

Health Education in the 21st Century:



A Skills-based Approach

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H **health and academics are undeniably connected.** Healthier students are ready and able to learn at higher levels than their unhealthier peers, students who have higher levels of academic achievement are less likely to engage in risky behaviors, and individuals who attain higher levels of education, particularly in successful school environments, experience positive health outcomes (Centers for Disease Control and Prevention [CDC], 2017; U.S. Department of Health and Human Services [HHS], 2010; Winkleman, Caldwell, Bertram, & Davis, 2016; Wong et al., 2014). In addition, students with more health assets are more likely to experience success on standardized tests in multiple subject areas, including math, reading and writing (Ickovics et al., 2014). The evidence is clear; when

the health of students is addressed, their academic achievement is supported and vice versa.

However, despite this evidence, it has not been until recently that the education world has begun to address *both* the health and academic outcomes of students. In 2013 the Whole School, Whole Community, Whole Child (WSCC) model was published. WSCC combines and expands on ASCD's Whole Child model and the

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Coordinated School Health approach to “create a unified model that supports a systematic, integrated, and collaborative approach to health and learning” (Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015, p. 730). The model provides a framework for shared decision-making between the health and education sectors as the goals of both sectors are now represented in this combined model, and when implemented effectively, can support both educational attainment and healthy development of students (Lewallen et al., 2015). This article is written for practitioners who have, or are planning to have, dedicated time for health education within their curriculum. The goal is to provide a foundational understanding of the importance of health education and the use of a skills-based approach to teach health education. We provide examples, where possible, to help illustrate the concepts presented in this article and strategies for implementation. In order to implement effective skills-based health education, practitioners need to know both the “why” and the “how”; both are presented here.

Health Literacy

Because health and educational outcomes are interconnected, it becomes part of a school’s responsibility to consider health as a key factor in overall academic success. In order for students to succeed, multiple factors that are most likely to help them do so must be considered. One such factor is students’ health literacy; when schools focus on the health of students through a more holistic and coordinated approach, they also address and improve students’ health literacy (HHS, 2010).

Health literacy

is linked to literacy and entails people’s knowledge, motivation and competencies to access, understand, appraise, and apply health information in order to make judgments and make decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course. (Sorenson et al., 2012, p. 3)

Limited health literacy is negatively associated with multiple health outcomes ranging from use of preventive services to people’s self-reported feelings of health (HHS, 2010). Data from the National Assessment of Adult Literacy in 2003 found that only 12% of Americans had proficient health literacy. This has been suggested to be the minimum level that individuals need to maintain or enhance health (HHS, 2010). At this level individuals are

able to complete tasks such as calculating health insurance costs (HHS, 2008). Fifty-three percent of Americans had intermediate health literacy, meaning they are able to read prescription labels and determine the correct timing of doses, while 35% had basic or below basics levels where individuals can read and understand pamphlets or short instructions for screenings or tests. When this is broken down further, this same study notes that there is even greater disparity across racial and ethnic lines. In fact, 65% of the Hispanic and 57% of the Black population are at basic or below basic proficiency compared to those identifying as White (28%) and other (34%; HHS, 2008). These data support that health literacy is an issue that is impacting the health of the nation.

Two recent systematic reviews provide further evidence that there are low levels of health literacy in adolescents and that health literacy impacts health at this age as well (Fleary, Joseph, & Pappagianopoulos, 2018; Sansom-Daly et al., 2016). In a 2016 literature review Sansom-Daly et al. found that across 14 studies that met their inclusion criteria, 60% of adolescents had “adequate” health literacy. They also found poor functional health literacy in adolescents along with challenges within the domain of critical health literacy. Both reviews found that health literacy impacts health behaviors, including obesity, smoking, alcohol use, health-related information-seeking, risky sexual behaviors, tobacco use and medical adherence (Fleary et al., 2018, p. 121; Sansom-Daly et al., 2016). The data clearly suggest that not only is health literacy an issue for adolescents as well as adults, but that it also impacts health behaviors. Addressing health literacy in youth could have a significant and lasting impact on the health of the nation.

