Children in K–12 settings comprise roughly one fifth of the population of the United States and are a cohort that has long drawn the interest of health educators. Early education and prevention efforts reduce human suffering, contribute to preparation for classroom learning, affect long-term health, and contain health costs due to preventable diseases. Despite the possible positive impact of a comprehensive approach, no broad-based federal legislation mandates regular school health education. Instead, the current state of school health education policy is a cobbled-together set of policies subsumed under existing laws. The purpose of this article is to provide information about the key legislation that is being used to promote school health education in the United States. Furthermore, the authors suggest opportunities for lobbying for the continuation of existing legislation and advocating for state and local operationalization of these policies. Finally, health educators are rallied to consider raising the issue of advocating for a more complete legislative strategy for school health education.

Keywords: advocacy; child/adolescent health; school health; public health laws/policies; health education

The National Center for Education Statistics (2011) estimated that 61 million K–12 students were enrolled in U.S. public and private K–12 schools in the fall of 2011. In recognition of the potential of schools to influence both the health and learning of children and adolescents, Healthy People 2020 (U.S. Department of Health and Human Services [USDHHS], n.d.) includes objectives and subobjectives in the topic areas of Early and Middle Childhood (EMC) and Education and Community-Based Programs (ECBP) that are directly aligned with comprehensive school health education (see Table 1). Unfortunately, many schools do not currently meet these objectives or subobjectives. For example, Centers for Disease Control and Prevention (CDC) scientists (Brener et al., 2011) reported that in 2010, the state median percentage of schools that required two or more health education courses for students in Grades 6 through 12 was only 52.3% (range = 12.4% to 92.4%). Allensworth (2011) noted in her 2010 SOPHE Presidential Address that this “paucity of health education . . . deprives all children of needed knowledge and contributes to health illiteracy in adults” (p. 335). Despite the current evidence related to the causal, reciprocal relationship between health and learning (see Basch, 2011) and the influence of school laws and regulations on students’ health and educa-

Authors’ Note: Address correspondence to Marlene K. Tappe, Department of Health Science, Minnesota State University, Mankato, 213 Highland Center North, Mankato, MN 56001, USA; e-mail: marlene.tappe@mnsu.edu.

Associate Editor, Policy and Politics Department
Regina Galer-Unti, PhD, is a faculty member in the School of Health Sciences, College of Health Sciences at Walden University.
FEDERAL LEGISLATION AND LEGISLATIVE INITIATIVES AND STATE LAWS AND REGULATIONS RELATED TO COMPREHENSIVE SCHOOL HEALTH EDUCATION

Although the federal government provides encouragement for health instruction through grant programs, regulatory authority with respect to health education in schools rests with states (see Hodge, 2006, and Hodge et al., 2008, for a full discussion of the role of local, state, and federal laws in public education). The following paragraphs identify recent or current federal legislation and legislative initiatives as well as provide guidance for identifying state laws and regulations related to comprehensive school health education. Federal legislation and legislative initiatives that affect health education in schools include those that provide categorical funding for health instruction, require the establishment of local school wellness policies, or include or fail to include health education as a core academic subject within school curriculum.

Categorical Funding for Health Instruction

Over the years, federal legislation has directly affected health education in schools by providing categorical funding for health instruction related to a narrow range of specific health topics. Most recent examples of categorical funding related to specific

<table>
<thead>
<tr>
<th>TABLE 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthy People 2020 Objectives and Examples of Subobjectives Related to Comprehensive School Health Education</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Healthy People 2020 Objective or Subobjective</th>
</tr>
</thead>
<tbody>
<tr>
<td>“EMC-4: Increase the proportion of elementary, middle, and senior high schools that require health education” (USDHHS, n.d., p. 61)</td>
</tr>
<tr>
<td>“EMC-4.1 Increase the proportion of schools that require newly hired staff who teach health education to have undergraduate or graduate training in health education” (USDHHS, n.d., p. 61)</td>
</tr>
<tr>
<td>“EMC-4.2 Increase the proportion of schools that require newly hired staff who teach required health instruction to be certified, licensed, or endorsed by the State in health education” (USDHHS, n.d., p. 62)</td>
</tr>
<tr>
<td>“EMC-4.3 Increase the proportion of schools that require cumulative instruction in health education that meet the US National Health Education Standards for elementary, middle, and senior high schools” (USDHHS, n.d., p. 63)</td>
</tr>
<tr>
<td>“ECBP-2: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy; HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity” (USDHHS, n.d., p. 66)</td>
</tr>
<tr>
<td>“ECBP-3: Increase the proportion of elementary, middle, and senior high schools that have health education goals or objectives that address the knowledge and skills articulated in the National Health Education Standards (high school, middle, elementary)” (USDHHS, n.d., p. 68)</td>
</tr>
<tr>
<td>“ECBP-4: Increase the proportion of elementary, middle, and senior high schools that provide school health education to promote personal health and wellness in the following areas: hand washing or hand hygiene; oral health; growth and development; sun safety and skin cancer prevention; benefits of rest and sleep; ways to prevent vision and hearing loss; and the importance of health screenings and checkups” (USDHHS, n.d., p. 70)</td>
</tr>
</tbody>
</table>

