4
CHAPTER

Content and Language Objectives

"Are you fit company for the teacher you wish to become?" —Author unknown

"If a child can't learn the way we teach, maybe we should teach the way they learn." —Ignacio Estrada

OBJECTIVES

Readers will be able to:

1. Describe why it is important to develop learner objectives
2. Define and give examples of health education content objectives
3. Explain how standards are used to develop content objectives
4. Define and give examples of health education language objectives
5. Differentiate between content objectives and language objectives
6. Develop clear and concise content objectives and language objectives
7. Modify content objectives and language objectives

Introduction

Travelers need maps and other tools to help direct and guide them to their destinations. Land travelers may need road maps and landmarks to assist them. Water travelers may need a compass and navigational maps to find the safest path to their destination. Using these tools increases the likelihood that travelers will arrive at their predetermined destination. In recent years, the increased use of Global Positioning Systems (GPS) has allowed travelers to more easily find their destinations. Likewise, teachers can use information and tools to help direct and guide them in providing the most appropriate learning experiences for their students.

Teachers who can clearly define the lesson's learner objectives are well under way to providing their students with appropriate teaching strategies

and student learning activities. Knowing where you, as the teacher, want the students to end up is a critical step in the educational process. In addition, students who have the opportunity to see (in written form) and hear (orally) their learning objectives prior to instruction are more likely to achieve the learner objectives than students who do not have those opportunities to see and hear their learning objectives. Stated another way, students who know what learning is expected of them, prior to instruction, are more likely to achieve their learner objectives. In addition, prior to instruction, students should also have the opportunity to ask clarifying questions about their learner objective(s).

The focus of this chapter is on learner objectives. Learner objectives differ from teacher objectives.

- Learner objectives are intended to clearly define what the *student* is expected to know and/or be able to do as a result of the instruction.
- Teacher objectives typically indicate what the *teacher* will do in providing the instruction, such as explain an assignment, show a video, assign student work groups, or monitor student progress.

In language diverse classrooms, there are two important and distinct learner objectives:

1. Content objectives
2. Language objectives

As mentioned previously, learner objectives—content and/or language—should be given to students every day using two important techniques: (1) Students should *see* (in written form) and *hear* (orally) their content and/or language objectives *prior* to instruction and (2) have the opportunity to ask clarifying questions about their learning objectives.

Question 4.1

What Are Content Objectives?

Content objectives define the essential intended knowledge of the discipline (Rohwer & Wandberg, 2005). These are typically characterized by facts, concepts, and/or skills. Content objectives are generated and derived from several sources. Most commonly, in school health education, these sources include the National Health Education Standards, state health education standards or guidelines, local school district health education standards or guidelines, and in some instances, teacher standards or guidelines.

In school health education, the National Health Education Standards (Joint Committee on National Health Education Standards, 2007) and their

corresponding rationale and performance indicators (see Appendix) provide, from a national perspective, the school health education content standards. Today, most states rely on these national standards to provide the school health education framework at the state and district level. The National Health Education Standards form the basis from which specific content objectives can be developed.

National Health Education Standards

The eight standards are:

- *Standard 1:* Students will comprehend concepts related to health promotion and disease prevention to enhance health.
- *Standard 2:* Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
- *Standard 3:* Students will demonstrate the ability to access information, products, and services to enhance health.
- *Standard 4:* Students will demonstrate the ability to use interpersonal communication skills to enhance health and to avoid or reduce health risks.
- *Standard 5:* Students will demonstrate the ability to use decision-making skills to enhance health.
- *Standard 6:* Students will demonstrate the ability to use goal-setting skills to enhance health.
- *Standard 7:* Students will demonstrate the ability to practice health-enhancing behaviors and to avoid or reduce health risks.
- *Standard 8:* Students will demonstrate the ability to advocate for personal, family, and community health.

See the Appendix for the rationale and performance indicators associated with each of the eight National Health Education Standards.

State Standards

In addition to the National Health Education Standards, individual states often develop state health education standards or guidelines. Although most states choose to base their state standards or guidelines on the national standards, some states may elect to use, not use, adapt, revise, or modify the National Health Education Standards.