However, as described above, health literacy is typically focused on a specific set of skills most relevant in the medical setting. Now, consider how many other types of health-related decisions individuals need to make, how much other information one may need to be able to read, understand and apply on a daily basis such as reading food labels to support our nutrition choices, determining an appropriate level of physical activity, communicating about and setting appropriate relationship boundaries with a partner, or deciphering and deciding whether or not to trust health claims in the media. Additionally, even people with higher levels of health literacy may face health literacy challenges in different contexts (HHS, 2008). The evidence strongly suggests that a majority of Americans do not have the health literacy levels necessary to avoid negative health outcomes and achieve positive health outcomes.

Table 1.
HHS Health Education Strategies

Early Childhood	<ul style="list-style-type: none"> • “Embed accurate, accessible, and actionable health information in all early childhood programs; • Require coursework in health education for all students who are in post-secondary schools and who are preparing for a career in early childhood education; • Increase the amount of health education instruction in early childhood education;
K–12	<ul style="list-style-type: none"> • Promote health literacy by including the National Health Education Standards in school curriculum reform initiatives; • Require all preservice teachers to have coursework in the instructional methods of health education; • Provide professional development for all teachers on health education teaching strategies, topics, skills, and age-appropriate health education”

Source: U.S. Department of Health and Human Services (2010, pp. 33–34). This work is in the Public Domain.

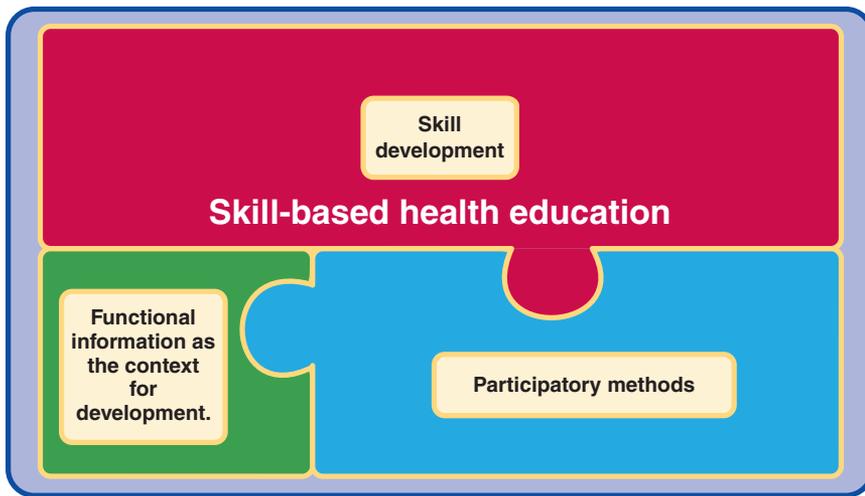


Figure 1.
Components of a skills-based approach to health education

Source: Reprinted by permission from S. Benes and H. Alperin, *The Essentials of Teaching Health Education: Curriculum, Instruction, and Assessment* (Champaign, IL: Human Kinetics and SHAPE America, 2016), p. 27.

In 2010 the U.S. Department of Health and Human Services (HHS) published a *National Action Plan to Improve Health Literacy* (HHS, 2010). In this document, health education is presented as one strategy for improving health literacy in the U.S. The importance of health education in the K–12 setting is acknowledged as a critical factor in addressing health literacy (CDC, n.d.; HHS, 2010; Manganello, 2008). In fact, evidence suggests that one of the reasons for the current low levels of health literacy in adolescents is the lack of consistent K–12 health education (IOM, 2004). Due to the role that health education can play in addressing health literacy, the U.S. Department of Health and Human Services presents many suggestions for stakeholders in the PK–12 education sector related to health education, some of which are included in the Table 1. The Centers for Disease Control and Prevention (CDC)’s Health Literacy Action Plan also calls for helping children and adolescents develop health literacy skills in order to help prevent not only chronic health problems but also to protect themselves from other adverse health outcomes such as injury and violence (CDC, n.d.). Both the U.S. Department for Health and Human Services and the CDC articulate the significant contribution that education, particularly health education, can have on improving health literacy of children and adolescents.

