

North Carolina's Standard Course of Study in Healthful Living Education

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Health education can save kids' lives. It is the subject area in the North Carolina Standard Course of Study (SCOS) which, if taught and taught well, can improve the quality and length of people's lives. However, despite its potential to enhance health and well-being, the teaching of health education is often shortchanged in North Carolina's schools.

A Skills-Based Approach to Prevention

The Standard Course of Study in Healthful Living Education (SCOS) includes health education and physical education, both of which are assigned five curriculum strands at each grade level, kindergarten through 8th grade. The health portion includes Mental and Emotional Health, Personal and Consumer Health, Interpersonal Communication and Relationships, Nutrition and Weight Management, and Substance Abuse Prevention. The SCOS is intended to prevent the serious health risks for adolescents identified by the Centers for Disease Control and Prevention and the North Carolina Department of Public Instruction (see Table 2, page 464).

The American Cancer Society has been a leader in creating and disseminating National Health Education Standards (NHES) to outline content knowledge (Standard 1) and skills (Standards 2 through 8) needed by youth to achieve health literacy. *Health literacy* is defined as "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 are health-enhancing."¹

North Carolina's SCOS is based on the prevention of serious health risks by youth and has adopted the NHES as the skills-based approach to prevention. The standards, listed in Table 1, are based on the belief that knowledge by itself does not change behavior. An example of the importance of skills acquisition is in tobacco prevention. Simple recall by students that tobacco is the leading preventable cause of death is insufficient for youth to avoid the use of all tobacco products. Medically accurate content should be taught along with the skills needed for influence analysis, decision making, goal setting, and effective refusal in order to sidestep negative peer pressure.

Course of Study Revision

The curriculum guide (competency goals and objectives at each grade level) is revised every five years. Consultants from the North Carolina Department of Public Instruction convene teachers and university faculty to review the Standard Course of Study and suggest revisions. In the subject area of health education, medical and public health professionals have been invited to advise public education in areas such as obesity, tobacco use, asthma, injury prevention, dental health, HIV prevention, and physical activity. Results from the North Carolina Youth Risk Behavior Survey (NC YRBS) are used to inform education professionals about the percentages of young people engaging in behaviors which can result in mortality,

"North Carolina's Standard Course of Study is based on the prevention of serious health risks of youth and the adoption of a skills-based approach to prevention."

morbidity, and social problems. Results from the 2007 NC YRBS can be found at <http://www.nchealthyschools.org>.²

After these consultations, the proposed curriculum guide is posted for public comment. Additionally, legislative mandates from the North Carolina General Assembly must be accommodated. These North Carolina statutes include the teaching of alcohol and drug prevention, CPR and the Heimlich maneuver, and sexual abstinence until marriage. Finally, the State Board of Education suggests revisions and then grants approval of the Standard Course of Study.

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Table 1.
National Health Education Standards
(NC Healthful Living Skills)

Students will be able to:

- Standard 1: Comprehend concepts related to health promotion and disease prevention
- Standard 2: Analyze the influence of factors on health behaviors
- Standard 3: Access valid information and products and services
- Standard 4: Use communication skills to enhance health and reduce risks
- Standard 5: Use decision-making skills to enhance health
- Standard 6: Use goal-setting skills to enhance health
- Standard 7: Practice health-enhancing behaviors
- Standard 8: Advocate for personal, family, and community health

Performance indicators for the Health Education Standards articulate what students should *know* or *be able to do* at grades 2, 5, 8, and 12 and can be found at <http://www.cdc.gov/HealthyYouth/SHER/standards/1.htm>.

Perceived Weaknesses and Barriers to Effective Health Education

In 1977, a document titled *Health Education: An Incomplete Commitment* was published by the North Carolina Center for Public Policy Research. The document cited four key reasons why health was not taught or taught well in many North Carolina Schools (see Table 2).³ Table 2 also lists current areas of improvement and continued weaknesses.

The lack of a comprehensive curriculum is no longer the reason health education has not measured up to its potential. The SCOS has been in place and is revised every five years to meet the needs of teachers, schools, and learners. The problems are attributable to hiring practices in local schools as well as a lack of accountability. Failure to employ appropriately credentialed teachers of health subjects is the result of a variety of factors, including a perception of health as a less important subject, emphasis on tested subjects such as math and language arts, hiring of coaches before teachers, lack of coursework in teacher preparation programs, controversy over and self-censorship of sexuality education (topics such as HIV, STD, and teen pregnancy prevention), and the assumption that physical education teachers are qualified to teach health education.

