SOCIETY FOR PUBLIC HEALTH EDUCATION

Global Leadership for Health Education & Health Promotion

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Society for Public Health Education's (SOPHE) comments on the proposed Healthy People 2030 Framework

The Society for Public Health Education (SOPHE) appreciates the opportunity to comment on the proposed Healthy People 2030 framework for the U.S. Department of Health and Human Services (HHS). We are pleased that the proposed framework seeks to build on the nearly 40 years of Healthy People history. Throughout its history, the Healthy People initiatives have focused on reducing health disparities and achieving health equity. SOPHE applauds this sustained commitment to health equity, but must advocate for using existing data collection and research to create action plans in order to move the needle toward a more equitable and healthy society. Given the advances in the field over the past decade, we see a critical opportunity for building upon previous generations of Healthy People to leverage the power of policy change to address the social determinants of health. To that end, SOPHE recommends that the framework be based on measurable goals associated with policy, systems, and environmental (PSE) changes that allow for the structural and institutional causes of population health inequities to be adequately addressed.

SOPHE is a non-profit professional organization founded in 1950 to provide global leadership to the profession of health education and health promotion. SOPHE contributes to the health of all people and the elimination of health disparities through advances in health education theory and research; excellence in professional preparation and practice; and advocacy for public policies conducive to health. SOPHE is the only independent professional organization devoted exclusively to health education and health promotion. Members include behavioral scientists, faculty, practitioners, and students engaged in disease prevention and health promotion in both the public and private sectors. Collectively, SOPHE's 4,000 national and chapter members work in universities, medical/health care settings, businesses, voluntary health agencies, international organizations, and all branches of federal/state/local government.

The Healthy People 2030 framework should be easily integrated into the physical, social, environmental, and health care environments in which all people live, work, play, and study. This will address a principal concern with the outcome measures associated with Healthy People 2020, notably that racial and ethnic health disparities are narrowing, while disparities identified by other socioeconomic identifiers that influence health (e.g., education or income level) are widening. One particularly effective intervention that addresses multiple health and socioeconomic outcomes to contribute to the health and well-being of the nation is the provision of skills-based health education in schools. The expansion of health education in K-12 schools is

critical to achieving the vision statement of Healthy People 2030 for "a society in which all people achieve their full potential for health and well-being across the lifespan" by imbuing children and adolescents with the health literacy skills to evaluate their choices and make healthy decisions for themselves, their families, and their communities before unhealthy habits that lead to costly chronic conditions can take hold. The National Health Education Standards identify eight skills that should be taught to students throughout K-12. These skills include: 1) Comprehending concepts related to health promotion and disease prevention; 2) Analyzing the influence of family, peers, culture, media, technology, and other factors on health behaviors; 3) Accessing valid information, products, and services to enhance health; 4) Using interpersonal communication skills to enhance health and avoid or reduce health risks; 5) Using decision making skills to enhance health; 6) Using goal setting skills to enhance health; 7) Practicing health enhancing behaviors to avoid or reduce risks; and 8) Advocating for personal, family, and community health. Decades of research demonstrate that strengthening students social and emotional skills (e.g., goal-setting, decision making, and communication skills) improves academic behaviors of students, increases motivation to do well in school, increases positive attitudes toward school, reduces absenteeism, improves performance on achievement tests and grades, and improves high school graduation rates.[1-4]

Comments on Mission - To promote and evaluate the nation's efforts to improve the health and well-being of its people

SOPHE supports the proposed mission as stated and shares the commitment to improving the health and well-being of people across the nation. We applaud the proposed five overarching goals including: attain health literacy, achieve health equity, eliminate disparities, and improve the health and well-being of all populations. SOPHE members are Health Education Specialists (HES) who work to promote population-based health through policy, systems, and environmental changes that can help prevent diseases, injuries, and other health problems. HES are integral members of the public health workforce that are equipped to assess community and individual health risks, plan, implement, and evaluate interventions that integrate the latest behavioral science theory, particularly those reaching vulnerable populations, (i.e. those more susceptible to social determinants that lead to increased incidence of chronic conditions).

