to in the next 6 months.
- NO, but I intend to in the next 30 days.
- YES, I have been, but for less than 6 months.
- YES, I have been for more than 6 months.

(6) Pros and Cons

Please tell us **how important** each item is in your decision about whether or not to ensure the delivery of elementary Health Education.

| My decision to ensure the delivery of elementary Health Education means that ... | Not at all important | Somewhat important | Moderately important | Very important | Extremely important |
|--|----------------------|--------------------|----------------------|----------------|---------------------|
| My workload will increase. | | | | | |
| Students will be healthier as adults. | | | | | |
| It will take away instructional time from other subjects. | | | | | |
| Students will be less likely to get sick. | | | | | |
| It will take a lot of planning. | | | | | |
| Students will be more knowledgeable about health. | | | | | |

(7) Confidence

Next are some situations that might make it hard to provide elementary Health Education. Please tell us **how confident** you are that you could ensure the delivery of elementary Health Education.

| How confident are you that you could ensure the delivery of elementary Health Education if ... | Not at all confident | Somewhat confident | Moderately confident | Very confident | Extremely confident |
|--|----------------------|--------------------|----------------------|----------------|---------------------|
| There was limited instructional time. | | | | | |
| There was no health teacher's manual provided. | | | | | |
| There were no health curriculum materials provided. | | | | | |
| You had no professional preparation in Health Education. | | | | | |
| You had no training in the last year in Health Education. | | | | | |
| Your workload was heavy. | | | | | |

(8)Beliefs

Please tell us how much you DISAGREE or AGREE with each of the following statements. Base your answers on how you are feeling at this time.

| How much do you agree or disagree with each statement? | Strongly disagree | Somewhat disagree | Neither agree or disagree | Somewhat agree | Strongly agree |
|--|-------------------|-------------------|---------------------------|----------------|----------------|
| It is my responsibility to ensure the delivery of elementary Health Education to students. | | | | | |
| I am accountable for the delivery of elementary Health Education to students. | | | | | |
| There is adequate instructional time in the elementary grades. | | | | | |
| There is adequate planning time for elementary teachers. | | | | | |

(9)Practices

Next are some statements related to practices that might occur related to the delivery of elementary Health Education. Please answer by indicating Yes or No.

| My school district ... | Yes | No |
|--|-----|----|
| Provides a teacher's manual for health in the elementary grades. | | |
| Provides health curriculum materials in the elementary grades. | | |
| Provides health textbooks for elementary students. | | |
| Requires lesson plans to be submitted for health in the elementary grades. | | |
| Lists health as a separate subject on elementary report cards. | | |
| Offers professional development in health. | | |

(10)Demographics

Please indicate the following by checking the appropriate boxes.

| Age | | | | | | | | | | |
|----------|-------|-------|-------|-------|-------|-------|-------|-------|-------------|--|
| Under 25 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65 and over | |

Sex Highest degree earned

| Male | Female | Bachelor's | Master's | EdS | EdD | PhD | Other (specify) |
|------|--------|------------|----------|-----|-----|-----|-----------------|
|------|--------|------------|----------|-----|-----|-----|-----------------|

What is your race/ethnicity? (Select all that apply.)

- Black or African American
- White/Caucasian
- American Indian or Alaska Native
- Hispanic or Latino
- Native Hawaiian/Pacific Islander
- Other

Job description (Select all that apply)

| Administrator | Teacher (K) | Teacher (first) | Teacher (second) | Teacher (third) | Teacher (fourth) | Teacher (fifth) | Other (specify) |
|---------------|-------------|-----------------|------------------|-----------------|------------------|-----------------|-----------------|
|---------------|-------------|-----------------|------------------|-----------------|------------------|-----------------|-----------------|

Number of years in your profession

| 0-3 | 4-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30 and up |
|-----|-----|-------|-------|-------|-------|-----------|
|-----|-----|-------|-------|-------|-------|-----------|

Number of years in your current position

| 0-3 | 4-9 | 10-14 | 15-19 | 20-24 | 25-29 | 30 and up |
|-----|-----|-------|-------|-------|-------|-----------|
|-----|-----|-------|-------|-------|-------|-----------|

| Please indicate Yes or No | Yes | No |
|---|-----|----|
| I hold current teaching certification in the state of Alabama. | | |
| I had at least one health methodology class during my professional preparation. | | |
| During the last year I participated in Health Education training. | | |

Thank you very much for taking the time to complete this survey. Your insights will make valuable contributions toward increased understanding.