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Commentary

Let Schools Do It! Helping Schools Find a Role in Cancer Prevention

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A B S T R A C T

Health, in its purest sense, is not the primary mission of the nation's K–12 schools, so why should schools feel obligated to address cancer education? The nation's educators are under tremendous pressure to prepare students to pass tests in English language arts and mathematics. As a result, health education and physical education are often assigned third-class status in many of the nation's schools, despite numerous studies supporting the connection between health and academic achievement. Is there a place for cancer prevention education in today's K–12 schools? This commentary explores existing structures that affect cancer prevention education and offers suggestions to improve K–12 health education initiatives.

"An education system isn't worth a great deal if it teaches young people how to make a living but doesn't teach them how to make a life." —Anonymous

"Let schools do it!" We have a bullying problem—schools can handle that. Teen pregnancy is a major issue—schools should teach abstinence. Children are overweight—schools should watch what students eat, sell only healthy foods in the cafeteria, and eliminate Parent-Teacher Association bake sales. Kids need physical activity, so just find a few minutes in every classroom for kids to dance around; there is no time for physical education or recess. School-based programs have become the "treatment" for just about every societal problem from gambling to texting while driving. Every "critical" issue wants time on the schedule or calendar and a place in the school curriculum. If there is grant money attached to an issue, chances are it will gain momentum until the funds run dry. Same goes for mandated issues: when a law first passes requiring schools to teach a topic, schools frantically search for whatever it takes to comply.

It is time to stop the "Let-Mikey-do-it" approach and engage in some serious discussion about what schools can and cannot do to improve the health of America's students. Health, in its purest sense, is not the primary mission of the nation's schools, so why should schools feel obligated to include cancer education in the curricula? Let's start with a look at what is happening in schools.

Schools are under great pressure to prepare students to pass "the test." Principal and teacher evaluations (and thus job security) may be tied to test results. English language arts, reading, and mathematics are taught to the exclusion of nontested subjects such as health education, physical education, and the arts. Schools are rated on the basis of student test scores—schools that need improvement are sanctioned and subject to personnel changes, reconfiguration, or even closure. As a result, in some schools health education may not even be on the radar screen. Health education was not a core academic subject under the No Child Left Behind Act and unless legislators include it in the reauthorization of the Elementary and Secondary Education Act, it will continue to have third-class status in education circles.

In *Health Education: Always Approved but Still Not Always on Schools' Radar* [1], the authors explore more than 50 years of studies and reports on school health initiatives and conclude that many barriers from 50 years ago (e.g., funding, hours in the school day, teacher preparation) are still relevant today. Education and public health officials must collaborate to support quality school health programs that meet the changing needs of today's youth [1]. Similarly, in a recent article in *Education Week* [2], Jane Isaacs Lowe, a senior program officer at the Robert Wood Johnson Foundation said:

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> It can be tempting to think that health and education are separate issues given that these two systems often exist in silos. But evidence has shown that when it comes to the success of our children, both are equally important.

Education and health are interdependent systems, with health status impacting academic achievement and academic status impacting health in childhood and adulthood [1]. This concept is not new. In 1918, the *Cardinal Principles of Secondary Education* [3] established that the purpose of schooling was to enable individuals to better themselves and society. According to the book, health was the first and main objective of education, even before reading, writing, and arithmetic. Commenting on the *Cardinal Principles*, noted education consultant Grant Wiggins [4] says:

> It's a bit startling to see health first on the list, ahead of readin', writin' and 'rithmetic isn't it? But that shock is also a helpful reminder of how much schools have lost their way. What could be more important in moving into adulthood than learning how to lead a healthy life, in the broadest sense?

In 1990, John R. Seffrin [5], now the chief executive officer of the American Cancer Society, wrote:

> When it is effective, comprehensive school health education maximizes the prospect that students will be able to make health-enhancing decisions which allow them to live artfully, to grow and develop naturally, and ultimately, to become fulfilled human beings. To foster this ultimate end is the raison d'etre of the place we call school.