States may choose to use the National Health Education Standards as stated and then add additional state-level health education standards. Other states may place increased effort on specific health education standards and lesser, or even none, on other health education standards. Some states may provide specific content objectives aligned with the state's specific standards. Some states allow the individual school districts within the

state to develop their own unique health education standards and content objectives.

District and School Standards

In some states, schools/districts develop their own unique health education standards and content objectives at the local level. As with the state level, some schools/districts may wish to put additional effort in some areas of health education and less or even none in other health education areas. For example, some states may wish to put a special health education emphasis on water safety, frostbite prevention and care, hunting safety, nutrition, or HIV infection.

Teacher Standards

And finally, health education teachers may have the opportunity to add additional standards and content objectives as they deem important and relative. Typically, teachers do not have the option to subtract from the district–school standards. One exception is where federal law permits—as with Individualized Education Programs (IEPs). The IEP documents describe the student's special education and related services. It also describes the current level of performance and the curriculum's long- and short-term goals and objectives.

Health education content objectives, at all levels, may be influenced by federal, state, or local public or private health-related agencies and/or organizations. Ideally, school health education programs should be part of a coordinated school health program (see Appendix).

Based on the National Health Education Standards, a comprehensive health education program should provide a planned, sequential, K–12 curriculum that addresses the physical, mental, emotional, and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve their health, to prevent disease, and to reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices (Joint Committee on National Health Education Standards, 2007). According to the CDC, the following are key elements of comprehensive health education programs:

1. A documented, planned, and sequential program of health instruction for students in grades kindergarten through twelve
2. A curriculum that addresses and integrates education about a range of categorical health problems and issues at developmentally appropriate ages
3. Activities that help young people develop the skills they need to avoid tobacco use; dietary patterns that contribute to disease; sedentary lifestyle; sexual behaviors that result in HIV infection, other STDs,

and unintended pregnancy; alcohol and other drug use; and behaviors that result in unintentional and intentional injuries
4. Instruction provided for a prescribed amount of time at each grade level
5. Management and coordination by an education professional trained to implement the program
6. Instruction from teachers who are trained to teach the subject
7. Involvement of parents, health professionals, and other concerned community members
8. Periodic evaluation, updates, and improvements

Question 4.2

How Are Standards Used to Develop Content Objectives?

As mentioned earlier, the National Health Education Standards are often used to form the framework for a state's or local school district's school health education curriculum.

As one reads through the eight National Health Education Standards, it becomes clear that the standards do not mention common curriculum content areas such as nutrition, tobacco, and physical fitness. So the question becomes, how do teachers develop content objectives from the standards?

Six commonly used high priority school health education content (high-risk behaviors) areas for children and youth are as follows:

1. Tobacco use
2. Intentional and unintentional injury
3. Physical fitness–activity
4. Sexuality behaviors
5. Nutrition (dietary practices)
6. Alcohol and other drugs

To integrate the process from standards to objectives, teachers must look at three items:

1. The national standard
2. The corresponding performance indicator(s)
3. The targeted high priority content area

Example 1:

1. The national standard (Standard 2): Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
2. The corresponding performance indicator(s) (Performance Indicator 2.8.5): Analyze how messages from media influence health behaviors.
3. The targeted high priority content area: Nutrition–dietary practices.

Using these three pieces of information, the teacher can now generate one or more content objectives such as the following:

- *Sample Content Objective 1:* Students will be able to explain and analyze four advertising techniques designed to promote a nutritional product.
- *Sample Content Objective 2:* Students will be able to identify and explain two internal and external advertising influences found in three different fast food ads.

Example 2:

1. The national standard (Standard 3): Students will demonstrate the ability to access valid information and products and services to enhance health.
2. The corresponding performance indicator(s) (Performance Indicator 3.12.4): Determine when professional health services may be required.
3. The targeted high priority content area: Intentional injury.
   - *Sample Content Objective 1:* Students will be able to identify three possible characteristics or behaviors of a person contemplating suicide.
   - *Sample Content Objective 2:* Students will be able to name three professional health services that deal with mental health issues.

The primary purpose of a content objective is to provide *measurability* to the standard and the performance indicator. Several content objectives are often required to meet the essence of a single standard.

Question 4.3

What Are Language Objectives?