NOTE: EMC = Early and Middle Childhood; USDAHHS = U.S. Department of Health and Human Services; ECBP = Education and Community-Based Programs; STD = sexually transmitted disease.
health topics include funding for sexual health education that contain personal responsibility education and/or abstinence education, nutrition education, and prevention curricula to prevent chronic disease. Section 2953 of Public Law 111-148 (the Patient Protection and Affordable Care Act of 2010) amended Title V of the Social Security Act to allocate funding through 2014 for the provision of personal responsibility education (see Table 2). Section 2954 amended Title V of the Social Security Act to restore funding for abstinence education (see Table 2). The Personal Responsibility Education program is designed to provide health instruction related to both contraception and abstinence for the prevention of pregnancy and sexually transmitted diseases, including HIV/AIDS. The Abstinence Education program focuses on abstinence education as defined by Section 510(b)(2) of the Social Security Act.

There are multiple pieces of legislation that provide either requirements or enticements for nutrition education. Section 204 of Public Law 111-296 (the Healthy, Hunger-Free Kids Act of 2010) requires goals for nutrition education, whereas Section 241 of this legislation provides for a grant program for nutrition education and obesity prevention (see Table 2). Section 19 of the Child Nutrition Act was amended by 42 U.S.C. § 1788 to provide funds for nutrition education through Team Nutrition Training Grants for Healthy School Meals.

Section 4201 of Public Law 111-148 (the Patient Protection and Affordable Care Act of 2010) also authorized Community Transformation Grants to state and local governmental agencies as well as community-based organizations for evidence-based prevention activities (see Table 2). These activities may include initiatives to create healthier school environments, including prevention curricula to prevent chronic disease.

The final, but significant, example of federal inducements for categorical instruction was related to drug education. In the summer of 2012, however, Congress failed to renew funding for drug education as authorized by the Safe and Drug Free Schools and Communities Act (Title IV, Part A of Elementary and Secondary Education Act [ESEA]).

As evidenced by data from both the School Health Policies and Practices (formerly Programs) Study (CDC, 2011; Kann, Telljohann, & Wooley, 2007) and School Health Profiles (Brener et al., 2011; CDC, 2012c) surveillance systems, the piecemeal approach to the funding of health instruction through categorical grant programs results in a rickety framework for health instruction that varies widely between and across cities. For example, the median percentage of secondary schools across states that taught all 14 key nutrition topics was 65.5%, with a range of 40.5% to 88.4%, whereas across cities the median percentage of secondary schools that taught all 14 key nutrition topics was 59.9%, with a range of 13.0% to 84.2% (Brener et al., 2011). Furthermore, these
categorical grant programs are clearly inconsistent with Healthy People 2020 (USDHHS, n.d.) objectives that call for comprehensive school health education related to the six CDC risk behaviors (i.e., ECBP-2), the National Health Education Standards (i.e., ECBP-3), and personal health and wellness topics (i.e., ECBP-4; see Table 1).

Establishment of Local School Wellness Policies

School wellness policies have an indirect impact on comprehensive school health education by creating potential impetus for the development of policies in each of the eight components of coordinated school health, including health education (see CDC, 2012a). In addition to having provisions related to nutrition education, Section 204 of Public Law 111-296, the Healthy, Hunger-Free Kids Act of 2010, requires local educational agencies participating in the National School Lunch Program to establish local school wellness policies and to involve a wide range of school and community stakeholders in the formation of these policies (see Table 2). The involvement of school and community stakeholders in the development of school wellness policies encourages the creation of school wellness councils, the assessment and development of plans related to each of the eight components of coordinated school health through the use of CDC’s (2012b) School Health Index, and the fashioning of policies and practices related to health education. These programs and policies should include, but not be limited to, practices aligned with Healthy People 2020 (USDHSS, n.d.) objectives and subobjectives related to required health education, the qualifications of staff teaching health education, staff professional development, and health education courses that include instruction related to the National Health Education Standards, CDC risk behaviors, and specific health and wellness topics (see Table 1).

Health Education as a Core Academic Subject Within School Curricula

Despite the promise of comprehensive school health education to address the concomitant health and learning needs of children and adolescents, health education was not included as a core academic subject in the No Child Left Behind Act of 2001 reauthorization of the ESEA of 1966. The best opportunity for federal legislation related to comprehensive school health education in 2012 was the companion ESEA reauthorization bills Promoting Health as Youth Skills in Classrooms and Life Act introduced as H.R. 2816 by Congresswoman Marcia Fudge of Ohio and as S. 392 by Senators Tom Udall and Jeff Bingaman of New Mexico. These bills included provisions for the establishment of an Office of Safe and Healthy Students in the U.S. Department of Education that would have assumed oversight of the Office of Safe and Drug-Free Schools as well as broader health education and physical education issues, including assessments for health education and physical education, a health education grant program, and continued authorization of the Carol M. White Physical Education grant program. Given the potential impact of these companion bills on comprehensive school health education, it is imperative for health education advocates to encourage their elected officials in the House of Representatives and Senate to support the next generation of these bills as part of the reauthorization of the ESEA of 1966.