A core competency of HES is improving the public's health literacy and communicating with and understanding the needs of the underserved, vulnerable, and/or limited English-speaking populations, including those who are disabled and suffer from one or more chronic diseases. HES also supervise community health workers, trusted members of the community served, who can facilitate access to priority populations, and improve the cultural competence of the education or service delivery. Given the wide range of populations with which they work and the

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[1] Zins, J.E., Bloodworth, M.R., Weissberg, R.P. & Walberg H.J. (2004). The scientific base linking social and emotional learning to school success. In Zins, J.E., Weissberg, R.P., Wang, M.C. & Walberg H.J. Building Academic Success on Social and Emotional Learning: What does the research say? New York: Teachers College Press.

[2] Christenson, S. & Havsy L. H. (2004). Family-School-Peer Relationships: Significance for Social, Emotional, and Academic Learning in Building Academic Success on Social and Emotional Learning. (J.E. Zins, R.P. Weissberg, M.C. Wang & H.J. Walberg, editors). New York: Teachers College Press, 59-75.

[3] Durlak, J.A., Weissberg, R.P., Dymnicki, A. B., Taylor, R.D., & Schellinger, K.B. (2011). The Impact of Enhancing Students' Social and Emotional Learning: A Meta-Analysis of School-Based Universal Interventions. Child Development, 82 (1), 405–432. Available at http://casel.org/wp-content/uploads/2011/04/Meta-Analysis-Child-Development-Full-Article.pdf.

[4] Hawkins, J., Catalano, R., Kosterman, R., Abbott, R., Hill, K. (1999). Preventing adolescent health-risk behaviors by strengthening protection during childhood. Archives of Pediatric Adolescent Medicine, 153, 226-234.

diverse settings in which they are employed, health education specialists have significant capacity to design, conduct, and evaluate individual, community, and population level health interventions. HES skills in health communications, cultural competency, community engagement, community needs assessment, health coaching, and inter-disciplinary collaboration make them natural leaders to work with public health partners including Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) toward an integrated, cost-effective preventive health care system that better serves beneficiaries as they access prevention programs.

The health education profession has a well-established, distinct body of knowledge, and multidisciplinary competencies guiding professional preparation and practice, in addition to a certification system for educators as well as a code of ethics.[5] During the last three decades, the profession has undertaken five research studies to verify the psychometric properties of competencies and sub-competencies needed by health education practitioners working in diverse settings. HES have formal training at the undergraduate and graduate levels, as well as the ability to gain advanced certification in the seven areas of responsibility, including the social determinants of health.[6]

Comments on Foundational Principle 1: Health and well-being of the population and communities are essential to a fully functioning, equitable society

Research in public health promotion and chronic disease prevention consistently points to the direct correlation between behavioral health and health outcomes. However, healthy behaviors, such as avoiding tobacco, eating healthy food and beverages, and getting regular physical activity, are influenced by many factors beyond individual control that require a socio-ecological approach. Therefore, it is essential to prioritize the principle of positive health and well-being of the population and communities, which is conducive to achieving a fully functioning, equitable society. This is made possible through communities and stakeholders who work to provide opportunities for children and their families to engage in easy choices that lead to healthier lifestyles. Approximately 40% of premature death is due to unhealthy lifestyles, which can be defined as engaging in health debilitating behaviors. Biology contributes 30% to premature death, health care 10%, social factors 15%, and the environment 5%.[7]

Chronic diseases in adults, such as heart disease, cancer, and diabetes, are often related to behaviors that are established in youth: tobacco use, physical inactivity, and poor diet. These chronic diseases are responsible for 7 of 10 deaths each year, and treating people with chronic diseases accounts for 86% of our nation's health care costs.[8] Therefore, addressing the health and well-being needs of children is an optimal prevention strategy. Specifically, by addressing the needs of children through day care centers, K-12 schools, after school centers, public health officials can reach not only students, but their parents and school staff. To illustrate the level of impact school-based health education has across these populations, consider the 76 million