Language objectives define the communication skills (language domains) needed to make the content of the discipline comprehensible (Rohwer & Wandberg, 2005). Language objectives can focus on a variety of language skills such as developing health-related vocabulary, reading comprehension, listening, speaking, brainstorming, summarizing, outlining, and basic language mechanics.

Although teachers frequently address content objectives in their lessons, they rarely discuss language objectives. Language objectives are crucial for ELLs. English language learners can more easily master content when teaching practices incorporate strategies for language learning, like the use of language objectives (Dong, 2005). Building from an understanding of the language demands of the curriculum, teachers can develop language objectives related to key vocabulary as well as reading or writing skills, listening, or speaking tasks. For example, teachers can help students learn to read and write in health class by conducting prereading activities, such as previewing the text chapter by examining the section headings and illustrations, and prewriting activities, such as using sentence starters and graphic organizers to record ideas on a topic (Short & Echevarria, 2004–05).

Reading opportunities should be provided for all students.

Reading, writing, listening, and speaking typically characterize these communication skills. These four communication skills, often referred to as **language domains**, are defined below.

1. *Reading:* Students are able to comprehend something written or printed such as letters, numbers, figures, and signs.
2. *Writing:* Students are able to communicate information in written or printed words.
3. *Listening:* Students are able to comprehend oral language.
4. *Speaking:* Students are able to say words, talk, express ideas, and converse in a variety of settings.

States and school districts use a variety of tools to assess and evaluate student language proficiency levels. For example, the Test of Emerging Academic English (TEAE) is a reading and writing test designed to demonstrate an ELL's growth from year to year. The Student Oral Language Observation Matrix, described in Chapter 3, is used to identify proficiency levels in listening and speaking.

Language objectives are important for all learners; however, they are critical for ELL students and many low-literacy students.

Let us suppose you were given an important test with four questions that had an influence on your class grade or evaluation. You would want to do your best. Below are the four health-related questions:

1. Name two risk factors for naqarsaa.
2. Name a body part below the onnee.
3. What is the best treatment for ua qoob?
4. What is a koob txhaj used for?

How did you do? Did you feel frustrated, hopeless, discouraged, or doomed for failure? That is often how ELLs feel when they understand some, but not all, of the language-related task—whether it is in reading, writing, listening, or speaking.

Today, many students in U.S. schools would be unable to answer these four questions because of a language barrier. Some words in the questions are comprehensible, some are not. A common response to the first two questions might be what is "naqarsaa" or where is the "onnee"? Questions such as these, especially if they were on an important test, can cause high anxiety for ELLs and other low-literacy students, oftentimes leading to the students' lack of effort and to giving up.

Understanding the health-related language and vocabulary is vitally important to achieving the standards called for in health education.

Below are the translations of the four questions:

1. Name two risk factors for naqarsaa. (naqarsaa means cancer; language: Oromo)
2. Name a body part below the onnee. (*onnee* means heart; language: Oromo)
3. What is the best treatment for ua qoob? (*ua qoob* means Chicken Pox; language: White Hmong)
4. What is a koob txhaj used for? (*koob txhaj* means syringe; language: White Hmong)

When one understands the question, the answers may be much less difficult.

As you may recall from Chapter 3, there are two levels of language proficiency:

1. Social or conversational language proficiency: This level of proficiency is commonly used in social, nonacademic settings. It is the language students often use in the school hallways, in athletic events, and on the telephone with friends (Schleppegrell, 2004; Gibbons, 2003).
   Social language characteristics include the following:
   - Informal
   - Predominately oral
   - Face-to-face, everyday situations
   - Usually many clues to aid in comprehension
   - 3,000 words or fewer
   - Short, simple sentence structures
   - Acquired within 6 months to 2 years
2. Academic language proficiency: This level of proficiency involves formal language skills and functions that are typically more cognitively complex (Schleppegrell, 2004; Gibbons, 2003). It is often the language found in most health education classrooms and content textbooks.
   Academic language characteristics include the following:
   - Predominately written
   - Few clues other than the language itself

- 100,000 words
- Long complex sentence structure
- Takes between 5 to 10 years to master

As with many languages, English can be difficult to learn. For example, read these ten simple sentences:

1. The bandage was wound around the wound.
2. The farm was used to produce produce.
3. The dump was so full that it had to refuse more refuse.
4. We must polish the Polish furniture.
5. He could lead if he would get the lead out.
6. The soldier decided to desert his dessert in the desert.
7. Because there is no time like the present, I decided to present the present today.
8. They were too close to the door to close it.
9. The insurance was invalid for the invalid.
10. I did not object to the object.