The NC School Health Education Profiles Study is conducted every two years (alternating with the NC Youth Risk Behavior Survey). Principals and lead health teachers at the middle and high school levels are asked to respond to a survey about the delivery of health education, coordinated school health programs, and health policy. Findings in the 2006 survey include these references to the offering of health and the assignment of its teaching to teachers not licensed in the subject area:

Teaching Health

Linda Harrill Rudisill

"Children today have a shorter life expectancy than their parents for the first time in 100 years." - Dr. William Kish, Professor of Pediatrics, Baylor College of Medicine

The shorter life expectancy of children is of deep concern to parents, teachers, and medical professionals and begs the question, "What are schools doing in the area of prevention education?" The discipline of health education has the potential to have a dramatic effect on students, families, communities, and society as a whole, and yet it is too often given a cursory nod in North Carolina's public schools. As a health educator for 41 years in junior high schools and then middle schools, I have witnessed the indisputable difference health education can have on young people. Furthermore, students recognize and appreciate this meaningful and engaging area of study. Their comments speak volumes:

"Maybe one day health could be a core class."

"Every health class should have a real **health-educated** teacher."

"I think health class is just as important as math and language arts, because if you are not healthy, you will never succeed."

"I think health class is more important than any other class."

I have witnessed firsthand countless behavior changes my health-educated students have made—from finding packs of cigarettes and smokeless tobacco on my desk with anonymous notes attached stating "I QUIT" to confidential talks about the crises of the teen experience: sexual behaviors (e.g. pregnancy, STDs), eating disorders, bullies, weight issues, and family conflicts. Some examples of students' affirmations of the power of health education include:

"Since this class started, I have started to eat better, act better, and exercise more."

"I just wanted you to know health has really changed my life."

"I really do appreciate you being my health teacher. I was going to have my tongue pierced, but now I am not."

"I go home and teach my parents what we learn in class every day so they will become more health educated."

"You helped my mom quit smoking. I see my daddy on weekends and have convinced him to quit too."

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Table 2.
Health Education from 1977-2008: Areas of Improvement and Areas of Continued Weakness³

Weakness in 1977	Status in 2008
Health education in areas without coordinators is likely to continue to be inconsistent and fragmented.	In the 1970s, North Carolina was well on its way to supporting a state-funded school health coordinator in each local education agency (LEA) with support from the NC Medical Society. The initiative was derailed by the movement toward local control and the demise of categorical funding. Funding for positions intended for health education was “folded” into general budgets. Many LEAs assigned additional duties to the school health coordinator or assigned the responsibilities to someone not trained in health education. Only a few school systems currently have a full-time health education consultant.
Health education may still be perceived as a sibling of physical education and not as being important in its own right.	In some school systems, appropriately credentialed health educators are employed to teach most of the health education at the middle and high school levels. Cabarrus County and Iredell-Statesville are two which seek applicants with a degree in health education as well as licensure. In most systems it has been assumed that a graduate of a physical education degree program is able to teach health education. The State Board of Education has approved proposed dual licensure along with the requirement of 30 hours of professional development for those assigned to teach health without the appropriate degree and licensure. This arrangement will exist until 2012, at which time schools must hire a person to teach only health, only physical education, or hold a dual license to teach both subject areas.
There is no statewide comprehensive curriculum guide for the subject.	This weakness was rectified fairly quickly. Since 1990, the State Board of Education has approved a curriculum guide for health education and physical education. The North Carolina Standard Course of Study in Healthful Living Education is revised by NCDPI with input from educators and the public and is approved by the State Board every five years. There are instructional materials developed by the professional organization, the North Carolina Association for the Advancement of Health Education: <i>Successfully Teaching High School Health</i> , <i>Successfully Teaching Middle School Health</i> , and <i>Health Education: An Integrated Approach</i> .
There is no evaluation program to determine health education’s effectiveness.	This identified weakness is still true and is likely to continue. In many LEAs, there may be little accountability to oversee that health education is taught. There is little support from school administrators for any additional subject (besides math, language arts/English, and science) to become end-of-grade or end-of-course tested. With support from federal grants, there has been some backing for authentic assessment to evaluate skills instead of simply giving paper and pencil tests. Some teachers have sought professional development in assessing health literacy to learn strategies for authentic assessment.

While almost all principals report health being taught in middle schools and high schools (93% and 98% respectively), only 80% of lead health teachers in North Carolina middle schools and high schools report requiring health (a drop of 6% since 2004). Health education is reported as being taught as a combined course with physical education in 96% of high schools and 92% of middle schools. Only 72% of middle schools and 90% of high schools require newly hired health teachers to be licensed or endorsed by the state of North Carolina in health education.⁴

- Teaching of health is currently not required after 9th grade
- The perception of some school administrators that health is a “minor” subject
- Combined scheduling and grading of health with physical education
- Shortage of classrooms
- Perception of physical education as “play” and health as “punishment”
- Accommodation of recommended minutes for physical activity (time taken from health education in some schools)

Additional barriers recognized by the North Carolina Association for the Advancement of Health Education (NCAAHE) include:⁵

Efforts to Improve Health Education

There are school systems that have worked to overcome barriers and meet the needs of students for quality health education. Cabarrus County and Iredell-Statesville Schools have employed appropriately credentialed teachers of health, while Moore, Cumberland, and Surry counties require multiple and intensive professional development of their teachers of health. Many other systems support regular in-service training.