Despite such support, most states require less than one credit in health education during the four years of high school [6]. In comparison, most high schools require four credits in English language arts and at least three credits each in mathematics and science [7]. The length of the school day or school year does not change to accommodate these increased demands for more mathematics, science, or technology—schools simply eliminate some requirements and reduce electives to make room. Students who struggle are placed in "test prep" classes and may be pulled from a music, art, health education, or physical education class to remediate in another subject.

A 1-year health education course (or a quarter course each year) must address many topics viewed as important for the well-being of adolescents: prevention of alcohol, tobacco, and other drug use; prevention of HIV, sexually transmitted disease, and teen pregnancy; mental health; nutrition; driver education and road safety; first aid; violence and bullying prevention—the list goes on and on. Grades 5–8 (the middle grades) usually have no credit requirements. Middle schools may use cycled scheduling in which noncore subjects (e.g., music, art, dance, health education, physical education) are taught once every 6 days. It is entirely possible that a student in grade seven might participate in a health education class less than 30 times per year.

Health education teachers are inundated with well-intended research-based programs that do not acknowledge these real-world constraints. When I was a novice teacher, my school district purchased a health education kit containing lesson plans, materials, videos, and parent education materials. Although the program itself was easy to implement, it required 30 lessons at each grade level on one health topic. Accounting for holidays, assemblies, and early dismissals, my seventh grade students had only 24 health education classes during that school year. In such situations, teachers become less concerned about the "research-based" curriculum and more concerned about covering what is required by the state or local school district. Because of these time constraints, student assessment becomes a series of true-false or multiple choice tests or poster projects rather than planned, meaningful assessments that inform teachers whether students understand and can apply the health concepts that were taught.

Who decides what gets taught? In 1995, with funding from the American Cancer Society, *National Health Education Standards: Achieving Health Literacy* (NHES) was released. The standards were designed to help students acquire the knowledge and skills to promote personal, family, and community health [8]. State education departments and local school districts either adopted the national standards or used them to develop their own state or local standards. Updated in 2007, the standards provide a framework for aligning curriculum, instruction, and assessment practices. The standards also describe the knowledge and skills students should have and be able to achieve; however, the standards leave how this will be accomplished to teachers and other local specialists who formulate, deliver, and evaluate curricula.

State and local education agencies play a critical role in deciding what gets taught because decisions are most often based on the state's standards and graduation requirements and who teaches health education is based on state teacher certification requirements. For example, legislative mandates in New Jersey stipulate that schools must address accident and fire prevention; breast self-examination; cancer awareness; bullying; domestic violence and gang violence; alcohol, tobacco, and other drug use prevention including the use of anabolic steroids; Lyme disease prevention; organ donation; sexual assault prevention; suicide prevention; and stress abstinence from sexual activity [9]. These mandates drive the content of state standards and thus dictate what gets taught in health education classes in New Jersey's public schools.

The Centers for Disease Control and Prevention (CDC) played a critical role supporting quality school health education. CDC funded state and local education agencies for HIV prevention and expanded funding to support healthy eating and physical activity as well as tobacco use prevention. However, the continuation of funding to education agencies is in jeopardy. The *Characteristics of a Quality Health Education Curriculum* [10] and the *Health Education Curriculum Analysis Tool* [11], both CDC documents, provide valuable information to teachers and curriculum developers about the science of health education. However, CDC's emphasis on HIV prevention, tobacco use, healthy eating, and physical activity may have inadvertently narrowed the content taught in some of the nation's schools. Similarly, funding from the U.S. Department of Education focused on preventing alcohol and drug use, improving school safety, and preventing violence as well as and character education [12]. The U.S. Department of Education also coordinates a competitive grant program, the Carol M. White Physical Education Program, which supports physical activity and physical education programs in public and private schools and at community organizations that serve young people [13]. In addition, the U.S. Department of Agriculture provides training grants to state agencies to support nutrition education programs in schools [14]. Although well-intended, these somewhat disconnected federal programs perpetuate the many silos connected with school health. Is it any wonder that school districts compartmentalize health education by funding stream or content? However, without these important