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## Book and Media Review

# Health Education and Physical Education Are Core Academic Subjects

Stephen F. Gambescia, PhD, MEd, MBA, CHES

Implementation of the federally mandated No Child Left Behind (NCLB) student, teacher, and school academic achievement initiative has been overwhelming for all those who play a key role in the education of our elementary and secondary school students.

So it may seem challenging for us to propose for the next reauthorization of this Act something additional that we really need to do, if we expect students to be ready to learn. The NCLB Act should include health education and physical education as core subject areas that require a highly qualified teacher.

NCLB is a relatively straightforward student standard, achievement-based initiative that understandably focuses on the “core academic subjects,” such as English, reading, or language arts; mathematics; science; foreign languages; civics and government; economics; arts; history; and geography.

The Act asks that teachers of these subjects be highly qualified. *Highly qualified* generally means that the teacher (a) holds a minimum of a bachelor's degree; (b) has obtained full state certification as a teacher or passed the state-sponsored teacher licensing examination and holds a license to teach in the state;

and (c) has demonstrated subject-matter competency in each of the academic subjects in which he or she teaches.

Unfortunately, two foundational subjects that do much to ready a student to learn are not required to have to have a “highly qualified teacher.” Consequently students are being exposed less to health education and physical education classes in our schools, and when a teacher is present, there is no NCLB incentive or oversight to ensure that the teacher is highly qualified, as is needed in the other subjects mentioned above.

If we expect our students to prosper academically, they must be healthy and fit. Health education programs that meet national standards and have qualified teachers improve students' health literacy and communication and decision making, stress management, peer pressure resistance to risky behavior, and positive goal-setting skills (Department of Health and Human Services, 2006a).

Critics of our proposal may think that physical education and health

class are incidental subject matters in school. We know that structured, curriculum-based physical education programs taught daily by well-qualified teachers not only improve student fitness but also improve academic performance in some standardized tests (Department of Health and Human Services, 2006b).

Ensuring that no child is left behind on basic learning skills must also include a concomitant commitment to our children's health and fitness. We are reading almost daily about the alarming rise in child and adolescent obesity. Risky behaviors that are often established during youth contribute markedly to the nation's major causes of death including heart disease, cancer, diabetes, and injuries.

Requiring teachers to be highly qualified in health education and physical education should not be a burden to schools. In fact, school health and fitness programs fare better when a coordinated school health program is in place. Teachers, administrators, and specialists already

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recognize the importance of promulgating health-enhancing information and developing healthy decision making and choices among students. The qualified health and physical education teacher can easily serve as the cross trainer or technical assistant on school health-enhancing policies and practices, as well as teaching in the classroom.

Sequelae due to risky behaviors invariably have short-term and even long-term academic impact. Consider, for example, that one underage drinking infraction buys a student a multiple-day suspension and could set the student back an estimated 2 weeks in his or her studies. Students who are energized and mentally alert tend to have fewer disciplinary problems and absences. A most dramatic example is teenage pregnancy that derails for years an adolescent achieving basic education.

Health education and physical education should be on the list of subjects taught that require a highly qualified teacher. This support helps all students learn critical life skills that enable them to prosper academically and then grow into healthy, productive citizens.

Those advocating for improved school health services and boosting comprehensive school health should consider reading the work below that we review in this issue of *Health Promotion Practice*.

Lear, J. G., Isaacs, S. L., & Knickman, J. R. (Eds.). (2006). *School Health Services and Programs*. San Francisco: Jossey-Bass. 542 pages. ISBN: 0-7879-8374-8. Paperback, \$50.00.

*School Health Services and Programs* is the second in a new

Robert Wood Johnson Foundation book series on health policy. (The first was on generalist medicine and the U.S. health system). The three editors worked with a large group of experts in the field to identify existing articles, reports, or book chapters that would have enduring value in the field of school health services. They settled on 22 pieces organized around seven sections that cover an overview and history of the field of school health services, rationale and importance of providing this health service at the schools to improve children's health, descriptions and analyses of major programs offered, and future opportunities and challenges.

The first three chapters of the book give an excellent history of school health services that is probably not familiar to most who work in providing health, social, and mental health services to students in our schools. Here, there is much to tell.

Health education, at least, has been part and parcel to the very founding of public education in the United States that aims to foster the mind, body, and spirit of children and adolescents. And many might associate the major influence of school health services with the popular school nurse programs. However, historically there has been much to include when providing health services to schools, especially if one begins with a simple, yet comprehensive, rationale of "take services to where the kids are" (p. xxi). Those who attempted to operationalize this reasonable health team provider strategy have had to answer much more than questions related to the efficacy of the intervention for keeping kids healthy, and struggled with the sociopolitical issues around:

- what health professional provides the service
- the nature (type) and extent of services (health, mental, social) to provide
- when students are eligible for an intervention
- exactly where on campus or the community can the services be delivered
- the balance between schools and parents playing their important guardian roles
- who will pay for the services

The book is useful at many levels to health educators (in schools and communities) who can see how structurally health education fits into the many areas that need to be addressed in schools to keep kids healthy. Traditionally school health had three components: health services, health education, and healthful environments. The Centers for Disease Control and Prevention Division of Adolescent and School Health Program (DASH) expands this construct to eight focus areas:

- health education
- physical education
- health services
- nutrition services
- health promotion for staff
- counseling and psychological services
- healthy school environment
- parent and community involvement

In addition, articles address the rationale and future plans for the CDC's School Health Policies and Programs Study (SHPPS) that helps us articulate the ecological and inclusive approach to keeping kids healthy using both school and community resources, rather than a polarizing dialogue about

whether it is the schools or the community who should take responsibility for our children's health.

An interesting and progressive approach to school health is advocated by Joy G. Dryfoos, a pioneer in school-based health services, who explains the reasonableness behind "full service schools" (pp. 182-214). Her reprint on "Schools as Places for Health, Mental Health, and Social Services" brings to the fore the logic of efficiency of providing comprehensive health services at schools (children are already assembled via compulsory education) and effectiveness, given the interplay and complexity of the mind, body, spirit dynamic in childhood and adolescents.

Several of the 23 chapters provide in-depth descriptions and evaluations

of successful school health services programs, including school-based health clinics. The final 2 chapters of the book address the financing of school health services.

A reading of these collected and reprinted works better positions the health educator to address the enduring issues in school health services, education, and health promotion, such as:

- the episodic argument that schools should stick to the intellectual development of our children
- the role of parents and family as the ultimate caregiver seems to be sacrosanct (cultural and legal arguments)
- parental notification versus adolescent confidentiality and risk
- who is best suited to provide the service (credentialing, economic impact, longer term clinical care issues)
- confidentiality of health records
- health protective information and social norms (e.g., sex education)

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