School-based Health Education

However, the value of health education is not only in the improvement of health literacy. Evidence also has suggested that effective school-based health education can improve health behaviors and health outcomes of students (CDC, 2015; Fisher et al., 2003; Hale, Fitzgerald-Yau, & Vine, 2014; Kirby et al., 1994; Michael, Merlo, Basch, Wentzel, & Wechsler, 2015; Rosemund, Blake, Jenkins, Buff, & Moore, 2015; St. Leger, 2001; Valois, Slade, & Ashford, 2011). Current evidence highlights two key aspects of health education: (1) the focus on functional information and (2) the development of skills. In fact, the *Characteristics of Effective Health Education Curricula* from the Centers for Disease Control and Prevention suggest that, along with other aspects, effective health education:

- Provides functional health knowledge that is basic, accurate and directly contributes to health-promoting decisions and behaviors;

- Builds personal competence, social competence, and self-efficacy by addressing skills;
- Provides opportunities to reinforce skills and positive health behaviors (CDC, 2015).

This article outlines an approach to health education, termed a skills-based based approach, which can help educators focus on functional information and skill development through participatory approaches and improve the health of their students in a “stand-alone” health education course. Figure 1 provides a visual representation of the core aspects of a skills-based approach to health education.

The Skills and Skill Development

In a skills-based approach the skills being referred to are the skills that are presented in the National Health Education Standards (NHES). These include:

- Analyzing influences (Standard 2)
- Accessing valid and reliable information, products and services (Standard 3)
- Interpersonal communication (Standard 4)
- Decision-making (Standard 5)
- Goal-setting (Standard 6)
- Self-management (Standard 7)
- Advocacy (Standard 8; Joint Committee on National Health Education Standards, 2007).

These skills become the foundation and focus of the curriculum. There is a shift from the more traditional approach in which curricular units are determined by topics such as drugs and alcohol, nutrition, and healthy relationships to one where the skills become the units and the emphasis shifts from knowledge acquisition to skill development. In a skills-based approach traditional topics and information provide a context for skill development. For example, a mental health unit becomes an “advocating for mental health unit” where the emphasis is on developing students’ ability to be effective advocates while incorporating information related to reducing stigma surrounding mental health, encouraging others to reach out and support or highlighting available resources in the community. An alcohol, tobacco and other drug unit becomes “decision-making to avoid substance use” where students consider how to work through a thoughtful decision-making pro-

Table 2.
Steps of the Skill Development Model

Step 1 Skill Introduction	<ul style="list-style-type: none"> ✓ Define the skill ✓ Share educational outcomes ✓ Discuss the relevance of the skill
Step 2 Steps of the Skill	<ul style="list-style-type: none"> ✓ Provide the skills cues/critical elements of the skill
Step 3 Skill Modeling	<ul style="list-style-type: none"> ✓ Provide examples of the skill being applied effectively
Step 4 Skill Practice	<ul style="list-style-type: none"> ✓ Provide opportunities for skill practice in relevant and realistic situations/contexts ✓ Provide feedback on skill performance during practice opportunities
Step 5 Feedback and Reinforcement	<ul style="list-style-type: none"> ✓ Evaluate student performance using summative assessment

Source: Based on concepts from Benes & Alperin (2019).

cess and consider how their values, beliefs and circumstances play a role in their choices related to alcohol, tobacco and other drugs as opposed to spending most of the time discussing the types and classification of drugs. Students are using the information for the purposes of applying the skill to their life circumstances. A nutrition unit may be revised into a “goal setting for healthy eating” where students assess their current dietary habits and then create and work toward a goal to improve behaviors related to their own nutrition. These unit titles show the emphasis on the skills of the NHES. Having a focus on skill development is one of the critical components of effective health education curricula.

Having the skills as the focal point of the units also means that the skills themselves become content students need to learn. It cannot be assumed that students know what it means to effectively analyze influences on their health or effectively work through a goal-setting process. Students must learn the components of each skill and have time to practice skill application, receive feedback for improvement, and then repeat skill practice in an effort to become proficient in the skill. This is similar to the model used in physical education in which skills are taught, but the emphasis is on practice. For example, if the physical educator is teaching underhand throwing, they might introduce the skill and give them examples

of when it is used, demonstrate and explain the skill cues or critical elements of the skill, and then provide multiple and varied practice opportunities (this is usually where the most time is spent). Students cannot practice a skill that they have not been taught or do not understand how to properly apply in a real-life setting. The same approach should be used in the health education classroom. For example, consider the elementary health classroom. If the focus is on decision-making, the teacher may discuss the types of decisions elementary students make every day, review the STAR process (Stop, Think, Act, Reflect) as the skill cues, model an example applying the STAR process to a decision an elementary student might need to make, and then provide time to practice the decision-making steps on their own.

