Advocacy for Quality School Health Education: The Role of Public Health Educators as Professionals and Community Members

David A. Birch, Hannah M. Priest, and Qshequilla P. Mitchell

Abstract

Advocacy at the local school or school district level has received emphasis as a strategy for improving school health education. The involvement of health educators in advocacy for school health education has been described as "imperative" at all levels of school-based policy. Allensworth's 2010 Society for Public Health Education (SOPHE) Presidential address indicated that public health educators could be catalysts for advocacy for health programs for children and youth, and encouraged SOPHE members to be advocates for quality school health programs in their local communities. The purpose of this article is to identify school health education advocacy opportunities at the local level for public health educators and provide direction for these efforts. To promote informed advocacy efforts, background information is presented on characteristics of quality school health education. In addition, local advocacy considerations are presented along with examples of advocacy opportunities public health educators may encounter in their professional practice and as involved community members.

Keywords: advocacy, professional responsibility, public health educator, quality school health education

While state policies and mandates have some influence on the quality of school health education, administrators, school board members and teachers at the local school district or individual school level determine specific direction and support for the curriculum and related instruction. Unfortunately, even with national standards in place for school health education, they are not often followed (Allensworth, 2015). In recognition of this situation, local advocacy has received emphasis as a strategy for improving school health education (Birch, Wallen, & Chaney, 2011; Chaney, Chaney & Eddy, 2006; Tappe & Galer-Unti, 2013; Wiley, 2005).

*David A. Birch, PhD, MCHES; Professor and Chair, The University of Alabama, 471 Russell Hall, Department of Health Science, Tuscaloosa, AL 35487-0311; Phone: 205-348-4751; Fax: 205 348-7568; Email: dabirch@ches.ua.edu

Hannah M. Priest, MAED, PhD, CHES; Assistant Professor of Public Health Sciences, School of Health and Applied Human Sciences, University of North Carolina Wilmington. Email: priesth@uncw.edu

Qshequilla P. Mitchell, MPH, PhD; Center for the Prevention of Youth Behavior Problems, The University of Alabama

*Corresponding Author

Background

In order to maximize impact, local advocacy campaigns for maintaining and enhancing school health education should involve individuals from within and outside of school health education (Wallen, Chaney & Birch, 2012). Public health educators can play an important role as advocates on the local level. The National Commission for Health Education Credentialing, Inc. has recognized advocacy as a professional responsibility for health educators and identified specific competencies related to this responsibility (National Commission for Health Education Credentialing, Inc. [NCHEC], Society for Public Health Education [SOPHE], American Association for Health Education [AAHE], 2010). These competencies are presented in Table 1. Supporting the role of public health educators as advocates, Goodhart (2002) indicated that communities have looked to health educators to influence policies and practices. Allensworth (2011), in her 2010 SOPHE Presidential address, described public health educators as potential catalysts for advocacy for health programs for children and youth, and challenged SOPHE members to "step up to the plate to ensure that their neighborhood preschools and K-12 schools implement a quality school health program that at least meets the minimum standards for health instruction" (p. 335). Tappe and Galer-Unti (2013) have described the involvement of health educators in advocacy for comprehensive school health education as "imperative" at all levels of school-based policy (p. 332).

The purpose of this article is to identify potential school health education advocacy opportunities at the local level for public health educators and provide direction for these efforts. To promote informed advocacy efforts, background information is presented on school health education including characteristics of quality programs. In addition, considerations are described that are relevant for local advocacy efforts. Moreover, specific examples are presented for advocacy opportunities that public health educators may encounter in their professional practice and as involved community members.

In order to be effective advocates, public health educators must be able to clearly articulate what is meant by "quality" school health education. They must be able to "sell" best practices to local decision-makers.

Characteristics of Model School Health Education Programs

The following characteristics, adapted from the Centers for Disease Control and Prevention (2013), are indicative of model school health education programs.

