

Chapter 64

Online Well–Being Focused Curriculums: A New Approach to Teaching and Learning for K–20 Health Education

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ABSTRACT

Education and health are among the most salient issues facing Americans today. The field of public health has moved away from a physical health medical model to a more well-being focused quality-of-life perspective. K-20 curriculums in the United States need to reflect this ideological shift. In this chapter, content-focused curriculums with process-focused health behavior change-oriented learning are proposed as a strategy to promote well-being. Other issues that need to be addressed in the current education system are that the delivery of health-related curriculums is often inconsistent and taught by untrained personnel. Well-being-focused curriculums delivered online can provide consistency to improve the quality of health courses. This innovative approach has the potential to improve educational and health outcomes for K-20 curriculums while addressing public health issues by promoting well-being and quality-of-life for children and adults throughout the United States.

INTRODUCTION

Education and health are among the most salient issues facing Americans today. With lower educational achievement, rising health care costs, an aging population, and the need to treat increasing numbers of people with chronic health conditions, both the United States education and health care systems are in immediate need of reform. While there are significant disparities relating to education and health

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associated with socio-economic status, demographics, and region, it seems all Americans, regardless of their background, are affected by behavioral and health trends like physical inactivity and obesity. In this chapter, solutions to improving public health in America include a redirection of health-related curriculums in the K-20 system.

According to Jourdan (2011), “From a public health point of view, even if the core business of schools is actually focused on educational outcomes, rather than the reduction of health problems, schools have a mission in relation to health” (p. 29). In the United States, the Centers for Disease Control and Prevention (CDC) recommends coordinated school health (CSH) to improve students’ health and learning in schools. Outside of the family, the K-12 system is the primary institution assigned to the development of youth in the United States (CDCd, 2013). Coordinated school health consists of eight components: health education; physical education; health services; nutrition services; counseling, psychological, and social services; healthy and safe school environment; and health promotion for staff (CDCb, 2013).

MAJOR ISSUES WITH TEACHING AND LEARNING ABOUT HEALTH IN K-20 ENVIRONMENTS

Statistics indicate schools have not provided two of the basic components of coordinated school health: comprehensive health education and adequate physical education. According to the SHPPS 2006 report, which is a national survey to assess school health policies and programs at the state, district, school, and classroom levels, it was found that only 6.4% of elementary schools, 20.6% of middle schools, and 35.8% of high schools required instruction on all 14 of the following health topics: alcohol- or other drug-use prevention, asthma awareness, emotional and mental health, foodborne illness prevention, HIV prevention, human sexuality, injury prevention and safety, nutrition and dietary behavior, other STD prevention, physical activity and fitness, pregnancy prevention, suicide prevention, tobacco-use prevention and violence prevention. Regarding physical activity, only 3.8% of elementary, 7.9% of middle, and 2.1% of high schools provided daily physical education or its equivalent (150 minutes per week in elementary schools; 225 minutes per week in middle schools and high schools) for the entire school year (CDC, 2006). Rates of implementation vary by state and district, however, this national report indicates that America’s schools are failing when it comes to comprehensive coordinated health education and physical education.

In theory, coordinated school health makes sense, however, as indicated by the aforementioned SHPPS statistics, the concept is difficult to implement throughout the United States. According to Deschesnes, Martin and Hills (2003), implementing coordinated school health would require a substantial change in the way schools operate. These authors explained, “This involves moving from practices that rely mainly on classroom based health education models to a more comprehensive, integrated construct of health promotion that focuses both on children attitudes and behaviors, and their environment” (p. 387). In this chapter, issues specific to health education are addressed, which is only one essential component of coordinated school health.

Concepts of health traditionally taught in the United States have been replaced by quality of life indicators and well-being measures in the field of public health. Historically, the focus of health education has been on disease and illness prevention, but in the past 50 years there has been a shift to view health from a more positive perspective. In 1995, the National Health Education Standards (NHES) were established to promote “health-enhancing,” not disease-prevention, behaviors for pre-Kindergarten through grade 12.

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