The support of federal grants from the CDC's Division of Adolescent and School Health has made a difference in the administrative support for health education, the quality of instructional materials, and the availability of professional development for teachers. Grants for HIV prevention and the Coordinated School Health Programs have resulted in the establishment of North Carolina Healthy Schools within the North Carolina Department of Public Instruction and in a position in the North Carolina Department of Health and Human Services.

The collaboration between public education and public health has been a "win-win" for promoting the health of school-aged children and youth. On the local level, many public health departments, medical facilities, and voluntary health agencies support health education through health fairs, guest speakers, and provision of materials.

Proposed Solution: Dual Licensure

Recognizing the lack of credentials of many teachers of health, the North Carolina State Board of Education (SBE) has recently established a policy regarding the qualifications of teachers of health education and physical education. In October of 2008, the SBE passed a policy to offer dual licensure by the year 2012. Colleges and universities will be able to continue separate degrees and also offer a dual degree to meet the standards and competencies of both disciplines. Until 2012, currently licensed teachers in physical education will be required to earn 30 hours (three Continuing Education Units) to earn a license in health education. Questions about accreditation and monitoring of the quality of dual programs will need to be addressed.

Proposed Solution: Professional Development

One way to enhance the quality of health education is to provide professional development for teachers who lack such a background. Even appropriately credentialed teachers need regular professional development, as health is a dynamic and ever-changing subject. In-service training is the mission of the North Carolina School Health Training Center, funded by the North Carolina Department of Public Instruction grants which originate with the Centers for Disease Control and Prevention. Approximately 45 six-hour workshops are offered each year in HIV/STD/teen pregnancy prevention, violence prevention and anti-bullying, tobacco prevention, and comprehensive health education through the Successfully Teaching Health manuals. The North Carolina Family Life Institute is a graduate-level

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When we examine the lifestyle costs of chronic disease, we know health education must address these issues. Students want a caring adult who will listen to and hear what they are saying. Their heart-wrenching stories are drawn from past and present experiences in a sometimes unfair and uncaring world.

Health education is the students' lifeline for becoming health literate as they encounter pressures from peers, the media, scholastic expectations, and family obligations. Armed with knowledge, statistics, and skills, we can empower students to choose healthy behaviors.

Our mission is clear and demands dedicated attention. It is imperative that we invest the best from every dimension: highly trained and competent teachers, financial resources, instructional materials such as the *Successfully Teaching* manuals, and scheduling that commits to the critical subject area of health education. Educated decision-making skills reduce the chances of student involvement in self-defeating behaviors that can lead to life-scarring consequences.

Schools that fail to teach health with appropriate concern for children and youth are failing them in the most vital area of their educational journey.

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intensive two-week workshop to prepare educators to be comfortable and confident to teach family life and sexuality education. The professional organization North Carolina Association for the Advancement of Health Education, within the North Carolina Alliance for Athletics, Health, Physical Education, and Dance, offers a statewide convention and other opportunities for professional development. East Carolina offers an online master's degree in health education for teachers of other subject areas.

Proposed Solution: Evidence-Based and Promising Curricula

There are evidence-based curricula in certain curriculum strands, including HIV prevention, violence prevention, and tobacco use prevention. These curricula show significant differences in risk reduction by students receiving the instruction as compared with students in a control group. For example, an HIV prevention curriculum might show students who have had the intervention reporting delayed sexual initiation, fewer sexual partners, increased condom use, and/or increased communication with parents. Barriers for the use of those curricula in North Carolina's schools include cost of instructional materials, cost of professional development, unsuitability of curricular materials based on state law or local policy, or lack of awareness that

effective curricula exist. Local school systems have been able to access funding for effective programs from grants such as Safe and Drug Free Schools funding.

Proposed Solution: Commitment and Accountability

Just as the State Board of Education's Healthy Active Children's Policy has resulted in schools requiring a minimum number of minutes allocated to physical activity during the school day, a demand for increased commitment to the teaching of health is needed. Principals and teachers must be accountable for the required SCOS being taught. As tests scores have

improved, new attention has been given to the percentage of young people dropping out before graduation from high school. Health education can reduce health-related reasons for dropout such as adolescent pregnancy and drug abuse.

Teen pregnancy, alcohol and drug abuse, overweight/obesity, suicide, tobacco use, violence, HIV/STDs, bullying and harassment, and injuries are all largely preventable through skill-building health education. For health education to realize its potential to truly enhance the quality of life for North Carolinians there must be recognition by educators and the public that healthy children learn better. There must be a serious and sustained commitment by public schools for young people to achieve their optimal health as well as their academic promise. **NCMJ**

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