

# 学校健康教育：義務教育における位置付けの日米比較

塩崎 万里

## School Health Education: A Comparative Review of Its Status in Compulsory Education in the USA and Japan

SHIOZAKI Mari

**Abstract:** School Health Education has been strongly promoted by the WHO and is being implemented in many countries throughout the world. This paper begins by documenting the development of the concept, details the component parts of the program, and examines how it is practiced in the USA and Japan by reviewing the curricula suggested by the 50 State Departments of Education (USA) and the Ministry of Education, Culture, Sports, Science and Technology (Japan). The effectiveness and benefits of the program will be discussed based on some of the studies performed in this area. The paper concludes by pointing out that the Japanese curriculum is far behind compared to the USA, and suggests that measures be taken to develop a program to ensure all Japanese children receive health education.

**Key words:** health education, school curriculum, health promoting school

キーワード：健康教育、学校カリキュラム、健康推進校

### Introduction

School Health Education has emerged in the last decade as a new framework to assist schools in addressing health issues. It has been strongly promoted by the World Health Organization (WHO) and is being implemented in many countries throughout the world. Are the programs and policies recommended by the WHO better ways of approaching school health? What are its building blocks and what is the evidence that they are useful in school health initiatives?

This paper reviews the development of the

concept of the "Health Promoting School" as defined by the WHO, details the component parts of the health promoting school, and summarizes the literature for the claimed benefits. The standards for health education which emerged from this concept will be introduced. The present status of health education within the school curriculum frameworks in both the USA and Japan will be reviewed.

### The Development of the Health Promoting School

Promoting the health of children through schools has long been an important task of the WHO,

beginning in 1950 when the Expert Committee on School Health Services laid the first theoretical groundwork for concerted worldwide action (WHO, 1998a). The report of the committee argued for the development of more comprehensive curriculum programs in health; teaching and learning methods, which were less instructional and didactic, and more comprehensive training in health for teachers (WHO, 1951).

In the early 1960s a number of conferences and meetings took place between the WHO and the United Nations Education, Scientific and Cultural Organization (UNESCO) to determine how school health could be improved. A publication was released in 1966 which was one of the first international documents to address pragmatically the planning and implementation of school health programs (WHO, 1966). The WHO continued to produce reports and documents about child and adolescent health during the late 1960s and early 1970s, although there was nothing as specific as the 1966 document which focused on planning and implementing school health. Most were about the emerging international epidemiological data on the health of young people. Reference was often made to the role of schools as a useful setting to improve the health of the young. The building blocks of the Health Promoting School and Comprehensive School Health Education (CSHE) frameworks which emerged in the 1980s and 1990s had clearly been articulated a number of years earlier.

Another influential stimulus for school health is to be found in the *Declaration of Alma Ata*. This statement came out of a major International Conference on Primary Health Care held in Alma Ata, which called on all Governments “to formulate national policies, strategies and plans of action; to develop a multisectoral approach, to involve citizens in planning, organization, operation and

control of primary health care; and to focus on education as a means of preventing and controlling health problems” (WHO, 1978, p.5). The focus of the *Declaration of Alma Ata* (‘Health for All by the Year 2000’), prompted a closer examination by governments and health authorities about how this could be achieved.

The First International Conference on Health Promotion held in Ottawa in 1986 created the vision by clarifying the concept of health promotion, highlighting the conditions and resources required for health and identifying key actions and basic strategies to pursue the WHO policy of ‘Health for All.’ The *Ottawa Charter for Health Promotion* identified prerequisites for health including peace, a stable ecosystem, social justice and equity, and resources such as education, food and income (WHO, 1986). Key actions to promote health included building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services. The *Ottawa Charter* provided an easily understood framework for the emerging settings approach, where the settings of schools, worksites and cities became the vehicles through which better health was actioned.