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[5] McKenzie, J. F., Dennis, D., Auld, M. E., Lysoby, L., Doyle, E., Muenzen, P. M., ... & Kusorgbor-Narh, C. S. (2016). Health education specialist practice analysis 2015 (HESPA 2015) process and outcomes. Health Education & Behavior, 43(3), 286-295.
[6] National Commission for Health Education Credentialing. (2016). Health education specialist practice analysis (HESPA) 2015 competencies and sub-competencies. Retrieved from http://www.nchec.org/assets/2251/hespa_subcompetencies_color_coded_33.pdf
[7] Schroeder, S. A. (2007). We Can Do Better -- Improving the Health of the American People, N Engl J Med, 357: 1221-1228. Available at http://aysps.gsu.edu/ghpc/5894
[8] CDC. (2016). Chronic Disease Prevention and Health Promotion. Retrieved from http://www.cdc.gov/chronicdisease/index.htm

students aged less than 30 in 2011, a group that represented 60% of the under-30 population.[9] This number cannot be overlooked, especially when combined with the student's caregivers, an additional 76 million, plus the teachers and school staff, which in the fall of 2017 equated to 3.2 million full-time-equivalent (FTE) teachers.[10] The Brookings Institute etimates that about half of the U.S. population can be reached through working with the institutions that are charged with educating students: early child care centers, K-12 schools, and universities.[11] These sites can not only involve parents and caregivers in their instruction but also provide worksite wellness initiatives for staff.

In summary, SOPHE encourages HHS to consider the research showing that society can achieve improved community health by focusing on youth health and learning. This is illustrated best by the Whole School, Whole Community, Whole Child (WSCC) Model that places the child in the center as the focal point of community health strategy to integrate activities for health education and promotion at all levels, ultimately producing a reflection of health outcomes to be seen in the community.[12] SOPHE is committed to the promotion of school health and policies that support a conducive learning environment as supported under the WSCCmodel and recommends this research to guide the proposed Healthy People 2030 framework.

Comments on Foundational Principle 2: Achieving the full potential for health and well-being for all provides valuable benefits to society, including lower healthcare costs and more prosperous and engaged individuals and communities

SOPHE supports school health and the holistic well-being of children in support of achieving the full potential for health and well-being including lower healthcare costs and more prosperous and engaged individuals and communities across the lifespan. Approximately 95% of children and youths attend school in the United States, making schools the ideal setting for collaboration between education and health for the benefit of society.[13] Schools can influence the nutritional choices and physical activity behaviors that kids make. Students spend a large proportion of their time in school, and are likely to eat as many as 2 out of 3 meals each day and are likely to get much of their physical activity through their school environment.[14] Evidence-based research shows a positive correlation between student participation in the United States Department of Agriculture (USDA) School Breakfast Program (SBP), and improved academic results, standardized test scores, and improved cognitive performance.[14] Such research also demonstrates a negative correlation between student participation in the USDA SBP and school absences.[14]

Moreover, students who are physically active are more likely to have better grades, school attendance, cognitive performance, and classroom behaviors.[14] Evidencedbased programs

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[9] Davis, Jessica and Bauman, Kurt. (2013), School Enrollment in the United States: 2011. US Census Bureau. Available at https://www.census.gov/prod/2013pubs/p20-571.pdf.

[10] IES/NCES. (2017). Fast Facts: Back to school statistics. Digest of Educational Statistics Available at https://nces.ed.gov/fastfacts/display.asp?id=372 and https://nces.ed.gov/programs/digest/d16/tables/dt16_105.20.asp?current=yes.

[11] Loeb, Susanna. (2016) Half the people working in schools aren't classroom teachers—so what? Brookings Institute. Available at: https://www.brookings.edu/research/half-the-people-working-in-schools-arent-classroom-teachers-so-what/ . January 14, 2016.

[12] Association for Supervision and Curriculum Development ASCD. (2014). Whole school, whole community, whole child: a collaborative approach to learning and health. Retrieved from

[13] ASCD. (2014). 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

[14] Centers for Disease Control and Prevention. (2014). Health and academic achievement. Retrieved from https://www.cdc.gov/healthyyouth/health_and_academics/pdf/health-academic-achievement.pdf

founded in nutrition and physical activity for K-12 schools are available for practitioners to use. Making healthy eating and physical activity in schools a priority can help to address barriers to learning. Healthy students are better learners and are therefore able to achieve higher levels of academic success, resulting in a generation of adults who engage with and strengthen their communities. SOPHE is committed to the promotion of school health policies that support a conducive learning environment including healthy nutrition and physical activity as supported under the WSCC model. Addressing child and youth related issues of oral health, nutrition and food insecurity, physical activity, health services, and other areas provides valuable benefits to society in terms of reduced healthcare expenditures and provides a solid foundation for such children to grow up as productive and engaged members of society.