Table 1

Competencies and Sub-competencies for Health Education Advocacy

Competency 7.1: Assess and Prioritize Health Information and Advocacy Needs
- 7.1.1 Identify current and emerging issues that may influence health and health education
- 7.1.2 Access accurate resources related to identified issues
- 7.1.3 Analyze the impact of existing and proposed policies on health
- 7.1.4 Analyze factors that influence decision-makers

Competency 7.2: Identify and Develop a Variety of Communication Strategies, Methods, and Techniques
- 7.2.1 Create messages using communication theories and models
- 7.2.2 Tailor messages to priority populations
- 7.2.3 Incorporate images to enhance messages
- 7.2.4 Select effective methods or channels for communicating to priority populations
- 7.2.6 Revise messages based on pilot feedback

Competency 7.3: Deliver Messages Using a Variety of Strategies, Methods, and Techniques
- 7.3.1 Use techniques that empower individuals and communities to improve their health
- 7.3.2 Employ technology to communicate to priority populations
- 7.3.3 Evaluate the delivery of communication strategies, methods, and techniques

Competency 7.4: Engage in Health Education Advocacy
- 7.4.1 Engage stakeholders in advocacy
- 7.4.2 Develop an advocacy plan in compliance with local, state, and/or federal policies and procedures
- 7.4.3 Comply with organizational policies related to participate in advocacy
- 7.4.4 Communicate the impact of health and health education on organizational and socio-ecological factors
- 7.4.5 Use data to support advocacy messages
- 7.4.6 Implement advocacy plans
- 7.4.7 Incorporate media and technology in advocacy
- 7.4.8 Participate in advocacy initiatives
- 7.4.9 Lead advocacy initiatives
- 7.4.10 Evaluate advocacy efforts

Competency 7.5: Influence Policy to Promote Health
- 7.5.1 Use evaluation and research findings in policy analysis
- 7.5.2 Identify the significance and implications of health policy for individuals, groups, and communities
- 7.5.3 Advocate for health-related policies, regulations, laws, or rules
- 7.5.4 Use evidence-based research to develop policies to promote health
- 7.5.5 Employ policy and media advocacy techniques to influence decision-makers

Competency 7.6: Promote the Health Education Profession
- 7.6.1 Develop a personal plan for professional growth and service
- 7.6.2 Describe state-of-the-art health education practice
- 7.6.3 Explain the role of health education associations in advancing the profession
- 7.6.5 Explain the benefits of participating in professional organizations
- 7.6.6 Facilitate professional growth of self and others
- 7.6.7 Explain the history of the health education profession and its current and future implications for professional practice
- 7.6.8 Explain the role of credentialing in the promotion of the health education profession
- 7.6.9 Engage in professional development activities
- 7.6.10 Serve as a mentor to others
- 7.6.11 Develop materials that contribute to the professional literature
- 7.6.12 Engage in service to advance the health education profession

Note. Adapted from "A competency-based framework for health education specialists – 2010" by National Commission for Health Education Credentialing, Inc., Society for Public Health Education, American Association for Health Education.

Stakeholders are engaged in the planning/curriculum development process. Similar to health education programs in other settings, the involvement of stakeholders (administrators, teachers, parents, students, community members) is critical to the process of curriculum development in the school setting. This involvement can occur through participation on a curriculum development committee; the gathering of data from stakeholders through surveys, interviews, public meetings, and other techniques designed to assess health education needs, interests, and capacity; and opportunities for the review of potential curriculum materials.

The curriculum is based on national or state health education standards. The National Health Education Standards were developed to provide direction for the design or selection of curricula, instructional methods, and assessment strategies in school health education programs. Skilled advocates should have an overall awareness of the purpose and content of the Standards. It is important to note that the Standards are not a curriculum. While the Standards identify knowledge and skills that should be addressed through instruction, the specific curriculum content is determined by the local district. Table 2 includes a listing of the eight Standards (Joint Committee on National Health Education Standards, 2007).

Instruction promotes knowledge acquisition, critical thinking, skill development, and the initiation and maintenance of healthy behaviors. School health education must include instruction that goes beyond the provision of information. While some knowledge acquisition is essential in making healthy decisions, the development of critical thinking and other health-related skills are also essential in establishing and maintaining healthy behaviors. Both instruction and student assessment must reflect an emphasis on these outcomes.

Content is addressed sequentially in an age/ developmentally appropriate manner. Health education should address topics that are both age and developmentally appropriate for students at various grade levels. Like other subjects, health education content should be introduced to students in an appropriate manner in early elementary grades. This instruction should then be enhanced and built upon as students mature and move through their middle and high school experience.

