ED482701 2003-07-00 The Need for Effective Professional Preparation of School-Based Health Educators. ERIC Digest.

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ERIC Identifier: ED482701
Publication Date: 2003-07-00
Author: Frauenknecht, Marianne
Source: ERIC Clearinghouse on Teaching and Teacher Education Washington DC.

The Need for Effective Professional Preparation of School-Based Health Educators. ERIC Digest.

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THE NEED FOR COMPREHENSIVE SCHOOL HEALTH EDUCATION (CSHE).

Comprehensive school health education (CSHE) can help youth obtain the greatest benefits from education and become healthy and productive adults (Institute of Medicine, 1997). One child out of four has an emotional, social, or physical health limitation that interferes with learning (Dryfoos, 1994; Tyson, 1999). Such problems include poor nutrition, lack of physical activity, substance abuse, family and social violence, mental health problems, and factors during pregnancy that affect children's development (Swingle, 1997). Because schools have the capacity to reach 53 million students every year for 12 years (U.S. Department of Education, 2000), they are in a unique position to influence young people's physical, mental, and social well-being.

Recent reports identify CSHE as a necessary component of a national infrastructure to support children's health (Kolbe, 2002). In Healthy People 2010, the Department of Health and Human Services (USDHHS, 2000) promotes increasing the proportion of secondary schools that provide school health education, with the goal of preventing the most significant health problems of youth, including unintentional and intentional injury and death; tobacco, alcohol, and other substance use and addiction; sexual behaviors that result in unintended pregnancy and sexually transmitted infections; unhealthy dietary patterns; and lack of physical activity. In addition, the Centers for Disease Control and Prevention (CDC) supports CSHE initiatives through the collection and analysis of surveillance data, identification of policies and procedures, and study of program's efficacy (Kann, Grunbaum, Banspath, & Wechsler, 2002).

The capacity of CSHE to prevent or eliminate health problems among young people depends on the effectiveness of their teachers. This digest reviews the essential elements of pre-service preparation of school-based health educators.

THE NEED FOR EFFECTIVE, STANDARDS-BASED HEALTH EDUCATION TEACHER

PREPARATIONResearch indicates that in order to influence students' health knowledge, skills, and behavior, well-prepared teachers must implement developmentally and culturally appropriate instructional strategies that provide basic information, engage participants to practice and apply relevant skills, and are of sufficient duration (Parker, 2001; USDHHS, 2000). It follows that the effectiveness of health educators depends on the quality of their professional preparation (Kolbe, 2002; Peterson, Cooper, & Laird, 2001; Summerfield, 2001). College and university programs

must prepare health-literate teachers who have the capacity to access and analyze functional health information and services as well as the competence to apply such information and services in ways that enable K-12 students to learn health concepts and skills (Peterson et al., 2001).

One means of assessing the quality of teacher training is professional program approval and accreditation; rigorous preparation programs at accredited colleges and universities have been demonstrated to enhance teacher quality (Laczko-Kerr & Berliner, 2002). The voluntary accreditation process of the National Council for Accreditation of Teacher Education (NCATE) is designed to ensure that candidates who graduate from accredited institutions have demonstrated the knowledge, competencies, and dispositions necessary to help all students learn (NCATE, 2001). As part of NCATE's accreditation process, learned societies are responsible for approving programs in their specialty areas.

STANDARDS FOR THE PREPARATION OF HEALTH EDUCATION TEACHERS

Between the late 1970s and early 1980s, professional associations aligned with health education began verifying the roles of health educators. In 1985, the National Task Force on the Preparation and Practice of Health Educators published these roles in A Framework for the Development of Competency-Based Curricula for Entry-Level Health Educators. This document described seven generic responsibilities, competencies, and subcompetencies that delineate the practice of health education in all settings. In 1986, NCATE approved these responsibilities as the standards upon which to base accreditation decisions for health education programs and designated the American Association for Health Education (AAHE) as the specialty professional association responsible for health education reviews (AAHE, 1995).
In April 2000, AAHE established a task force to align its 1985 teacher education standards with NCATE's revised professional standards (2001) that focus on performance-based assessment for accreditation. In February 2002, NCATE approved the revised health education standards (AAHE, 2002) as follows:

* Standard I, candidates assess individual and community needs for health education, requires that teacher candidates obtain health-related data about the environment, growth and development factors, and needs and interests of students. Candidates must also distinguish between behaviors that foster and those that hinder well-being and determine health education needs based on observed and obtained data.