Graduation from high school is associated with better health and an increase of approximately nine years of average lifespan.[15] As income levels increase, positive health behaviors and health outcomes are enhanced.[16] Post-secondary education leads to even healthier lives by improving earning power, social status, and cognitive ability, which in turn influences positive lifestyle choices, an enhanced understanding of health issues, and better negotiations in the medical care system.[17] Better adult health status improves the health status of future children.[16] In this way quality health education improves population health for this generation as well as future generations.

Comments on Foundational Principles 3: Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy

SOPHE suggests amending the principle to include "…and attaining health literacy and numeracy." SOPHE supports achieving health equity for all persons, starting with children and youth. Utilizing the WSCC model provides a framework to reduce health disparities, improve health equity and increase health literacy and numeracy. As illustrated in WSCC, the child is the focal point, and the goal is that each child be healthy, safe, engaged, supported, and challenged.[18] All children need educational and health services as they develop, but the need for these services is particularly great for the 20% of children living in poverty. Living in a high poverty family often results in two major consequences for children: a health disparities gap and an achievement gap limiting students' success in school. Children from poor families experience more chronic disease, more infectious disease, more childhood injury, more social/emotional and behavioral problems that reduce their ability to concentrate on learning in addition to experiencing more violence and death compared to children who do not live in poverty.[18] Further, for poor children the prognosis is worse as poor children receive less and lower-quality medical care than their more affluent peers.[19] Because these students tend to be sicker, they are absent from school more often than their peers from more affluent families. These illnesses and absences cumulatively

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[15] Wong M, Shapiro M, Boscardin W, & Ettner S. (2002). Contribution of major diseases to disparities in mortality. New England Journal of Medicine 347 (20) November 14., 1585-1592.
[16] Egerter S., Braveman P., Sadegh-Nobari T., Grossman-Kahn R., & Dekker M. (2009). Education Matters for Health. Princeton, New Jersey: Robert Wood Johnson, Commission to Build a Healthier America. Retrieved from http://www.rwjf.org/files/research/commission2009eduhealth.pdf.
[17] Murray, Nancy et al. (2006) Education and Health: A Review and Assessment, Appendix E.in Code Red: The Critical Condition of Health in Texas. Available at: http://www.coderedtexas.org/files/Appendix_E.pdf.
[18] Currie, J. & Lin W. (2007) . Chipping Away at Heath: More on the Relationship Between Income and Child Health. Health Affairs 26, 331-334.
[19] Chen, E., Matthews, K.& Boyce, W T. (2002). Socioeconomic Differences in Children's Health: How and Why Do These Relationships Change with Age? Psychological Bulletin, 128(2); 295-319.

lead to an observed achievement gap.[20] The achievement gap is the term given to the difference in academic performance between poor students and wealthy students, as well as minority students and their non-minority peers. This achievement gap is evident at kindergarten and increases throughout students' educational career if no interventions are provided to address this gap. These students start kindergarten behind their peers, fall further behind during elementary and secondary school, and complete college and graduate school at lower rates than those students from higher-income families.[21]

While the observed need for school-based services to address student's health status and health behaviors has increased, the level of health and social services available in schools to address these needs has decreased. Only 31.5% of schools nationwide have a full-time registered nurse.[22] While instruction is the main business of schools, when 25% or more students live in extraordinary circumstances, as is typically the case in truly disadvantaged schools, a coherent, organized response is needed. Engaging families and community health and social service agencies as partners to supplement limited school resources reduces student health problems and improves academic achievement.[23] When students receive the education and health interventions that they need, academic performance and educational achievement levels improve.

The limited level of health literacy of the nation is a serious and escalating public health issue. Health literacy is noted in Healthy People objectives as the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[24] Both literacy skills (being able to read) and health knowledge skills (understanding how a healthy body functions, how to keep it healthy, and how to make healthy choices) are required to achieve health literacy. Individuals must be proficient in health literacy to lead healthy lifestyles, to effectively navigate the health care system, to advocate for their health care needs, to respond to public health alerts, and to vote on decisions affecting the health of their environments and communities. While there is no national survey of children's health literacy levels, a national survey of adults found only 12% were proficient and only 53% had intermediate health literacy.[25] Limited health literacy affects Americans of all ages, races, incomes, languages, cultures, and education levels and is estimated to cost the United States between $100 and $200 billion a year in increased medical costs.[26]

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[20] Barton P.E. & Coley, R. J. (2009). Parsing the Achievement Gap, Princeton, NJ: Educational Testing Service. Available at http://eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_&ERICExtSearch_SearchValue_0=ED505163&ERICExtSearch_SearchType_0=no&accno=ED50516317.

