In addition to their backpacks, students come to school burdened with worries about family issues and anxieties about being at school and interacting with peers. For many, poverty, homelessness, violence, lack of access to health care, and other social or economic issues interfere with their opportunities for academic success. They hear about or experience bullying, cyberbullying, gangs, and violence, including shootings and stabbings. Mental health issues related to suicide, depression, alcohol, or drugs such as opioids can derail even the best student or the most well-rounded curriculum. As summarized by one leading education researcher, "Learning is inherently social and emotional. If students don’t feel safe and engaged, they aren’t learning."1

Where in the curriculum do students learn to cope with threats to their safety and well-being? Too often, educators develop lesson plans in response to a crisis. Adjusting existing curricula to accommodate these new lessons is not a sustainable way to build students’ coping skills and does nothing to prevent tragedies. Students need access to a focused, evidence-based curriculum that equips them with the social and emotional competencies to deal with contemporary issues, as well as provides the foundation for healthy decision making as adults.

Health education offers a natural curricular home for important life skills and ways students can optimize physical, social, and emotional health. Although many schools have implemented social and emotional learning (SEL), health education provides a broader framework by encompassing the connections between physical and emotional health and the contributions health makes to academic success. Students who receive high-quality SEL instruction in school have achievement scores on average 11 percentile points higher than students who do not receive SEL instruction.2 In addition, the impact of SEL instruction extends into adulthood.

State boards can address wellness by shoring up its natural curricular home.

Susan Goekler, M. Elaine Auld, and David A. Birch

The Role of Health Education
Standards provide a framework for teachers, administrators, and policymakers in designing or selecting curricula, allocating instructional resources, and assessing student achievement and progress (table 1). The standards describe what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. A curriculum based on these standards helps students learn not only health-related concepts and facts, but more importantly, social skills such as interpersonal communication, decision making, goal setting, and advocacy. It provides a foundation for analyzing and responding to the pressures of peers and the media and for assessing the validity of health messages. Students have opportunities to practice such skills in a variety of situations within the safety of a classroom, so they can then confidently apply them in the real world.

Schools and state education agencies can use the CDC’s Health Education Curriculum Analysis Tool to identify curricula that align with these standards. The CDC stresses that an effective health education curriculum requires more than imparting scientific facts. Rather, the curricula should also emphasize teaching functional health information (essential knowledge needed to make healthy choices), shaping values and beliefs that support healthy behaviors, shaping group norms that value a healthy

Box 1. Definition of Health Education

CDC’s WSCC model defines health education this way:

A combination of planned learning experiences that provide the opportunity to acquire information and the skills students need to make quality health decisions. When provided by qualified, trained teachers, health education helps students acquire the knowledge, attitudes, and skills they need for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviors, and promoting the health of others. Comprehensive school health education includes curricula and instruction for students in pre-K through grade 12 that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention. Health education curricula and instruction should address the National Health Education Standards and incorporate the characteristics of an effective health education curriculum. Health education, based on an assessment of student health needs and planned in collaboration with the community, ensures reinforcement of health messages that are relevant for students and meet community needs.a


Quality health education delivered by teachers trained in health education not only develops students’ SEL skills but also other competencies related to wellness. Health education is as important in the curriculum as attention to other academic subjects and is correlated with academic outcomes and high school graduation. Yet the content and quality of health education, including SEL, varies within states and across states.

Health education is one aspect of the Centers for Disease Control and Prevention’s (CDC’s) Whole School, Whole Community, Whole Child (WSCC) model, which details the many health-related factors that affect students’ academic success. Tobacco use, premature sexual activity, inadequate physical activity, and unhealthy eating—in addition to social and emotional health and exposure to violence or substance use—are significantly related to academic success. Schools need an approach that addresses all aspects of health and well-being and embraces the core WSCC elements. (For more on WSCC, see the article on creating healthy schools in this issue, page 11.) The model also includes a definition of health education (see box).

When taught to do so, students can acquire and apply the knowledge, skills, and attitudes they need to be socially and emotionally competent. The National Health Education Standards provide a framework for teachers, administrators, and policymakers in designing or selecting curricula, allocating instructional resources, and assessing student achievement and progress (table 1). The standards describe what students should know and be able to do by grades 2, 5, 8, and 12 to promote personal, family, and community health. A curriculum based on these standards helps students learn not only health-related concepts and facts, but more importantly, social skills such as interpersonal communication, decision making, goal setting, and advocacy. It provides a foundation for analyzing and responding to the pressures of peers and the media and for assessing the validity of health messages. Students have opportunities to practice such skills in a variety of situations within the safety of a classroom, so they can then confidently apply them in the real world.

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lifestyle, and developing the skills to adopt, practice, and maintain health-enhancing behaviors. CDC’s website details 15 characteristics of effective health education curriculum.

Effective health instruction requires adequate time and “teachers who have a personal interest in promoting positive health behaviors, believe in what they are teaching, are knowledgeable about the curriculum content, and are comfortable and skilled in implementing expected instructional strategies. Ongoing professional development and training is critical for helping teachers implement a new curriculum or implement strategies that require new skills in teaching or assessment.”6

The CDC’s School Health Policies and Practices Study (SHPPS) revealed that all but four states had adopted national or state health education standards, and some three-quarters had adopted standards based on the National Health Education Standards.7 However, during the two years before the study was published, less than half of states had developed, revised, or assisted in developing model policies, policy guidance, or other materials to inform district or school policy on any of the six topics listed in the questionnaire (table 2).

Most states offered certification, licensure, or endorsement for teaching health education, but the requirements varied significantly in terms of mandatory coursework for initial licensure and continuing education for licensure renewal. Some states only required licensure, certification, or endorsement in health education for those middle or high school teachers whose primary responsibility was for health education instruction. If an educator taught only one or two health classes, and the remainder of the teaching load was in another content area, the teacher might not need health education certification, endorsement, or even training.