To ensure students have ample time to develop skill proficiency for health-related skills, a skill development model can be applied (Table 2). First, skill introduction at the start of a unit sets the stage and makes a personal connection with students. A definition of the skill is provided; the educational outcomes are shared with students, and the relevance of the skill in students’ lives is discussed. During this first step students make connections between the skill being taught and their daily life. For example, in a communication unit the teacher may ask students to give examples of when they communicate in their day-to-day lives or times they did or did not communicate well. This will help students see the relevance of the skill to various aspects of their lives. Next, the steps of the skill or skill cues (the critical elements of the skill) are presented to show students what it means to properly apply the skill. The skill cues are the critical elements of the skills that need to be completed in order to effectively apply the skill. Sample skill cues for decision-making are included in Table 3. The teacher may present the skill steps in a more teacher-directed format or through more active learning strategies such as having students match the skill cues with the acronym, having stations for each skill cue, or having them search the school and find the skill cues on QR codes distributed throughout the building.

Once the skill cues are presented, the skill must be modeled so students see it being applied effectively. Providing students with concrete examples of what the skill looks like supports their skill practice because they have seen the skill applied effectively. Here, the teacher may show short, purposefully selected video clips, real-

Table 3.
Sample Skill Cues for Decision-making

D	Determine the decision
E	Examine options
C	Consider consequences
I	Identify values and influences that may affect the decision
D	Decide on the healthiest option and act on the decision
E	Evaluate the outcome

Source: Reprinted by permission from S. Benes and H. Alperin, The Essentials of Teaching Health Education: Curriculum, Instruction, and Assessment (Champaign, IL: Human Kinetics and SHAPE America, 2016), p. 119.

Table 4.
Characteristics of Effective Skill Practice

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| <ul style="list-style-type: none"> • Align practice opportunities with lesson and unit objectives • Set clear expectations for student performance to demonstrate proficiency • Practice opportunities should provide students with an opportunity to apply skill cues • Provide specific feedback aligned with expected outcomes • Ensure students have opportunities to experience success with skill practice (this helps build self-efficacy) | <ul style="list-style-type: none"> • Make practice opportunities realistic and relevant for your audience • Provide opportunities for student choice/input into practice activities • Activities are developmentally appropriate • Critical thinking is embedded in activities • Practice opportunities provide increased challenge as students progress |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

life examples of commercials or advocacy campaigns, use a local news story to discuss valid and reliable information sources, or use a TED Talk to show effective communication. Next comes skill practice — the most critical part of the model.

In a skills-based approach students must have ample time to practice and receive feedback on their skill application. Effective skill practice is a critical element because it is through practice that an individual can increase self-efficacy (belief in one’s ability to do something), which is a factor that positively and directly impacts health behavior (Bandura, 2004). The more confident someone is in their ability to do something, the more likely is it that they will do it. In health education the goal is to increase students’ self-efficacy related to the skills of the standards so that they have confidence in their ability to apply these skills outside of the classroom and in a variety of settings. Although a detailed discussion of skill practice in the health education classroom is beyond the scope of this article, some suggestions are provided in Table 4. More information can also be found in the *Appropriate Practices in School-based Health Education* document (SHAPE America – Society of Health and Physical Educators, 2015).

Finally, the ability to properly perform a skill is assessed through authentic performance tasks. As the skills are something that students must *do*, they need to provide evidence of their ability to apply the skill in meaningful and authentic ways. The use of performance tasks that align with the verb of the performance indicators of the National Health Education Standards will provide the teacher with a measure of students’ ability to perform each of the skills. To do this, educators need to move away from the traditional “test” and quizzes that measure knowledge acquisition

and instead create engaging and relevant performance tasks that ask students to showcase their knowledge and ability. For example, in an advocacy unit students create public service announcements that are read during the morning announcements. In an analyzing influences unit, students complete a photo journaling project in which they analyze the root causes of issues in their community. In a decision-making unit, students create a scenario and then work through the decision-making model showing each of the steps and arriving at a health-enhancing decision. In a communication unit with a focus on demonstrating refusals, students video themselves applying effective refusals in a variety of situations. These assessments allow students to think critically about how the skill operates in their life now and how they can continue to use the skill outside of the classroom. This becomes more meaningful to students since they have the ability to apply the skill to their real-life context as opposed to the memorization of facts and information. Tips for assessment in a skills-based approach are provided in Table 5.