In a language diverse classroom, the importance of having language objectives is instructionally critical. Let us look at Alejandra's class schedule. Alejandra is a 10th grade Level 3 ELL student. Her high school schedule is as follows:

- Period 1: Music
- Period 2: Math
- Period 3: Geography
- Period 4: Biology
- Period 5: Health

During Period 1, Alejandra's music teacher is describing a musical scale. The teacher uses this definition for the term *scale*—a series of tones ascending or descending in pitch—and this sample sentence: She practices scales on the piano. Her teacher indicates that this is a term Alejandra is expected to learn.

During Period 2, Alejandra's math teacher is describing the decimal scale as a system of numbering. The teacher explains that the decimal scale counts by tens, as in cents, dimes, dollars. Her teacher indicates that this is a term Alejandra is expected to learn.

During Period 3, Alejandra's geography teacher is asking the students to draw a city map to scale. Specifically, the teacher wants the map's mileage scale to be 1 inch for each 100 miles. Her teacher indicates that this is a term Alejandra is expected to learn.

During Period 4, Alejandra's biology teacher is giving a minilecture on the topic of fish. The teacher states, "Most jawed fish have a protective covering of scales. A scale is one of the thin, flat, hard plates forming the outer

covering of many fishes, snakes, and lizards." Her teacher indicates that *scale* is a term Alejandra is expected to learn.

And finally, during Period 5, Alejandra's health teacher, when speaking about growth and development, says, "A baby scale helps record the growth of tiny infants." The health teacher fails to define the term *scale*. One can only imagine what might be going through Alejandra's mind, hearing and learning about fish scales and then hearing that they (scales) may also help to record the growth of infants!

Alejandra had quite a day. While providing content information, each teacher used the term *scale*. All five teachers used the term correctly in the context of their topic. All five teachers gave a significant but different definition of the term scale.

Multiple Meaning Terms

Multiple-meaning terms describe identical academic terms that have different meanings depending on the discipline. Countless terms in health education have multiple meanings as illustrated in Alejandra's scenario. Many teachers, in a wide variety of disciplines, do not take the time to consider which instructional terms in their content area have multiple meanings. Health education is no exception (Rohwer & Wandberg, 2005). As you think about the terms commonly used in health education topics, such as nutrition, fitness, disease, sexuality, tobacco, and alcohol, it is often easy to find several that have multiple meanings. Can you think of some?

Expanding ELL's academic language vocabulary knowledge requires moving beyond the highlighted words in a textbook to include words crucial to the conceptual understanding of a topic. Students need multiple opportunities to practice using these words orally and in print. Reading glossary definitions is not sufficient. Strategies such a word wall and semantic webs can help students organize the new words in meaningful ways. Other vocabulary techniques include demonstrations, illustrations, art projects, and students' selection of specific vocabulary words to study (Short & Echevarria, 2004–05).

Question 4.4

What Are the Steps in Developing and Writing Clear and Concise Content and Language Objectives?

It is important that teachers have the ability to write clear and concise health education content and language objectives. Teachers who are licensed or credentialed in school health education typically have the ability to prepare appropriate content objectives for the students in their classes. Often, however, many professional preparation programs in health education do not provide instruction in the need for language objectives. By following some simple steps, both content and language objectives can be easily developed.

Writing a Content Objective

The focus of a content objective is the development and enhancement of the student's health literacy. As stated by the Joint Committee on Health Education Standards, "Health literacy is the capacity of an individual to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which enhance health" (1995, 5). This requires significant instruction in health-related facts, concepts, and skills. The content objective clearly defines the learning expectations for these facts, concepts, and skills.

Writing a Language Objective

Writing effective health education language objectives is quite similar to writing clear and effective content objectives. The primary difference between a language objective and a content objective is that the language objective will specifically define what learning is expected in the context of using English. The terms to describe the students' achievement of a language objective are typically read–reading, write–writing, listen–listening, and speak–speaking.