[21] Wyner J. S., Bridgeland J. M., DiIulio, Jr. J. J. (2007). Achievement Trap: How America is Failing Millions of High-Achieving Students From Lower-Income Families. A Report by the Jack Kent Cooke Foundation & Civic Enterprises with original research by Westat. Retrieved from: http://www.civicenterprises.net/pdfs/jkc.pdf.

[22] Brenner, N.D., Wheeler, L., Wolfe, L. C., Vernon-Smiley, M., Caldart-Olsen, L. (2007). Health Services: Results from the School Health Policies and Programs Study, 2006. Journal of School Health, 77 (8) 464-485.

[23] Bryk, A., Sebrig, P.B., Allensworth, E.M., Luppesca, S., & Easton, J. Q. (2010). Organizing Schools for Improvement. Lessons from Chicago. Chicago: University of Chicago Press. Available at http://ccsr.uchicago.edu/downloads/8499safety_in_cps.pdf

[24] Ratzan, S. C., & Parker, R. M. (2000). Introduction. In C. R. Selden, M. Zorn, S. C. Ratzan, & R. M. Parker (Eds.), National library of medicine current bibliographies in medicine: Health literacy (NLM Pub. No. CBM 2000-1). Bethesda, MD: National Institutes of Health.

[25] Kutner M., Greenberg, E., Jin, Y., & Paulsen, C. (2006). The health literacy of America's adults: Results from the 2003 National Assessment of Adult Literacy (NCES 2006-483). Washington, DC: National Center for Education Statistics, U.S. Department of Education. Retrieved from http://nces.ed.gov/pubs2006/2006483.pdf

[26] Vernon, J., Trujillo, A., Rosenbaum, S., & DeBuono, B. (2007). Low health literacy: Implications for national health policy. Washington, DC: School of Public Health and Health Services, George Washington University. Retrieved from http://sphhs.gwu.edu/departments/healthpolicy/CHPR/downloads/LowHealthLiteracyReport10_4_07.pdf

SOPHE advocates for including the words "health numeracy" to this principle. There is an expanding scientific literature underscoring the need for specifically addressing health numeracy.[27] The concept of health numeracy represents "a constellation of skills necessary to function effectively in the health care environment and act appropriately on health care information." Even highly educated individuals can be innumerate. Only 13% of the population is considered proficient in numeracy. That means that 87% of the U.S. population cannot solve a problem where they are asked to calculate the yearly cost of life insurance using a table that gives the cost per month for each $1,000 of coverage.[28] This could be changed with quality health education meeting national standards of health instruction.

Comments on Foundational Principles 4: Healthy physical, social and economic environments strengthen the potential to achieve health and well-being

SOPHE believes that addressing the physical, social and economic environment in schools will ultimately strengthen the potential of students, allowing individuals to achieve health and well-being. Evidence-based research shows that students who are physically active typically have better grades, school attendance, cognitive performance, and classroom behavior.[29] Consequently, such students are more likely to grow into healthy adults. However, schools located in neighborhoods with high levels of poverty are significantly less likely to have safe places that encourage children to be physically active. In advocating for school health, SOPHE pushes for all aspects of school and community to be utilized in the overall promotion of the health and education of each child.

SOPHE recommends that school districts use resources to support professional development of school teachers and educational staff to be well trained on the WSCC model. Additionally, it is beneficial for school districts to complete a needs assessment of the students within the school's community, to offer an individualized approach to address health disparities. Needs assessments can provide insights into the development of curricula and instruction.[30] Including information on the health needs of the students and surrounding community ensures reinforcement of health messages that are relevant for students and meet community needs.[30] Health education curricula and instruction should meet the National Health Education Standards (NHES) and integrate the characteristics of an effective health education curriculum. Health education should also be relevant to the needs of the students in that school and community. Collectively, these recommendations support the goal for school districts to have teacher and educational staff that are culturally competent.