State and Local Laws and Regulations

State and local laws and regulations for comprehensive school health education vary widely between states as well as within states (Brener et al., 2011). For example, across states the median percentage of schools in which all teachers of health topics had state certification, licensure, or endorsement to teach health education in 2010 was 85.7% (range = 25.6% to 98.8%) and across cities the median percentage of schools in which all teachers of health topics had state certification, licensure, or endorsement to teach health education was 71.4% (range = 0.0% to 100.0%; Brener et al., 2011).

► ADVOCACY FOR COMPREHENSIVE SCHOOL HEALTH EDUCATION

There are respected sources of information and data related to the status of comprehensive school health education at both the federal and state levels. Additionally, Healthy People 2020 (USDHHS, n.d.) and the Joint Committee on National Health Education Standards (JCNHES; 2007) provide specific guidance for policies related to comprehensive school health education. Together, these sources are invaluable in the creation of advocacy messages for federal, state, and local advocacy activities for comprehensive school health education.

Sources of Information and Data for Advocacy Activities

Information sources regarding state-specific laws and regulations as well as data regarding the status of comprehensive school health education are prized tools for constructing advocacy initiatives. A robust source of information regarding state laws and regulations related to comprehensive school health education is the National Association of State Boards of Education (n.d.) State Healthy School Policy Data Base. Sources of national and state-specific data regarding the status of
comprehensive school health education include the School Health Policies and Practices Study (CDC, 2012d) and School Health Profiles (CDC, 2012c) surveillance systems.

Policy Recommendations for Comprehensive School Health Education

Two important sources of guidance for local, state, and national policy related to comprehensive school health education include Healthy People 2020 (USDHHS, n.d.) objectives and subobjectives and the action steps for implementing the National Health Education Standards (see JCNHES, 2007). The Healthy People 2020 objectives and subobjectives provide specific direction related to required health education, the qualifications of staff teaching health education, staff professional development, and health education courses that include instruction related to the National Health Education Standards, CDC risk behaviors, and specific health and wellness topics (see Table 1). The action steps for local education agencies, state education agencies, institutions of higher education, and national organizations and agencies for community agencies, organizations, institutions, and businesses for implementation of the National Health Education Standards (see Chapter 3, JCNHES, 2007) are usually completely overlooked by users of the National Health Education Standards document. These action steps provide specific local, state, and national policy recommendations for comprehensive school health education that not only are aligned with but also transcend the Healthy People 2020 objectives and subobjectives. For example, action steps recommended for local education agencies include the establishment of policies related to not only each of the Healthy People 2020 objectives and subobjectives (e.g., health education taught by licensed or certified health education teachers) but also class sizes and instructional facilities that are equitable with other academic disciplines (see JCNHES, 2007). Similarly, the action steps recommended for state education agencies also include policies related to each of the Healthy People 2020: objectives and subobjectives (e.g., professional standards for the licensure of teachers) as well as policies to support professional development related to health education curriculum, instruction and learning, technology, and assessment (see JCNHES, 2007). The action steps for national organizations and agencies are closely aligned with each of the Healthy People 2020 objectives and subobjectives, but they also include recommendations for supporting funding for research and evaluation related to comprehensive school health education (see JCNHES, 2007).

CONCLUSION

Given the potential contributions that comprehensive school health education can make to the reciprocal, causal relationship between health and learning, it is imperative for health educators to be involved in advocacy activities at every level of school-based policy. This can be accomplished by using data from the School Health Profiles (Brener et al., 2011; CDC, 2012c) and School Health Policies and Practices Study (CDC, 2011; Kann et al., 2007), Healthy People 2020 (USDHHS, n.d.) objectives and subobjectives, and National Health Education Standards: Achieving Excellence (JCNHES, 2007) action steps as the basis for advocacy messages. Additionally, fact sheets from the annual Health Education Advocacy Summit provide information and guidance for comprehensive school health education advocacy (see: www.healtheducationadvocate.org). These messages can be delivered as concerned family and community members, participants in school wellness councils, members of local school boards, members of professional health education organizations such as the Society for Public Health Education, and constituents of federal, state, and local policy makers.

Furthermore, it is now time for health policy advocacy for comprehensive school health education at the federal, state, and local levels to achieve and exceed Healthy People 2020 objectives and subobjectives (USDHHS, n.d.) and support student health and learning. The Patient Protection and Affordable Care Act and notable recent legislation point toward legislative bodies and a general population interested in improving the health of children. This could be a time of opportunity for health educators who want to advocate for a uniform policy that supports comprehensive school health education across the United States.

REFERENCES


