Reducing Youth Health Disparities Requires

K-12 Health Education

SOPHE-ASCD Expert Panel on Reducing Youth Health Disparities

In June 2010, the Society for Public Health Education (SOPHE) and ASCD convened 24 subject matter experts in health education, health care, public health and education to develop recommendations for eliminating health disparities among youth, based on best practices and policies. Recommendations from the Expert Panel include these five overarching areas:

- ☐ Cross-agency collaboration
- ☐ Using data for continuous improvement
- ☐ Health care access
- ☐ Supportive, nurturing, & healthy learning environment
- ☑ **Promotion of health-enhancing behaviors through K-12 health education and physical education**

OVERVIEW

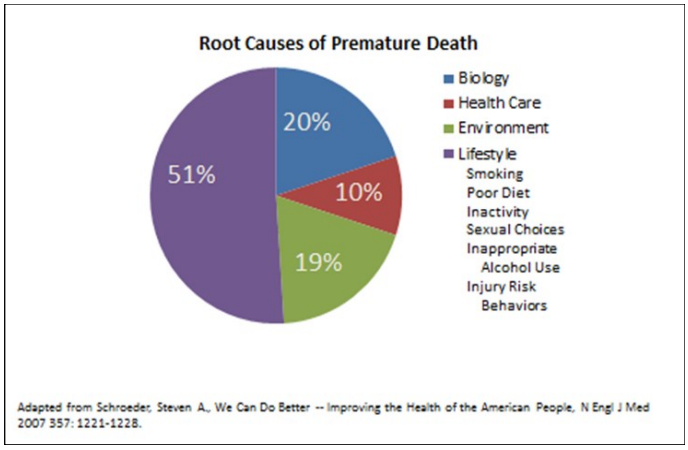

Figure 1

Engaging in health-risk behaviors threatens both the current and future health status of youth. Approximately 50% of premature death is due to unhealthy lifestyles.[1] Alcohol use is a major factor in the three leading causes of death for teenagers — auto crashes, homicide and suicide.[2] Chronic diseases in adults such as heart disease, cancer and diabetes are related to behaviors that are often established in youth: tobacco use, physical inactivity and poor diet. Unprotected sexual behaviors can lead to HIV, other sexually transmitted infections, and unintended pregnancy (See Figure 1). This fact sheet examines the recommendation by the SOPHE-ASCD Expert Panel on Reducing Youth Health Disparities to promote a healthy lifestyle among youth by providing health education in all grades.

MANY ADOLESCENTS HAVE ENGAGED IN HEALTH RISK BEHAVIORS[3]

- 44.7% of students have tried cigarettes
- 70.8% of students have had at least one drink of alcohol
- 21.9% of students have had five or more drinks of alcohol in a row
- 33.7% of teens are sexually active. Only 9.5% used both a condom to protect against a sexually transmitted disease along with a birth control method at their last sexual encounter

MOST ADOLESCENTS HAVE ADOPTED ONE OR MORE HEALTH DEBILITATING BEHAVIORS THAT LEAD TO CHRONIC DISEASE AS ADULTS: TOBACCO USE, SEDENTARY LIFESTYLE AND POOR DIETARY CHOICES.

Tobacco Use[3]

- 18.1% of students smoked tobacco on at least one day 30 days before the survey
- 7.7% of students used chewing tobacco snuff or dip on at least one day 30 days before the survey

Physical Inactivity[3]

- 71% of students did not routinely engage in physical activity 60 minutes every day
- 14% did not participate in any physical activity on any day during the 7 days before the survey

Unhealthy Dietary Behaviors[3]

- Only 28% of students ate vegetables two or more times per day
- Only 30% of students ate fruit two or more times per day
- 11% drank soda pop three or more times per day during the 7 days before the survey

MANY ADOLESCENTS ENGAGE IN MULTIPLE HEALTH RISK BEHAVIORS.