Research indicates that 32% of children and adolescents (ages 2-19) nationwide are overweight or obese, most do not meet physical activity recommendations, nor are they offered sufficient physical education in schools to meet national physical education guidelines.[31] Further, only

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[27] Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., Viera, A., Crotty, K., . . . Viswanathan, M. (2011). Health literacy interventions and outcomes: An updated systematic review. Evidence Report/Technology Assessment No. 199. (Prepared by RTI International–University of North Carolina Evidence-based Practice Center under contract No. 290-2007-10056-I. AHRQ

[28] National Academies. (2014) Health Literacy and Numeracy: A Workshop Summary. Available at Nhttp://www.nationalacademies.org/hmd/Reports/2014/Health-Literacy-and-Numeracy.aspx

[29] Centers for Disease Control and Prevention. (2014). Health and academic achievement. Retrieved from https://www.cdc.gov/healthyyouth/health_and_academics/pdf/health-academic-achievement.pdf

[30] Centers for Disease Control and Prevention. (2015). Components of the whole school, whole community, whole child (WSCC). Retrieved from https://www.cdc.gov/healthyschools/wscc/components.htm

[31] Society of Health and Physical Educators: SHAPE of the Nation: Status of Physical Education in the USA 2016. Available at http://www.shapeamerica.org/advocacy/son/2016/upload/Shape-of-the-Nation-2016_web.pdf

15.3% of high school students nationwide met the Healthy People 2020 objective for aerobic activity (60 minutes per day, 7 days per week). The Comprehensive School Physical Activity Program (CSPAP) recently promoted by the CDC is a multi-component approach in which a quality physical education class is foundational but also includes physical activity during school; physical activity before and after school, staff involvement in worksite wellness activities; and family and community engagement.[32] Although physical education has long been in the curriculum for K-12 students, the caliber and consistency of instruction that students receive is far from the ideal and is not provided to all students in all grades. SOPHE recommends that the framework identify cross-cutting solutions to providing healthy physical, social, and economic environments including identifying policies that encourage community and family engagement. Community engagement allows for maximum use of school and community resources and creates a connection between school and community-based physical activity opportunities.[32] Family engagement in physical activity influences children to become physically active.[32]

Comments on Foundational Principles 5: Promoting and achieving the nation's health and well-being is a shared responsibility that is distributed among all stakeholders at the national, state, and local levels, including the public, profit, and not-for-profit sectors

SOPHE supports the principle as presented, and advocates for a culture of wellness in communities that begins with the child and spans into the generations of adulthood. The shared responsibility for promoting and achieving the nation's health and well-being is rooted in the focus of the learning and health of the whole child. SOPHE recommends that school health education programs engage stakeholders, including but not limited to schools, health agencies, parents, and community members, with planning and evaluation. Based on the WSCC model, the success of sector collaborated approaches to the whole child is measured by the outcome of every young person becoming healthy, safe, engaged, supported, and challenged.[32]

Comments on Foundational Principles 6: Working to attain the full potential for health and well-being of the population is a component of decision-making and policy formulation across all sectors

SOPHE understands that many stakeholders have not been exposed to quality school health education. We recommend that health education be a priority in decision-making and policy formation across all sectors. Relative to policy, funding and health education, Title IV, Part A is an integral component of the Every Student Succeeds Act. The Part A allocation of funding authorizes three activities: 1) providing students with a well-rounded education (STEM, arts, civics, International Baccalaureate (IB)/Advanced Placement (AP) courses, health and physical education); 2) supporting safe and healthy students through drug and violence prevention, school mental health, health and physical education; and 3) encouraging the effective use of technology for professional development and blended learning.[33]

The WSCC Model is an expansion of the CDC's coordinated school health approach, the blueprint for health-promoting practices that is essential for students success at all levels. Taking a well-rounded approach to school health means integrating curricula and instruction for students

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[32] Centers for Disease Control and Prevention. (2013a). Comprehensive School Physical Activity Programs: A Guide for Schools. Atlanta, GA: U.S. Department of Health and Human Services.