Teachers actively engage students in learning through diverse instructional techniques and materials that are culturally inclusive. A hallmark of quality school health education is the use of a variety of instructional techniques that actively involve students in diverse learning experiences. Students should be involved in individual and group activities that promote analysis, cooperation, creativity, critical thinking, and skill development. Health education should not be primarily PowerPoint presentations, worksheets and videos – it should be an active experience for students. Further, the materials that are utilized should include information, examples, activities, and assessments that are representative and inclusive of individuals from diverse races, ethnicities, religions, ages, genders, sexual orientations, and physical and mental abilities.

Learning is evaluated using authentic assessment techniques. School health education should be focused on students' development of knowledge and skills that are directly applicable to their current and future life experiences. In order to best gauge this learning, students should demonstrate their level of mastery of knowledge and skills through a variety of authentic assessments that relate to real-life application of their learning. Examples of these assessments include: demonstration of a stress management technique, analyzing the benefits and risks associated with various contraceptive methods using a

Table 2

National Health Education Standards

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

Note. Adapted from "National Health Education Standards: Achieving Excellence (2nd ed)" by Joint Committee on National Health Education Standards. Copyright 2007 by The American Cancer Society.

case-study, writing a persuasive letter to a magazine publisher regarding negative body image messages and ideas for more positive messages, creating an info-graphic to advocate for healthier school lunches via social media, reviewing pertinent literature and interviewing experts on cardiovascular health.

Teachers prepared in and passionate about health education teach the curriculum. Similar to other subjects, teacher training and ongoing professional development is essential for quality health education. At the elementary level, health education, similar to other classroom-based subjects, is usually taught by the elementary classroom teacher. These individuals are professionally prepared to work with elementary grade students and are logical teachers of health education providing they have received adequate professional preparation and/or professional development in health education. At the middle school and high school level, ideally instruction should be delivered through separate courses taught by teachers professionally prepared in health education.

Health education is linked to other school programs through the Whole School, Whole Community, Whole Child approach (WSCC). School health education is essential to promoting health for students. However, to maximize the impact of instruction through health initiatives in other school programs, health promotion interventions beyond instruction are needed. The Whole School, Whole Community, Whole Child approach is a collaborative, child-centered model comprised of ten components designed to promote each child's cognitive, emotional, physical, and social health, and subsequently their academic success (ASCD®, 2014) (see Figure 1). WSCC combines and builds on elements of the traditional Coordinated School Health model and the ASCD's Whole Child Initiative. The child serves as the focal point of the model, surrounded by tenets of a 'whole child' approach to education: healthy, safe, engaged, supported, and challenged.

Strategies

While understanding the characteristics of quality school health education is a necessity, additional information is essential for informed advocacy. The following considerations are important for public health educators engaged in school health education advocacy.

Present information about youth behavior and health status. Potential supporters may not be aware of the nature of poor health behaviors of youth and the related health and social issues. In many advocacy situations, this information is useful in making the case for the importance of school health education. An excellent source for information related to health-related behaviors of youth is the Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (DASH), Youth Risk Behavior Surveillance System (YRBSS). The YRBSS monitors, through a semi-

Figure 1

Whole School, Whole Community, Whole Child Model

Figure 1. The child is at the center of the model, surrounded by the whole child tenets. The school (second outermost ring) serves as a hub and provides comprehensive health and learning support systems for each child. The community (outermost ring) indicates that the school is a part of the community and needs community input, resources, and collaboration to succeed. Adapted from "Whole School, Whole Community, Whole Child: A Collaborative Approach to Learning and Health" by ASCD®, 2014, p. 7. Copyright 2014 by ASCD®. Reprinted with permission.

annual national survey, youth behaviors in six health risk areas: behaviors that contribute to unintentional injury and violence; sexual behaviors that contribute to unintentional pregnancy and transmission of sexually transmitted diseases, including HIV infection; tobacco use; alcohol and other drug use; physical inactivity; and unhealthy dietary behavior. Data are also collected through state, territorial, tribal and school district surveys. The YRBSS also monitors the prevalence of asthma and obesity (CDC, 2014a).