Building healthy public policy was explored in greater depth at the Second International Conference on Health Promotion in Adelaide in 1988. The Conference started from the position that health is both a fundamental human right and a sound social investment. Participants reaffirmed the commitment to the strong public health alliance which the *Ottawa Charter* called for. Four priority areas for action were identified: supporting the health of women; improving food security, safety and nutrition; reducing tobacco and alcohol use; and creating supportive environments for health.

This latter priority became the focus of the Third International Conference on Health Promotion in Sundsvall in 1991 (WHO, 1991). Armed conflict, rapid population growth, inadequate food, lack of means of self determination and degradation of natural resources are among the environmental influences identified at the conference as being damaging to health. The *Sundsvall Statement on Supportive Environment for Health* stressed the importance of sustainable development and urged social action at the community level, with people as the driving force of development.

The Fourth International Conference on Health Promotion was held in Jakarta in 1997 (WHO, 1997). The Conference not only endorsed the results of the previous International Conferences on Health Promotion, but also confirmed relevance for both developing and developed countries of placing health promotion firmly at the center of health development. These findings helped to shape renewed commitment to the key strategies and led to further refinement of the approaches in order to ensure their continuing relevance. Five priorities were identified in the *Jakarta Declaration on Leading Health Promotion into the 21st Century*: promoting social responsibility for health; increasing community capacity and empowering the individual; expanding and consolidating partnerships for health; increasing investment for health development; and securing an infrastructure for health development.

The Fifth Global Conference on Health Promotion was held in Mexico City in 2000 (WHO, 2000). At the start of the new century, two challenges remained: to better demonstrate and communicate that health promotion policies and practices can make a difference to health and quality of life, and to achieve greater equity in health. The Conference focused on bridging the equity gap both within and between countries. The *Mexico*

*Ministerial Statement for the Promotion of Health: From Ideas to Action* (MMS) states that health promotion must be a fundamental component of public policies and programs in all countries in the pursuit of equity and better health for all and pledges support for the preparation of countrywide plans of action for promoting health.

The WHO further increased the momentum for school health with its *Global School Health Initiative*. The general direction of the initiative is guided by the *Ottawa Charter* and the *Jakarta Declaration*. It is also guided by the recommendation of the WHO's Expert Committee on Comprehensive School Health Education and Promotion, while the WHO's Division of Health Promotion, Education and Communication (WHO/HPR) is charged with the Initiative's implementation and also with maintaining the secretariat for the WHO's inter-divisional Working Group on School Health. In 1986 the WHO and the UNICEF published *Helping a Billion Children to Learn about Health* based on the findings of an international consultation on health learning (WHO, 1998b). In 1991 an expert consultation was jointly convened by the WHO, UNICEF, and UNESCO to gain a common understanding of comprehensive school health education and to outline action for countries to consider to strengthen implementation. From the WHO's contemporary perspective, school health programs are today one of the critical factors for realizing 'Health for All.'

School health programs are an efficient way to prevent important risks and improve both health and education. In 2000, the WHO, UNESCO, UNICEF, the World Bank and Education International launched a joint initiative to speak with one voice about school health (WHO, 2002). FRESH (Focusing Resources on Effective School Health) is an interagency initiative fostering the

implementation of four basic components of an effective school health program: 1) school health policies; 2) safe water and sanitation as first steps in creating a healthy physical and psycho-social environment; 3) skills-based health education; 4) school health services. The agencies are calling upon education and health officials, teachers and students, and parents and community leaders to work together to implement the four components in all schools.

All these actions have set the scene for and established the frameworks of the health promoting school.