Nearly 63% of adolescents reported engaging in two or more of the five risk behaviors associated with chronic disease—smoking, sedentary lifestyle, insufficient consumption of fruits and vegetables, excessive consumption of foods high in fat and episodic heavy drinking of alcohol.[4] Another study[5] assessed the participation of students in 12 health risk behaviors and found that:

- 53% of high school students reported engaging in two or more health risk behaviors
- 36% reported engaging in three or more risk behaviors
- 15% reported engaging in five or more risk behaviors

Engaging in even one type of risky health behavior consistently can undermine a student's progress toward graduating on time from high school.[6] Students engaging in health-risk behaviors are more likely to receive "D's and F's" on their report cards[7] (See Figure 2).

EVIDENCED-BASED HEALTH EDUCATION PROGRAMS IMPROVE STUDENTS' HEALTH BEHAVIORS.

Quality health education has been proven to be effective in reducing health-risk behaviors, including preventing tobacco use,[8,9] preventing alcohol use,[9] reducing heavy drinking,[10,11] preventing dating aggression and violence,[10,12] and decreasing risky sexual behaviors.[13] Quality health education also improves health enhancing behaviors such as increasing physical activity[14] and improving dietary behaviors.[14,15]

Further, the teaching of social and emotional skills improves academic behaviors of students, increases motivation to do well in school, increases positive attitudes toward school[16] reduces absenteeism,[17] improves performance on achievement tests and grades,[18] and improves high school graduation rates.[10]

QUALITY HEALTH EDUCATION K-12 CAN ALSO IMPROVE HEALTH LITERACY.

Health literacy is the ability to gather and understand basic health information and health services necessary to make appropriate health decisions. Poor health literacy is associated with poor health outcomes,[19] including:

- Increased hospitalization
- Greater use of emergency care
- Lower use of preventive services
- Not taking prescribed medication appropriately

Health illiteracy is estimated to cost the United States between $100 and $200 billion a year in increased medical costs.[20] Increasing health instruction in K-12 schools is one strategy to reduce health illiteracy and the health care costs associated with health illiteracy.

Percentage of high school students who engaged in selected risk behaviors, by type of grades earned — United States, Youth Risk Behavior Survey, 2009

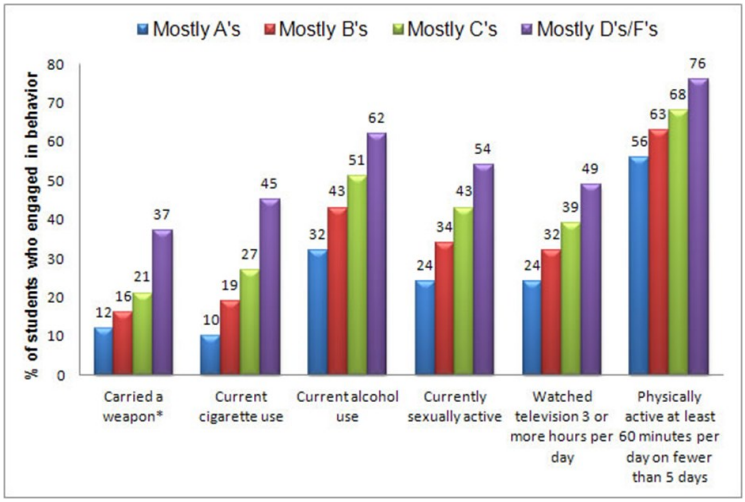

Figure 2

"One study estimates the cost of limited health literacy to the Nation's economy to be between $106 and $236 billion U.S. dollars annually. When accounting for the future costs that result from current actions (or lack of action), the real present day cost of limited health literacy may be closer to $1.6 - $3.6 trillion U.S. dollars "

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2010, page 10

QUALITY HEALTH INSTRUCTION IS CRITICAL FOR CHILDREN LIVING IN POVERTY.

Advances in our knowledge over the last 20 years have unequivocally demonstrated that experiences in childhood, as well as one's health in childhood, are predictors of health in adulthood.[22,23] This means that whatever health disparities are being experienced by children today, also have implications for their future health as adults.[23] While the lack of health instruction is serious for all students, the consequences are even more serious for poor students. These students often:

- Participate in more health-risk behaviors[4]
- Have more safety concerns that keep them from exercising outdoors[24]
- Have fewer role models who engage in a health-enhancing lifestyle[21]

Engaging students to provide health instruction to their peers is an effective way to supplement health education taught by the classroom teacher.[25.26] An analysis of 13 peer-led versus adult-led health education programs found that peer-led initiatives, when properly supervised, were as effective or more effective than adult-led programs.[27]

SCORE CARD: HOW ARE WE DOING TODAY IN THE UNITED STATES?