The 2013 YRBSS results are available in the June 13, 2014 *Morbidity and Mortality Weekly Report* (CDC, 2014b). This document presents a detailed report regarding behaviors in each of the six areas and can serve as an advocacy tool. Additionally, *Youth Online* is an interactive, web-based, YRBSS data exploration tool that allows for YRBSS result comparisons across health risk behaviors, locations, and demographic subgroups (CDC, n.d.). *Youth Online* can be used to ascertain pertinent information and develop relevant materials such as graphs and tables for advocacy efforts at the national, state, and local level.

Be familiar with state and local policies. Advocates must be knowledgeable of state mandates and policies for school health education. In addition, advocates must also be aware of the local policy for school health education related to sequence of instruction (at what grades and how much time) and curriculum content. It is important for advocates to know what provides direction for the curriculum. Ideally the curriculum should be driven by the needs of the local school district, and national and state standards.

Emphasize the linkage of health and academic success. Because of their understandable interest in academic success for students, parents, community members and school administrators may place emphasis on subjects such as math, language arts, science and technology at the expense of health education. What is often missed in these situations is the impact of health status on student learning. Basch, in a series of articles in the October 2011 issue of the *Journal of School Health*, presents a comprehensive description of the connection between health and learning (Wechsler, 2011). Dr. Gene Carter, former ASCD® Executive Director and CEO, presents a rationale for this connection.

> Health and education are related. They are interrelated. They are symbiotic. Boosting one boosts the other. There is a connection between the two sectors. When one fails, so does the other. When one succeeds that success feeds the other. We do not just have an isolated duty to want the child to be healthy and educated—we have a moral imperative. (Carter, 2013, August, para. 7).

Advocates must stress the importance of the connection between health and academic success.

Consider school district instructional priorities. Health education must fit in with other school and school district priorities. School districts often identify educational philosophies, instructional approaches, and specific outcomes as priorities for teaching and assessment. For example, if a school district places emphasis on 21st Century Skills, advocates must be able to identify how health education contributes to the development of these skills. Other examples of possible priorities include Common Core, science, technology, engineering, and math (STEM), service-learning, inquiry-based learning, global education, and authentic assessment. Regardless of the focus, advocates must be able to articulate the health education connection to district instructional priorities.

Identify organizations and policies supportive of school health education and WSCC. It is important that advocates identify organizations outside of health education that have indicated support for the importance of quality school health education. ASCD®, a global leader committed to quality teaching and learning, is a prime example, as demonstrated by its co-development and endorsement of the WSCC model in "*Whole School, Whole Community, Whole Child: A Collaborative Approach to Learning and Health"* (ASCD®, 2014a, 2014b). One important document is a joint statement titled *"Health Education in Schools – The Importance of Establishing Healthy Behavior in our Nation's Youth"* that was published by the American Cancer Society (ACS), the American Diabetes Association (ADA) and the American Heart Association (AHA) (ACS, ADA, & AHA, n.d.). This joint statement "encourages quality school health education within all schools in the United States" (p. 3).

Another organization with a strong position statement in support of quality health education is the National Parent Teacher Association (PTA). Their statement recognizes the importance of a "health curriculum that is comprehensive for all students preschool through 12th grade, sequentially developed, age and culturally appropriate, reflects current health issues of the community, and is taught by educators qualified to present health instruction" (National PTA, 2005, p. 1).

Discussion

Advocacy Opportunities as a Public Health Educator

Public health educators often plan, implement and evaluate health promotion programs that involve interventions for school-age youth. For example, obesity is a current topic that is often addressed through public health promotion programs. Public health educators may initiate a program that includes a school nutrition education component for students in a particular grade(s). Involvement in such a program presents an opportunity to advocate for quality school health education programs that go beyond nutrition education. Advocates can present the potential impact of school health education and WSCC; the need for a sequential, comprehensive PreK-12 program; and the connection of health and academic success. Involvement in these types of programs for students should not only be viewed by the public health educator as an opportunity for education in a particular topic area (in the preceding example, nutrition education) but also an opportunity to advocate for additional topics that are components of a comprehensive school health education program.