Another important aspect of a skills-based approach is that the information related to health topics becomes the *context* for the development of the NHES skills. Stated differently, the purpose of health information is to provide a means to develop skills. In contrast to current programs where information acquisition is the primary purpose of the course, now there is a shift to information providing the lens through which students consider their health and the health of others.

There are three main reasons why this perspective is important. The first is that health behavior theory suggests that knowledge alone does not change behavior; in fact, one theory describes

Table 5.
Assessment in a Skills-based Approach

Assessment should:

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| <ul style="list-style-type: none"> • Be aligned with and measure unit objectives • Be created before lessons and learning activities • Be authentic and relevant to students’ real lives outside of the classroom • Allow students to demonstrate their level of skill performance | <ul style="list-style-type: none"> • Measure skill proficiency and application of functional information • Provide an opportunity for students to apply learning in meaningful ways • Measure one skill at a time and all skill cues of the skill • Provide feedback on student performance and guide future instruction |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

knowledge as the *pre-condition* for change (Bandura, 2004). In order for health programs to be the most effective, time needs to be spent on factors that will contribute to behavior change and that is not through knowledge acquisition. Including “basic, accurate information that contributes to positive decisions and behaviors” along with a focus on skills applies principles from both health behavior and effective health education curricula into health programs (CDC, 2015).

The second reason for using information as the context for skill development arises from research in teaching and learning. Transfer is enhanced when the content is practiced in multiple contexts (Bransford, Brown, & Cocking, 2000). Students need the opportunity to learn, practice and attain competence in each skill individually before being able to apply it in new contexts (i.e., with new topics). For example, if students learn how to access valid and reliable information related to drugs and alcohol, they can use the same skill to find valid and reliable information on healthy eating habits or mental health. Once a student has learned how to effectively set a goal and work through a process to achieve the goal related to their intellectual health, they can use that same skill set to set and achieve a physical activity goal. Once a student can demonstrate competency in a skill, continuing to practice and apply this skill in multiple contexts (in this case through multiple topics) increases the likelihood of effective transfer to a new context. To relate this to PE, if a student gains competence in striking with a long-handled implement, the same strategies can be used in a number of different sports. The students do not necessarily need to have been taught all the different sports because the core skill of striking can be transferred. If students have the opportunity, either in our courses or through health classes in multiple grades, to practice the skills of the NHES with different topics, it is more likely they will be able to apply this learning to any topic and outside of our classrooms.

The third is that the skills addressed in the NHES, Standards 2–8, impact a variety of health behaviors that are associated with a variety of health topic areas. For example, peers influence a variety of health behaviors, including sexual activity, risk taking and risky decision-making, and prosocial behaviors, as well as alcohol, marijuana and tobacco use (Gardner & Steinberg, 2005; Maxwell, 2002; Widman, Choukas-Bradley, Noar, Nesi, & Garrett, 2016). If students learn how to analyze and effectively manage the influence of peers, it can have an impact on a variety of typical “topic areas.” The data are similar for refusal skills (one of the communication skills in Standard 4). Refusal skills have been shown to support the reduction of binge-drinking, to be a statistically significant predictor of effectiveness of health programs relating to alcohol use in high school students and drug use programs for 6th and 7th grade, and are skills included in effective sexual health programming (Jander, Crutzen, Mercken, & De Vries, 2015; Layzer, Rosapep, & Barr, 2014; Onrust, Otten, Lammers, & Smit, 2016). These are just two examples that highlight the fact that the skills of the NHES can impact behaviors across multiple topic areas. When we provide students with the opportunity to, first, develop competence in the skills in one topic area and then, second, apply and practice the skill in other areas, we are mirroring the way that these skills will be used in their real lives.