Content and language objectives can, and should be, written at the various levels of the health education curriculum, such as the following:

- Lesson level objectives (e.g., immediate effects of tobacco use)
- Topic level objectives (e.g., tobacco)
- Unit level objectives (e.g., tobacco, alcohol, and other drugs)

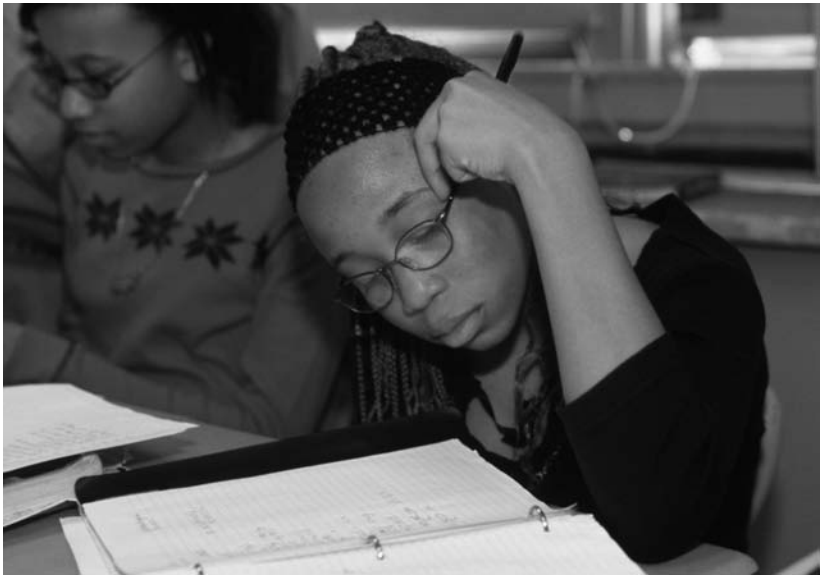
Content and Language Objective Components

Content and language objectives typically have four major components. They can be simply written by following an ABCD method: A = Audience; B = Behavior; C = Conditions; D = Degree (Hunter, 1971).

Audience

Who are the students? Who is the target individual or group? For example, does the content objective target the entire 10th grade health education class? Or, does it target a class subgroup, such as students who were absent yesterday, ELLs, or special education students? Does it target an individual who has some other special learning situation?

Guided by the class demographics, a teacher may need to have two or more content and language objectives for a single lesson. For example, a teacher with 24 on-level students, 4 Level-3 ELLs, and 2 special education students with speech and language impairments in his or her class may need three different content and/or language objectives for one lesson. If the content objective applies to all students in the class, the content objective should say that. On the other hand, suppose a teacher placed



Writing opportunities should be provided for all students.

each student in the class into one of three groups. This situation might suggest that three different content and language objectives be developed. The difference in the objectives could be based on several factors such as rigor, demonstration options, or content focus.

Behavior

Essentially, the behavior component clearly defines what the student(s) will be expected to know or be able to do at the end of the lesson, topic, or unit. It is essential that the teacher use clear, concise, specific, relevant, attainable, and measurable terms.

- *Clear:* Easily understood, not confusing
- *Concise:* Stated in few words, but meaningful
- *Specific:* Precise
- *Relevant:* Connected with the content and student; authentic
- *Measurable:* Quantifiable

The behavior part of the ABCD model is very important. The expected student learning behavior must be free from ambiguity; it must be brief. The teacher should not try to connect or combine several learning behaviors into one learner objective. It is far better to have a few single learner objectives

rather than one multifaceted, cumbersome objective. Another critical portion of this section is measurability.

Read this objective: Students will understand carbohydrates. The term *understand* is ambiguous, and its measurability is clearly open to interpretation. The measurability of content standards must be equally clear to the teacher and students.

A better objective would be "Students will be able to name the two types of carbohydrates" (answer: simple and complex). Stating the objective in this manner is far less ambiguous. It provides the students with a clearer understanding of what learning is expected.

During the study of nutrition, a teacher may choose to include several additional objectives associated with carbohydrates, such as information and skills related to food sources, calories per gram, dietary guidelines, food labels, selection, and preparation.