The study reported that all but two states provided professional development on at least one of the 15 health topics included in the questionnaire, and 36 states provided professional development on at least eight topics. These topics reflect the leading causes of morbidity and mortality among both youth and adults, as well as other important public health issues. Between 2006 and 2012, the percentage of states

Table 1. National Health Education Standards

| 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 valid information, products, and services to enhance health. |
| Standard 4 | Students will demonstrate the ability to use interpersonal communication skills to enhance health and 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 avoid or reduce health risks. |
| Standard 8 | Students will demonstrate the ability to advocate for personal, family, and community health. |

for example, “comprehensive health” is one of 10 content areas in Colorado’s academic standards. Maine’s plan presents health education as a key content area that contributes to 21st century skills and promotes social, emotional, and physical health, which in turn contributes to academic success. Because health education is included as part of ESSA, federal funds may be used to support professional development for those who teach health.

In a 2015 NASBE report, Erima Fobbs suggested ways that state boards of education can coordinate policy, process, and practice across all dimensions of WSCC, working in concert with state education agencies and health departments. We expand here on the suggestions that are directly applicable to health education:

1. Provide specific direction in the form of a policy or recommendation to school districts related to school health education. The direction should require or strongly recommend sequential instruction in health education in all grades at the elementary level and middle school level and at least two courses at the high school level. Instruction should be based on state or national

### Table 2. States That Provided Policy-Related Assistance to Districts and Schools (percent)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Developed, Revised, or Assisted in Developing Model Policies, Policy Guidance, or Other Materials*</th>
<th>Distributed or Provided Model Policies, Policy Guidance, or Other Materials*</th>
<th>Provided Technical Assistance†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certification or licensure requirements for health education teachers</td>
<td>43.1</td>
<td>46.0</td>
<td>64.7</td>
</tr>
<tr>
<td>Graduation requirements for high school health education</td>
<td>41.2</td>
<td>47.1</td>
<td>70.0</td>
</tr>
<tr>
<td>Professional development or continuing education requirements to maintain licensure or certification</td>
<td>45.1</td>
<td>49.0</td>
<td>66.7</td>
</tr>
<tr>
<td>Time requirements for elementary school health education</td>
<td>23.5</td>
<td>29.4</td>
<td>58.8</td>
</tr>
<tr>
<td>Time requirements for middle school health education</td>
<td>30.0</td>
<td>35.3</td>
<td>60.8</td>
</tr>
<tr>
<td>Time requirements for high school health education</td>
<td>27.5</td>
<td>38.0</td>
<td>60.0</td>
</tr>
</tbody>
</table>

*During the two years before the study. †During the 12 months before the study.


State Boards’ Role in Strengthening Health Education

The Every Student Succeeds Act (ESSA) of 2015 included health education in its definition of a well-rounded education, and several states have explicitly addressed health education in their ESSA plans. In the Colorado ESSA plan, decreased from 77 to 51 percent that provided funding for professional development or offered professional development to those teaching health education on using classroom management techniques (e.g., social skills training, environmental modification, conflict resolution and mediation, or behavior management).

According to the SHPPS data, 45 states had a health education coordinator within the state education agency in 2012. Having a coordinator increases the likelihood that the state provides professional development and resource materials for those with responsibility for implementing health education at the district and school levels. However, federal rather than state funding was used for many of these positions. With significant decreases in federal funding since 2012, the number of state coordinators also declined.
curriculum standards and should incorporate CDC’s characteristics of an effective health education curriculum.

2. **Promote state-level certification requirements that ensure health education is taught by teachers with appropriate professional preparation in health education.** Ensure such teachers receive in-service opportunities and professional development. In too many schools, health education is taught by teachers without adequate professional preparation, often teachers whose primary preparation was in physical education. Pre-service instruction in physical education and health education are not interchangeable and are based on distinct competencies for teacher candidates. Health teachers at all levels also need opportunities for professional development, especially given the rapidly changing discoveries in health and disease and the dynamic technologies that affect students’ health decisions and interpersonal interactions. Boards of education should encourage districts to provide health teachers with release time and financial support to attend professional development opportunities that would help them remain current in the field.

3. **Create or support a statewide school health leadership group.** Interagency coordination provides vital leadership for policy and system changes that support all elements of the WSCC, including health education. A statewide school health leadership group could recommend and advise on specific health policies (e.g., privacy laws that relate to school monitoring of students’ social media), review health education curricular materials (e.g., sex education content), and monitor implementation of school health programs. The group should include representatives from the state health department, state-level affiliates of health organizations (such as the American Cancer Society, American Heart Association, Action for Healthy Kids, Medical Society), local school districts, and parent organizations. Members should include parents and others reflecting the diversity of the student population, such as tribal leaders, members of the Urban League, and La Raza.

   In summary, high-quality school health education is a vital component of the WSCC model for promoting students’ safety and wellness. In combination with other school health programs, school health education that is evidence-based, coordinated, and strategically planned helps promote high school graduation and closing the achievement gap. Students receiving high-quality K-12 health education will develop the social-emotional knowledge and skills they need to recognize, prevent, or cope with daily threats to their well-being as well as adopt lifelong health habits. The changes in ESSA, supported by NASBE and CDC resources, provide bold new opportunities for boards to assess their states’ approach to school health education and encourage school authorities to give it the priority it deserves. Students are literally crying for change, and our nation’s education leaders must reply with more than tissues and Band-Aids.

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7. U.S. Centers for Disease Control and Prevention, “Results from the School Health Policies and Practices Study: 2016” (Atlanta: CDC, 2017). Due to budget reductions, these 2012 state-level data are the latest available.