Functional Information

Functional information has a narrow focus and contributes to healthy decisions and behaviors (CDC, 2015). It is information

that is usable, applicable and relevant to students (Benes & Alperin, 2016). Including only information that is usable, applicable and relevant builds on principles of effective learning and health behavior theory. Research has shown that when information interests students or is relevant to aspects of their lives that they view as important, motivation is increased, which in turn positively affects their learning (Ambrose, Bridges, DiPietro, Lovett, & Norman, 2010). Health behavior theory suggests that knowledge related to risks, consequences, benefits to action, strategies for action and overcoming barriers can support behavior change (National Cancer Institute, 2005). While there is a wealth of available information available, health education needs to focus only on the information that is most likely to support healthy behaviors: the functional information. It is important to consider what information will provide the best foundation for students in order to maintain or improve their health.

The challenge for health educators is that there is not one specific or predetermined list of functional information for each health education topic that will apply to all students in every community. This is due, in part, to the fact that every school and every student is different. While there is some overarching information that most people can agree on, information that is functional for one person is not necessarily functional information for another. For example, all students should have a basic understanding of body systems and how health behaviors such as sleep, nutrition and stress impact their ability to function. Less important is that students know the names and characteristics of all drugs, can list all the bones or muscles in the body, or know the names and signs and symptoms of all possible STIs. All students should be able to consider how they will use the information presented to improve or maintain their health. Developing a habit of mind to question and consider information being included in the curriculum and using a lens of looking for the “need to know” information related to a topic will help determine what information is functional for students. One resource that can be useful is the Health Education Curriculum Analysis Tool (HECAT; CDC, 2008). In particular, in each content-based module the HECAT presents knowledge objectives and health behavior outcomes. This can be a good place to start while also considering community need.

Imagine a situation where a health teacher has students with a range of weight and activity levels (for example, students who are overweight and sedentary, some who are overweight and active, some healthy weight and active, and others who are student athletes). The unit being taught is “Making Healthy Nutrition Decisions.” The useable, applicable and relevant nutrition information is different for each of these students. Some students may need information about how to read a food label to inform nutrition choices, while others are confident in their ability to understand the food label, yet lack how to compare food items and eat for energy balance. Other students might need to understand the role proteins and fruits and vegetables play in sport performance or exercise, or the dangers of taking supplements to improve performance or control weight. Perhaps it is some combination of any of these factors. In class, the teacher then provides a baseline of information around how to read and use food labels, the role and components of each food group, and then considerations for selecting foods to meet your energy needs. Additionally, they discuss valid and reliable sources of nutrition information, and students are encouraged to find additional information that will help inform their decision. Together, all of this information (both presented by the teacher and researched on their own) allows students to use the most relevant

and appropriate information to help inform their specific nutrition decision. This will be far more valuable to students than a one-size lesson that assumes all students are at the same place nutritionally.

A similar situation could arise within decision-making unit with a different content area — for example, “Making Healthy Decisions about Vaping.” One student is currently vaping and started because it was one way of staying connected to friends. Another student has heard of vaping but has no intention of vaping due to their belief that it may hinder their performance in the band. In each of these examples the information that each student needs in order to make health-enhancing decisions is different. Again, both students may need to understand the mechanisms and physical health consequences of vaping, applicable laws and policies, and even the role of marketing related to the safety of vaping. Following this, each student must consider how their personal values, beliefs and intentions play into their decision to vape. In essence, the effective health education classroom provides information that is relevant to most students as well as the tools for students to access any additional information they need within a variety of topics.