Equally important in this behavior component is the focus on language and the use of language. As with content objectives, language objectives should use clear, concise, specific, relevant, attainable, and measurable terms. Language objectives specifically define what learning is expected in the context of using English.

For example, "Students will be able to tell a partner the two types of carbohydrates." In this example, the term *tell* focuses on the communication skill (language domain) of speaking. The teacher could also develop a reading, writing, or listening language objective focusing on the two types of carbohydrates.

Language objectives in health education often focus on vocabulary or academic language functions such as comparing, informing, decision-making, problem solving, classifying, evaluating, and information seeking (**Table 4.1**).

Conditions

The condition section of both content and language objectives describes under what circumstance, time line, or situation the learning is expected. It answers the question: When in the instructional or learning process is the student expected to demonstrate his or her learning?

For example, a student might be expected to demonstrate a specific nutrition knowledge or skill after one or more of these situations:

- Reading pages 136–138 in the textbook
- Viewing the videotape, "Nutrition World"
- Completing the nutrient worksheet
- Discussing nutrition in class on Wednesday
- Listening to the guest speaker on nutrition
- Visiting the nutrition center
- Completing the nutrition report

Table 4.1 Sample Language Functions, Descriptions, and Examples

Examples of Language Functions	Descriptors/Uses	Health Education Example
Know	Name, define, list	Tell a partner four items required on food labels.
Comprehend	Explain, describe, distinguish	Explain how a ball-and-socket joint works.
Seek information	Who, what, where, when, how	Read the article "Communicable Disease," and write three types of pathogens that cause communicable disease.
Persuade	Reasons, point of view, justify, convince	Research and tell why one exercise is better than another for cardiovascular fitness.
Analyze	Classify, categorize, differentiate	Create a mind map classifying common STDs by infecting agents.
Order	Sequence ideas, objects, or events	Draw a sequence map illustrating the correct CPR steps.
Synthesize	Conclude, propose, synthesize	Propose, in writing, one advocacy skill to encourage others to avoid tobacco use.
Evaluate	Compare, contrast, appraise	Make and share a graphic organizer comparing two national diet programs.

Degree

The degree indicates the level of learning that is expected. What level of learning does the teacher expect? What is the acceptable level of learning? In measurable terms, this section answers the students' question: What specific learning level am I expected to achieve? For example, in a content or language objective, a student might be expected to demonstrate a specific nutrition knowledge or skill with a detailed degree of learning expectation.

Example levels of specific degrees of learning include the following:

- 100% accuracy
- 80% correct
- 3 out of 5
- In 6–8 minutes
- The correct use of
- Reach a decision
- Three items in each category
- Achieve a score of 32

Putting The ABCDs Together

Sample Content Objective

Each student will be able to name the two types of carbohydrates after completing the nutrient worksheet with 100% accuracy.

A = Audience (Each student)
B = Behavior (will be able to name the two types of carbohydrates)
C = Conditions (after completing the nutrient worksheet)
D = Degree (with 100% accuracy)

To increase grammatical clarity, teachers may write and indicate the ABCDs in any order they prefer.

Example 1: After completing the nutrition worksheet each student
C A
will be able to name the two types of carbohydrates with 100% accuracy.
B D

Example 2: Each student, after completing the nutrient worksheet,
A C
will be able to name the two types of carbohydrates with 100% accuracy.
B D

Sample Language Objective

The 8th grade health education students will be able to tell a partner the six steps, in order, of the decision-making model following the class discussion with 100% accuracy.

A = Audience (the 8th grade health education students)
B = Behavior (will be able to tell a partner the six steps, in order, of the decision-making model)
C = Conditions (following the class discussion)
D = Degree (with 100% accuracy)

As with content objectives, for grammatical clarity, the teacher may write the ABCDs in a different order such as the following:

Following the class discussion, all 8th grade students
C A
will be able to tell
B
a partner the six steps, in order, of the decision making model
with 100% accuracy.
D

Listening opportunities should be provided for all students.

Question 4.5

What Are the Steps in Modifying Content Objectives and Language Objectives?

Many commercially prepared health education textbooks and other instructional materials offer learner objectives that align with the program's content. Most of these prepackaged objectives are content objectives that are intended for the on-level student at the targeted grade or ability level.