* Standard II, candidates plan effective health education programs, says that teacher preparation programs must train candidates to engage in the entire curricular planning process. This includes recruiting school and community representatives to support and assist in program planning, developing a health education scope and sequence,

formulating measurable learner objectives, and designing strategies consistent with specified learner objectives.

* Standard III, candidates implement health education programs, engages teacher preparation candidates in analyzing factors affecting the successful implementation of CSHE programs, selecting resources and media to be used in program plans for diverse learners, exhibiting competence in carrying out planned programs, and monitoring educational programs by adjusting objectives and teaching strategies as needed.

* Standard IV, candidates evaluate the effectiveness of comprehensive school health programs, requires that candidates develop plans to assess students' achievement of program objectives, carry out evaluation plans, interpret results of program evaluation, and infer implications of evaluation findings for future program planning.

* Standard V, candidates coordinate provision of health education programs and services, asks candidates to develop a plan for coordinating health instruction with other components of CSHE, Demonstrate the dispositions and skills required for cooperation with other school staff, facilitate collaboration among health educators in all settings and other school and community health professionals, and organize professional development programs for school personnel and other interested community members.

* Standard VI, candidates act as a resource person in health education, requires candidates to effectively utilize computerized health information retrieval systems, establish consultative relationships with those requesting assistance in solving health-related problems, interpret and respond to requests for health information, and select effective educational resource materials for dissemination.

* Standard VII, candidates communicate health and health education needs, concerns, and resources, says candidates must interpret concepts, purposes, and theories of health education; predict the impact of societal value systems on CSHE programs; select a variety of communication methods and techniques to provide health information; and foster communication between health care providers and consumers.

OTHER STANDARDS PERTINENT TO HEALTH EDUCATION TEACHER PREPARATION

Although these seven professional standards provide the foundation of health education teacher training, some health education professionals suggest that programs should assimilate additional standards into candidate preparation. According to the Joint Committee on National Health Education Standards (1995), entry-level health teachers should be able to integrate the National Health Education Standards for students with relevant health content into skill-based lessons. Lessons should enable students to solve problems, make decisions, set goals, effectively communicate, manage risks,

access valid information, analyze influences, and advocate for healthy practices (Summerfield, 1995). In addition, teacher-training programs should provide a foundation in general pedagogical research or the most current best practice including applying principles of child development in lesson planning; establishing an environment conducive to learning; engaging students in the learning process; applying appropriate assessment techniques for diverse student groups; and effectively communicating to students, parents, other school staff, and community stakeholders (AAHE, 2002; Danielson, 1996).

In summary, evaluation studies of health education programs conclude that effective curricula implemented by well-prepared teachers can reduce risky behaviors among youth (Lohrman & Wooley, 1998). Teachers trained according to national standards can have a positive impact on children's health knowledge, skills, and behaviors by effectively delivering CSHE (Summerfield, 1995).

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This project has been funded at least in part with Federal funds from the U.S. Department of Education, Institute of Education Sciences, under contract number ED-99-CO-0007. The content of this publication does not necessarily reflect the views of or policies of the U.S. Department of Education nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Government.

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Title: The Need for Effective Professional Preparation of School-Based Health Educators. ERIC Digest.
Document Type: Information Analyses---ERIC Information Analysis Products (IAPs) (071); Information Analyses---ERIC Digests (Selected) in Full Text (073);
Available From: ERIC Clearinghouse on Teaching and Teacher Education, 1307 New York Ave., NW, Suite 300, Washington, DC 20005-4701. Tel: 202-293-2450; Tel: 800-822-9229 (Toll Free).
Descriptors: Academic Standards, Comprehensive School Health Education, Elementary Secondary Education, Higher Education, Mental Health, Preservice Teacher Education, Program Effectiveness, Teacher Qualifications
Identifiers: ERIC Digests, Health Educators