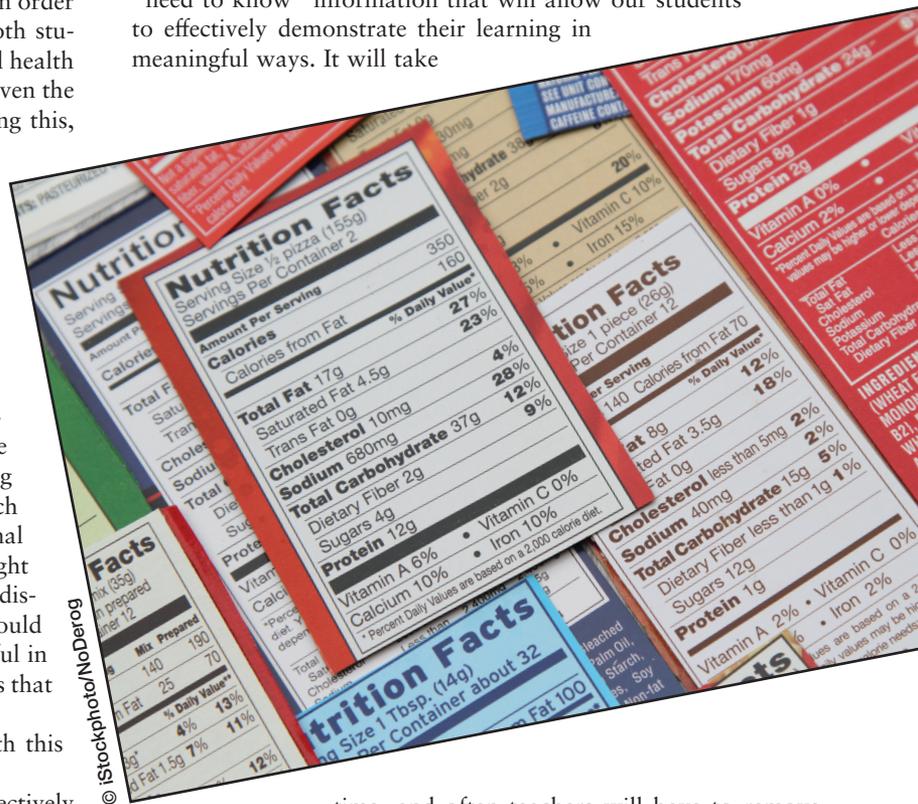
When determining functional information for health topics, consider the following. First, get to know the students and the community. Use data to help determine the needs of students. The more often relevant and meaningful topics are integrated into health curricula, the more likely students are able to see themselves in the lessons being taught. The types of data can range from formal data such as the Youth Risk Behavior Survey (YRBS) to more informal such as a preassessment at the start of a course. Data might also be in the form of mandates, state standards, or local district policies related to what topics and/or information should (or must) be included in the curriculum. Data can be helpful in narrowing down topics. Here are some additional questions that can be used to determine functional information:

1. What will happen if students are not presented with this information?
2. Without this information, will students be able to effectively apply this skill in a real-life situation?
3. When students learn this information, how will they use it to benefit their health or the health of those around them? (Benes & Alperin, 2019, p. 9)

Imagine another scenario. A local district wants to reduce the number of students who use drugs, and in particular opioids. As the health teacher works to decide what to cover related to illicit drugs, they remember an engaging activity that involves students classifying drugs. Then the teacher considers the questions above. They consider that in order to refuse drugs or to make a decision not to use drugs, perhaps students don't need to be able to identify and classify the drug. After all, maybe they won't even know what they are actually getting or taking. Being able to classify drugs will not help students if they are given a random pill. However, what they do need to know is that only medication prescribed to them by a healthcare provider or given by a trusted adult should be taken, they might need to learn about some of the negative effects of drugs on their bodies, relationships and success, and they will definitely need to know how to give an effective refusal by saying no and being confident enough to get themselves out of the situation. The teacher decides not to use this activity and finds a different activity related to creating and practicing refusal statements.

Because there is no right answer to which information will be most functional for a given topic, teachers are encouraged to be

selective about the amounts and type of information included and base decisions on the needs of their students. This includes being thoughtful about and responsive to the diversity of students and ensuring that what is included is appropriate, relevant and meaningful for all students. Students live in an age of instant access to information. The health educator must help them navigate this information landscape by providing them with the tools they need to be informed, critical consumers of information. This will require thoughtful consideration and a narrowing down to the “need to know” information that will allow our students to effectively demonstrate their learning in meaningful ways. It will take



time, and often teachers will have to remove some (and in some cases a lot) of the information currently taught, but the narrow focus on applicable information will benefit students.

Participatory Methods

The third aspect of a skills-based approach is the use of participatory teaching and learning methods; these are the methods through which people learn best: observation, modeling and social interaction (World Health Organization, 2003). This is very similar to what happens in physical education. A skill is introduced (including the critical elements of the skill) and modeled. Students practice the skill — sometimes individually but often with partners, in small groups, and/or in game-like settings. Finally, the skill is applied and assessed in real-life contexts. This is what health education should also look like. A majority of the time is not teacher directed. Most of the time is spent on practice and students working together and actively learning and applying content. Students are researching information, role playing communication, participating in gallery walks, talking in small groups about influences on a health behavior, and providing peer feedback on an advocacy project (Herbert & Lohrmann, 2011). The teacher becomes a “guide on the side” or a facilitator rather than the leader of the classroom.