[33] ASCD. (2014). 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

throughout their educational experience that address a variety of topics such as alcohol and other drug use, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco, and violence prevention.[34]

Comments on Foundational Principles 7: Investing to maximize health and well-being for the nation is a critical and efficient use of resources

SOPHE believes that health education curricula in schools is a key strategy to access children in an environment that has been shown effective in reducing rates of obesity and improved health promoting behaviors such as increased physical activity and healthy nutrition.[35] It is important for students in pre-K through 12th grade to receive a comprehensive school health education. Taking a holistic approach to school health and health education means incorporating curricula and instruction for students throughout their educational experience that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention.[34]

Comments on Plan of Action

SOPHE understands that the proposed Healthy People 2030 framework provides the initiative and new objectives for the United States to work towards improving the health and well-being of all people in the nation. However, to establish a society in which all people achieve their full potential for health and well-being across the lifespan, health education must be an integral component within that framework. Health education curricula emphasizes a skills-based approach to help students practice and advocate for the health needs of themselves, their families, and their communities. These skills help children and adolescents find and evaluate health information to make informed health decisions.

In the field of public health, evidence-based research has identified the need for health education as a method for reducing health-risk behaviors and promoting healthy decision-making to prevent the onset of chronic diseases and other risk factors for poor or diminished health. SOPHE cautions that it is pivotal for teachers and health educators to implement best practices in the school setting, as opposed to searching for alternatives that are not evidence-based. SOPHE also urges that within health education curricula, sequential age appropriate school health education span the entire school experience. Another example includes the need for professionally prepared teachers at all grade levels, in every school in every community in the nation. When provided by effective educators at all grade levels, health education allows students to attain the knowledge, attitudes, and skills necessary to make health-promoting decisions, reach health literacy, assume health-enhancing behaviors, and promote the health of others.[34]

SOPHE also emphasizes the importance of the environment and how it impacts school health. The WSCC model demonstrates the impact that the physical environment has on school health.

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[34] ASCD. (2014). 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

[35] Melnyk, B.M., Jacobson, D., Kelly, S., Belyea, M., Shaibi, G., Small, L., O'Haver, J., Marsiglia, F.F. (2013) Promoting Healthy Lifestyles in Adolescents: A Randomized Control Trial. American Journal of Preventive Medicine 45(4): 407-415.

SOPHE believes that addressing the physical, social and economic environment in schools will ultimately reduce barriers that hinder students and allow them to achieve health and well-being. Students lacking access to safe and healthy built environments also increases health disparities. The physical school environment includes the school building and everything inside of it, the land that the school is situated on, and the area surrounding it.[36] A healthy school environment will address a school's physical condition during normal operation and during renovation (e.g., ventilation, temperature, noise, etc.), while protecting students, faculty and staff.[36]

A healthy built environment is essential to a student's learning experience. Evidence-based research demonstrates that students who are physically active tend to have better academic performance including better grades, school attendance, cognitive performance, and classroom behavior.[36] It is because of these aspects of a healthy built environment that healthy students grow into healthy adults. However, schools located in neighborhoods with high levels of poverty are significantly less likely to have safe places that encourage children to be physically active. Economic disparities proliferate health disparities and poor health outcomes in children. SOPHE pushes for all aspects of school and community to be utilized in the overall promotion of the health and education of each child.

The WSCC model also emphasizes the importance of community involvement in the healthy development of children. In addition to making health education relevant to the needs of communities, it is beneficial for schools to create partnerships, share resources and volunteer with community groups, organizations, and local businesses.[36] Such relationships support student learning, development, and health-related activities in schools and communities.[37] The school, its students, and their families also benefit when leaders and staff at the district or school petitions for and arranges data, assets, and services available from community-based organizations, businesses, cultural and civic organizations, social service agencies, faith-based organizations, health clinics, colleges and universities, and other communal groups.[36] Schools, students, and their families can get involved with their communities through service-learning opportunities and by sharing school facilities with community members (e.g., school-based community health centers, fitness facilities, etc.).[36]

Thank you for your consideration of our comments. SOPHE is pleased to support the strategic initiatives of HHS and Healthy People 2030, working hand in hand to create a society for every person to have access to health education and an opportunity for total health. Please contact Dr. Cicily Hampton at (champton@sophe.org) or 202-408-9804 with any additional questions.

Sincerely,

Elaine Auld, MPH, MCHES
Chief Executive Officer

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[36] ASCD. (2014). 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