If one does not already exist, public health educators can be catalysts for the formation of a local community coalition or advocacy organization for school health education. A coalition or advocacy organization can promote quality school health education through local and state advocacy efforts. In addition, such organizations can educate community members and other key stakeholders about the characteristics of quality school health education and its potential health and academic impact, monitor local school district policies and actions that might affect school health education, and promote candidates in

local school board elections who support quality school health education.

Public health educators can promote quality school health education as professional members of local school or school district committees. Committees that address issues such as school health education, school safety, school nutrition policies, or address student health issues such as substance abuse; obesity; sexual health; and mental and emotional health often include health professionals as members. In some cases, public health educators may be overlooked for this role. One important step in being considered for these roles is creating a relationship with school administrators responsible for school health education. These contacts could include health education coordinators, curriculum coordinators, principals, associate superintendents, and superintendents. To establish these relationships, public health educators must reach out to individuals in these positions and indicate their interest in working with local schools to promote the health and academic success of students.

Advocacy Opportunities as a Community Member

All public health educators live in communities with a local public school district. Thus, all public health educators have the potential of being advocates as community members outside of their professional responsibilities. Community members can initiate school health education coalitions or advocacy groups. Because of their professional background, public health educators can play a key role in the initiation of a school health education advocacy body in their local community. It is important to note that involvement as a community member in this type of activity will take place, in many cases, outside of the professional responsibilities of the public health educator and perhaps, outside of the geographic region of their professional responsibilities.

Another potential role for public health educators is serving as a community representative on a school committee. Similar to the professional opportunities, these committees might be curriculum development committees or committees addressing student health issues.

In all elections, public health educators should be informed of candidates' positions related to health issues. This is especially important in relationship to school health education. Informed community members should be aware of the importance placed by school board candidates on school health education and WSCC. Questions could be asked of candidates regarding their positions in public forums or in direct communication with candidates. Another action related to influencing policy is becoming a candidate for a local school board position. Having a health educator as a school board member puts a school health education advocate in perhaps the most important individual advocacy position.

Some public health educators may have unique school health education advocacy roles in their local communities as parents of children enrolled in local schools. Advocacy opportunities can be present in meetings with teachers and administrators in situations such as back to school nights, parent-teacher conferences, and other interactions with school faculty and administrators. These settings can be used to inquire about the school approach to health education and WSCC and provide a forum for parents to advocate for such programs.

Conclusion

Local advocacy for maintaining and improving the quality of school health education is an important public health strategy. Public health educators can play key roles in such advocacy efforts as professionals and community members.

While most health educators understand the potential of quality school health education, it is important to realize that many parents, stakeholders and school decision-makers do not possess this same understanding. Because of their past experiences, these individuals may only be familiar with sub-standard school health education. To counteract these perceptions, local advocates must be prepared to describe the characteristics of quality school health education programs. In addition, advocates must be able to describe how quality school health education not only addresses the health needs of students but also promotes academic success for students and the educational priorities of the district.

Recommendations

Public health educators should actively seek out and examine opportunities to advocate for school health education as professionals and as community members. Additionally, professional preparation programs in public health education can address advocacy for school health education as an important competency for students. Whenever advocacy efforts are made, it is critical that health educators conduct evaluation to determine if their actions made a positive difference, and discuss steps that could be taken to improve future initiatives. Lastly, results of school health education advocacy efforts should be widely disseminated so that others may can learn from and build upon those experiences.

Acknowledgements

The authors declare no conflicts of interest. The research received no specific funding from any agency in the public, commercial, or not-for-profit sectors.

References

Allensworth, D. (2015). Historical overview of coordinated school health. In D. A. Birch & D. M. Videto (Eds.), *Promoting health and academic success: The whole school, whole community, whole child approach* (pp.13-28). Champaign, IL: Human Kinetics.