Frequently, a teacher has several students in his or her health education class that are outside of that on-level range. Some of the teacher's students may be above the on-level range. Sometimes these students are referred to as gifted, talented, or excel students. In many cases, teachers have students in the classroom that are below the on-level range. Some of these students may be ELLs, special education students with varying disabilities, or other lower literacy students due to a variety of other possible factors.

For this reason, it is imperative that teachers know the process of modifying objectives to better meet the needs and abilities of their students.

There are four sequence steps to consider when modifying objectives. The same sequence is used for both content and language objectives.

Step 1

Determine the language and proficiency level of the students.

As you read in Chapter 3, the professional organization Teachers of English to Speakers of Other Languages (TESOL) identifies and defines five levels of language proficiency:

- Level 1: Starting
- Level 2: Emerging
- Level 3: Developing
- Level 4: Expanding
- Level 5: Bridging

Some states and school districts choose to modify these five categories to better meet their instructional models. Some use only four categories; some use different terms to identify the varying proficiency levels, such as beginning, intermediate, advanced, transitional, and fluent.

It should be noted that ELLs progress through these five levels at different rates. Some ELLs, due to previous education and academic experiences, may progress much more rapidly than an ELL who has had little or no education and academic experiences.

Therefore, teachers should know the language level and proficiency of their students before modifying their content and/or language objectives. Many school districts employ ELL specialists who administer various language proficiency tools to ELL students and then are readily able to pass that information on to the classroom teacher.

Once the teacher knows the student's language proficiency, the teacher can move to the next step in modifying content and language objectives.

Step 2

The teacher should ask the following question: Can my ELL students work toward the same objective as the other students? If, in the judgment of the teacher, the rigor of the objective is attainable by all students, then objective modification is probably unnecessary; however, if the teacher deems the objective to be inappropriate, he or she should move to Step 3.

Step 3

The teacher should ask this question: Will my ELL students be more successful with a modified objective? If the answer is yes, one way to change the objective's rigor or cognitive demand is to change the objective's verb.

Professor Benjamin Bloom of Chicago University and his co-workers (1956) devised what is commonly known as the stairway with six steps to learning. Bloom's six taxonomic cognitive levels can be used effectively to describe a cognitive progression. A quick review of Bloom's taxonomy is described below.

- *Level 1:* Knowledge. The student is able to remember and recall an idea, fact, information, rules, and/or steps of a process in a form very close to the way it was first encountered.
- *Level 2:* Comprehension. The student is able to explain, recount, or represent an understanding of something in one's own words.
- *Level 3:* Application. The student is able to demonstrate abstractions such as theories, principles, ideas, rules, and methods for the solution of a problem.
- *Level 4:* Analysis. The student is able to break down a theory or plan into its separate parts and determine the relationship of those parts and how they are organized.
- *Level 5:* Synthesis. The student is able to put new elements and parts together so as to form a new pattern or structure not clearly there before.
- *Level 6:* Evaluation. The student is able to make judgments about the worth of ideas, works, choices, and solutions. Also, the student is able to critique, judge, predict, and justify based on standards and criteria.

According to Bloom's taxonomy, the higher the level, the higher the cognitive demand and required thinking skill is (Anderson & Krathwohl, 2001). When writing this portion of a learning objective, it is important to consider (1) the ability of the student and (2) the targeted degree of difficulty, based on the standard. With ELL students, the level of English proficiency (Chapter 3) roughly approximates the same level in Bloom's taxonomy. For example, to align and support the learning and achievement of a Level 2 ELL student (reading level 1.6–2.5), the teacher may want to first focus on Bloom's level 1 or 2 to define the content objective.

The verb used in the learner objective to describe the specific behavior is critical. Again, using Bloom's six-level taxonomy as a reference (1956), several verbs can be generated that align with the rigor, or cognitive complexity, called for in the corresponding ELL proficiency level (**Tables 4.2** through **4.7**).