The health teacher is creating experiences through which students can develop skills and engage with the content. For example, rather than lecturing or using a PPT to present information on healthy relationships, the teacher asks students to use valid and reliable websites to determine characteristics which are then shared out to the class. In this example students are both practicing accessing valid and reliable information and learning functional information. Another example would be having students use valid and reliable sources to find information about the effects of various drugs on physical, emotional and social health. Students then use this information as they work through a decision-making model. This can also be as simple as engaging their prior knowledge and providing them a chance to share what they already know or their ideas on the subject rather than giving students information. The teacher then uses those ideas as a springboard into the lesson.

Teachers are providing space for students to share ideas, concerns and questions and for them to discuss what is really going on in their lives. There are multiple and varied practice opportunities for students. There is limited information given directly to students; rather, they become the investigators to search for and analyze relevant and meaningful information. There is a shared responsibility for the curriculum and the classroom. In a skills-based classroom the teacher and students are working together to create and implement a meaningful, relevant curriculum that they can connect to and get excited about.

In a participatory classroom students can personalize learning, internalize learning, and apply their learning. Students see themselves reflected in the curriculum, have input into the curriculum, and have a voice. This approach lends itself to being culturally relevant and inclusive of diverse cultures and backgrounds and requires the health educator to be culturally competent and to ensure that all students have the opportunity to connect with the curriculum and find relevance. A health teacher can accomplish this in a variety of ways. Here are some examples: (1) ensuring examples used are connected to the community they live and/or go to school in, (2) using names that are similar to students in the class, (3) asking students what questions they have related to various health topics and using that to determine what functional information is included in a unit, or (4) allowing students to choose the product

they create for an assessment rather than telling them what they must create.

Consider an advocacy unit. Because the focus is on skill development, the main goal is to develop their ability to effectively advocate for an issue or cause; less emphasis is placed on both the information or topic they are advocating for and on the product through which students choose to demonstrate advocacy. For the final assessment students choose a health-enhancing topic they are passionate about and want to encourage others to engage in, or YRBS data are used and students choose issues that are most prevalent in their community for which to advocate. By backing up their choice with data they have also demonstrated their ability to consider the functional information likely to support their position. The students can also choose whether they want to create a poster, a PSA, a video commercial, or some other product that they thought of on their own. In this example students have the opportunity to decide on the topic and the product — students have been given voice and choice and the skill can still be assessed.

Here is another example. The skill of accessing valid and reliable information, products, and services has been previously covered so the teacher is confident that students are competent in their ability to apply this skill. In the decision-making unit students work in groups to choose a drug of choice to research. They are given a task that includes finding functional information (that meets the standard for being valid and reliable) that will help a teen make a health-enhancing decision and whether this drug has appropriate uses, dangers of misuse, and likelihood of abuse. Students present the information from their research and then create scenarios that the students may find themselves in related to this drug. Finally, students work through a decision-making process using the scenarios developed in class to determine health-enhancing outcomes in relation to the identified substance. Students have essentially created the entire unit, and they still covered functional information, can develop skills, and have had a voice throughout.

The above examples highlight that participatory methods in health education go beyond students feeling safe or engaged. We must also ensure that we are providing space and time for students to apply their learning to their real-world context. Doing so validates their individual experiences and supports their development of self-efficacy.

Conclusion

Schools are a place of learning and self-exploration. A skills-based approach in the health education classroom challenges students to go beyond knowing to applying. They must critically analyze their own health and then consider the tools, strategies and information that will help them to maintain and enhance their own health or the health of those around them. The health educator's role is to support students in developing the competence and confidence to make health-enhancing choices across their lifespan. Health educators must develop curricula and utilize strategies in the classroom that support students' skill development and application within multiple dimensions of wellness. Gaining competence or proficiency in skills of the National Health Education Standards, along with the acquisition of functional health information, supports the development of health literacy, which impacts not only health behaviors but long-term health outcomes as well. When this is done, there is alignment with best practice, and students are able to recognize how their individual experiences within the context of their "real life" plays out in their health and wellbeing.



While information will change during their lifetime, students' ability to apply that information in health-enhancing ways is the critical element of success. Effective health education programming can help students lead healthier lives and support academic success and should be an integral part of students' academic experience.

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