Allensworth, D. (2011). Addressing the social determinants of health of children and youth: A role for SOPHE members. *Health Education & Behavior*, *38*, 331-338. doi:10.1177/1090198111417709

American Cancer Society, American Diabetes Association, & American Heart Association. (n.d.). *Health education in schools – the importance of establishing healthy behaviors in our nation's youth* [Position statement]. Retrieved from: http://www.cancer.org/acs/groups/content/@nho/documents/document/healthedstatementpdf.pdf

ASCD®. (2014a). *Whole school, whole community, whole child: A collaborative approach to learning and health*. Retrieved from: http://www.ascd.org/ASCD/pdf/siteASCD/publications/wholechild/wscc-a-collaborative-approach.pdf

ASCD®b. (2014b). *ASCD mission.* Retrieved from: http://www.ascd.org/about-ascd.aspx

Birch, D. A., Wallen, M., & Chaney, E. H. (2011). Developing school health education advocacy skills through college personal health courses. *Health Education Teaching Techniques Journal*, *1,* 70-76.

Carter, G. R. (2013, August). *The whole child blog: Improving schools: The integration of health and education.* Retrieved from: http://www.wholechildeducation.org/blog/improving-schools-the-integration-of-health-and-education

Centers for Disease Control and Prevention. (2014a). Y*outh Risk Behavior Surveillance System*. Retrieved from: http://www.cdc.gov/healthyyouth/yrbs/index.htm

Centers for Disease Control and Prevention. (2014b). Youth Risk Behavior Surveillance – United States, 2013. *Morbidity and Mortality Weekly Report*, *63*(4), 1-168,

Centers for Disease Control and Prevention. (2013). *Characteristics of an effective health education curriculum.* Retrieved from: http://www.cdc.gov/HealthyYouth/SHER/characteristics/

Centers for Disease Control and Prevention. (n.d.). *Youth Risk Behavior Surveillance System: Youth Online*. Retrieved from: http://www.cdc.gov/healthyyouth/yrbs/pdf/2013_yrbs_youth_online_flyer.pdf

Chaney, E. H., Chaney, D. J., & Eddy, J. M. (2006). Utilizing a multi-level approach to support advocacy efforts in the advancement of health education. *American Journal of Health Education*, *37*(1), 41-50.

Goodhart, F. W. (2002). Teaching advocacy to public health students: How and why. *Health Promotion Practice, 3*, 341-346. doi:10.1177/152483990200300302

Joint Committee on National Health Education Standards. (2007). *National Health Education Standards: Achieving Excellence* (2nd ed.). Atlanta: American Cancer Society.

National Commission for Health Education Credentialing, Inc. (NCHEC), Society for Public Health Education (SOPHE), American Association for Health Education (AAHE). (2010). *A competency-based framework for health education specialists - 2010.* Whitehall, PA: Author.

National Parent Teacher Association. (2005). *Position statement – Elements of comprehensive health programs.* Retrieved from: http://www.pta.org/files/FileDownloads/11_POSITION_Elements_Comprehensive_HealthPrograms_FINAL.pdf

Tappe, M. K., & Galer-Unti, R. G. (2013). U. S. policies for school health education: Opportunities for advocacy at the local, state, and national levels. *Health Promotion Practice, 14*(3), 328-333. doi:10.1177/1524839913475624

Wallen, M., Chaney, B., & Birch, D. (2012). Assessing the efficacy of a school health education advocacy lesson with college students. *The Health Educator, 44*(1), 14-20.

Wechsler, H. (2011). Preface. *Journal of School Health*, *81*(10), 3-5.

Wiley, D. C., & Howard-Barr, E. M. (2005). Advocacy to action: Addressing coordinated school health program issues with school boards. *Journal of School Health*, *75*(1), 6-10.

As a reminder, please check out the online edition of *The Health Educator* at:

http://www.etasigmagamma.org/healtheducator.

There is general information about the publication and also guidelines for manuscript preparation.

Back issues of *The Health Educator* are also readily available.

CALL FOR APPLICATIONS

EDITORIAL ASSOCIATES

The Health Educator will have editorial associate openings for a three-year term beginning January 2016. The Editorial Associates perform a vital service role in serving as peer reviewers for manuscript submissions and advising the editor on editorial policies and practices. These are voluntary positions with no remuneration provided for services rendered. All applicants are expected to hold ESG membership or be willing and eligible to join Eta Sigma Gamma through the At-Large Chapter as described on the ESG website (www.etasigmagamma.org).

If you would like to be considered, please send a letter of application and a current resume or curriculum vitae no later than February 30, 2016 to:

Dr. Sheila M. Patterson, Editor
s.m.patterson@csuohio.edu