- The *National Standards in Health Education* are organized around eight health-enhancing concepts and call for 40 hours of instruction in grades K-2 and 80 hours of instruction annually for grades 3 to 12.[28] This is the equivalent to 55 minutes of daily health education instruction for one semester per year for grades K-12.
- Even though nearly 80% of all schools, districts, and states promote the content of the *National Health Education Standards,*[29] most schools do not provide the recommended hours of health instruction.
- Only 34% of high schools, 60% grades 4-8, and 48% of grades K-3, require health instruction at that grade level.[29]
- The actual percentage of schools providing the recommended hours of health instruction is dismal:
  - ⇒ 7.5% of K-5 schools nationwide provide the recommended 360 hours cumulative for health education
  - ⇒ 10.3% of 6-8 schools nationwide provide the recommended 240 cumulative hours
  - ⇒ 6.5% of high schools provide the recommended 320 cumulative hours[30]

HEALTH EDUCATION IS NOT ROUTINELY TAUGHT IN ALL GRADES.

Because health education is not a core subject that is tested on state achievement tests, it often is eliminated to make more time for core subjects. Quality health education K-12 is critical to ensuring the adoption of health enhancing behaviors, as well as reducing health illiteracy, which costs our nation $100-200 billion annually.[20] However, health education is not required for approximately half of the students in grades K-12 in any one year.[8]

Expert Panel Policy Recommendations

Ensuring that all students adopt a health-enhancing lifestyle requires the collaboration of the education sector and the public health and health care sectors in each community. Specific indicators identified by the Expert Panel that would demonstrate that students are being exposed to a health-enhancing lifestyle include:

Community and School Level:

- Health education instruction that meets the time requirements in the *National Standards for Health Education* is provided as a core subject at all grades.
- Annual K-12 health education classes help students achieve health literacy as well as proficiency in the use of personal and social skills.
- Consistent health instruction for young people ages 5-25 is provided about the dangers of tobacco use as well as the dangers of engaging in other health-risk behaviors.
- Youth are engaged in planning and implementing peer education programs to improve health literacy and reduce health risk behaviors.
- Social media campaigns are implemented that promote healthy behaviors including no tobacco use, active lifestyles, good nutrition habits and appropriate sexual behaviors.

State Level:

- State education agencies increase the required frequency of health and physical education classes to achieve recommended national time standards for students K-12.

National Level:

- Health education and physical education are included as core subjects in the re-authorization of the Elementary and Secondary Education Act (ESEA).
- Funding and accountability mechanisms that cut across health and education sectors ensure that the needs of the whole child are met from infancy through adolescence for all children, and particularly low income, minority and ethnic students.

About the SOPHE-ASCD Panel on Eliminating Youth Health Disparities
Convened in June 2010 in Washington, DC, the SOPHE-ASCD Panel on Eliminating Youth Health Disparities was a major first step in breaking down the silos between the education and public health leaders to address some of the most pressing problems facing poor children and youth. The summit promoted expert and innovative solutions for improved collaboration, programs and policies at the federal, state, district, community and school levels to reduce youth disparities and provide all children with a foundation for a healthy and productive future. For more information, see http://www.sophe.org/SchoolHealth/Disparities.cfm.

About the Expert Panel Sponsors
Founded in 1950, the **Society for Public Health Education** (SOPHE) provides global leadership to the profession of health education and health promotion and promotes the health of society. SOPHE's 4,000 National and chapter members work in schools, community-based organizations, health care settings, worksites and national/state/local government. For more information, see www.sophe.org. Founded in 1943, **ASCD** (formerly the Association for Supervision and Curriculum Development) is an educational leadership organization dedicated to advancing best practices and policies for the success of each learner. ASCD's membership includes 150,000 professional educators from all levels and subject areas - superintendents, supervisors, principals, teachers, professors of education, and school board members – in more than 145 countries. For more information, see www.ascd.org.

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