Table 4.2 Taxonomic Category Level 1: Knowledge

Tell	List	Name	State
Relate	Repeat	Label	Match
Recite	Recognize	Locate	Select
Underline	Collect	Recall	Show

Table 4.3 Taxonomic Category Level 2: Comprehension

Explain	Describe	Relate	Discuss
Infer	Report	Prepare	Debate
Change	Restate	Draw	Express
Translate	Summarize	Transform	Generalize

Table 4.4 Taxonomic Category Level 3: Application

Apply	Solve	Show	Sketch
Classify	Illustrate	Demonstrate	Practice
Operate	Role play	Schedule	Transfer
Restructure	Modify	Plan	Construct

Table 4.5 Taxonomic Category Level 4: Analysis

Analyze	Dissect	Detect	Examine
Compare	Contrast	Deduce	Survey
Separate	Categorize	Differentiate	Experiment
Criticize	Classify	Diagram	Calculate

Table 4.6 Taxonomic Category Level 5: Synthesis

Create	Invent	Compose	Assemble
Predict	Construct	Design	Modify
Prepare	Organize	Plan	Imagine
Formulate	Improve	Produce	Manage

Table 4.7 Taxonomic Category Level 6: Evaluation

Judge	Select	Decide	Evaluate
Justify	Debate	Verify	Choose
Argue	Recommend	Assess	Critique
Rank	Validate	Defend	Score

Modification Examples

Modifying downward to lower level of cognitive demand:

- *Original statement:* Students will be able to demonstrate the three steps of assertive refusal.
- *Modified statement for level 2–3 ELL:* Students will be able to explain (or describe) the three steps of assertive refusal.
- *Modified statement for level 1–2 ELL:* Students will be able to tell (or name) the three steps of assertive refusal.

Modifying upward to a higher level of cognitive demand:

- *Original statement:* Students will be able to explain four risk factors associated with cardiovascular disease.
- *Modified statement for level 4–5 ELL or higher:* Students will be able to prioritize (and defend?) four risk factors associated with cardiovascular disease.

Prior to any content or language objective modification, the teacher should clarify and confirm that all associated vocabulary is clearly understood by all students. In both modifying examples listed above, there may also be a need for the teacher to develop language objectives related to terms such as assertive, refusal, risk factor, associated, cardiovascular, and disease.

Step 4

Another instructional question a teacher should ask when modifying objectives is: Do my ELL students have "independence and/or demonstration" options?

Speaking opportunities should be provided for all students.

Many ELLs will enjoy greater success when they are offered options as to how they will be asked to complete and demonstrate their learning.

- Achievement may be improved by modifying the student's independence by allowing him or her to work in small groups or with a partner rather than independently.
- Achievement may be improved by allowing students to demonstrate their learning in a variety of ways, such as in a written or oral report, diagram, poem, skit, news article, map, game, or other project. In other words, just because a student, for example, is unable to *write* the correct response does not necessarily mean that he or she does not *know* the correct response.

For each objective, it is recommended that a criteria rubric be prepared for the students (see Chapter 12).

Conclusion

Developing clear, concise, specific, relevant, attainable, and measurable content and language objectives is an essential step in the instructional process. Students who clearly understand their learning expectations are more likely to achieve them. To assist student learning, teachers should provide students with their content and language objectives prior to instruction and provide students with the opportunity to ask clarifying questions about the objectives. Students should receive their content and language objectives in both a written and oral manner.

The National Health Education Standards are often used to form the framework for a state's or local school district's school health education curriculum. Content objectives can be developed from these standards and their corresponding performance indicators.

Content and language objectives have specific, but distinct, purposes. Content objectives define the specific knowledge and skill required in the discipline. Content objectives often are derived from the content's national or state standards. In health education, content objectives are commonly derived from the National Health Education Standards. Language objectives define the learning that is expected in the context of using English. Language objectives focus on the language domains of reading, writing, listening, and speaking.

Content and language objectives that are prepared for on-level students can often be modified for ELLs or low-literacy students. This can often be achieved by reducing the objective's action verb to a less rigorous and lower cognitive demand verb, by reducing the students' independence (e.g., move from independent learning to partners), and/or by providing product options to demonstrate learning.

REVIEW ACTIVITIES

1. Why is it important to develop content and language objectives?
2. What are the attributes of an objective?
3. What is a content objective? What are three examples?
4. What is a language objective? What are three examples?
5. Differentiate content objectives and language objectives.
6. What are the four components of a content and language objective?
7. What are the three ways to modify content and language objectives? Describe a modification example for each of the three ways.

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