### **The structure of the Health Promoting School**

The WHO promotes school health programs as a strategic means to prevent important health risks among youth and to engage the education sector in efforts to change the educational, social, economic and political policies/conditions that affect risk. The WHO defines the Health Promoting School as one that constantly strengthens its capacity as a healthy setting for living, learning, and working (WHO, 2002). Health Promoting Schools focus on:

- Caring for oneself and others.
- Making healthy decisions and taking control over life's circumstances.
- Creating conditions that are conducive to health.
- Building capacities for peace, shelter, education, food, income, a stable ecosystem, equity, social justice, sustainable development.
- Preventing leading causes of death, disease and disability: helminths, tobacco use, HIV/AIDS/STDs, sedentary lifestyle, drugs and alcohol, violence and injuries, unhealthy nutrition.
- Influencing health-related behaviors: knowledge, beliefs, skills, attitudes, values and support.

Health promoting schools have grown considerably in number during the 1990s. They have their origins in the WHO initiatives and programs developed at country and state levels. There have been major initiatives in the European and Western Pacific Regions, and in Northern America, particularly with the CSHE in the US.

In the US, the Surgeon General's Report on Health Promotion and Disease Prevention which was published in 1979 placed great value on the health of children and adolescents, and how the young could be supported through more comprehensive health programs at school (USDHEW, 1979). This report was one of the major elements to have a marked effect on how school health was developed in the US during the 1980s. The American Cancer Society and the Center for Disease Control (CDC) also played very significant roles.

During the 1980s, school health in the US was shaped by three domains—classroom health instruction, school health services, and a healthy school environment (NPSHO, 1984). Programs appeared to focus on these areas with little attempt to integrate health themes. A significant shift occurred in the late 1980s following Allensworth and Kolbe's expansion of the CSHE model from three to eight components (Allensworth and Kolbe, 1987). The additional five components, i.e. school food services, school site health promotion for staff, school counseling and psychology programs, school physical education, and integrated community and school health promotion efforts, spelt out a much broader focus for school health and moved the CSHE further away from classroom curriculum. The map reflected the five elements of the *Ottawa Charter* which was developed one year earlier, and provided schools, government jurisdictions and departments, and health organizations with a

framework to facilitate an integrated approach to school health.

In late 1994, an Institute of Medicine (IOM) committee was convened to carry out a study of CSHE programs in grades K-12 (Allensworth et al., 1997). Whereas earlier generations of school health programs were predominantly concerned with stemming the threat of infectious diseases, these problems have now to a large extent been ameliorated and replaced with the “new social morbidities”—injuries, violence, substance abuse, risky sexual behaviors, psychological and emotional disorders, and problems due to poverty—and many student’s lack of access to reliable health information and health care.

Jackson (1994) reviewed the CSHE programs and argued that a new paradigm for comprehensive school health was emerging. She highlighted the moves from:

- School-based to school-wide and community programs.
- Formal instruction to needs driven, skill based classroom education.
- An emphasis on health information to health attitude and value clarification.
- Health education to health promotion with its strategies and community-wide focus.
- School centered approach to an interdisciplinary, interagency team approach.
- Teaching skills in isolation to a focus on generic health skills (e.g. media analysis, assertiveness, coping, problem solving).

The concept of the health promoting school had now emerged internationally with considerable commonality between the structural frameworks in the different regions.

#### Standards for Health Education-USA

For several decades, health education curricula have addressed from 10 to 15 traditional health topics. This construct had contributed to fragmented instruction and a lack of attention to skills. Cumulative research has demonstrated the interrelatedness of health risk behaviors and the effectiveness of skills-based health education in reducing risk behaviors and enhancing protective behaviors. The standards-based approach introduced with the publication of the *National Health Education Learning Standards* in 1996 fused health and safety concepts with essential skills:

#### National Health Education Standards (1996)

1. Students will comprehend concepts related to health promotion and disease prevention.
2. Students will demonstrate the ability to access valid health information and health-promoting products and services.
3. Students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks.
4. Students will analyze the influence of culture, media, technology, and other factors on health.
5. Students will demonstrate the ability to use interpersonal communication skills to enhance health.
6. Students will demonstrate the ability to use goal setting and decision-making skills to enhance health.
7. Students will demonstrate the ability to advocate for personal, family, and community health.

These learning standards are interwoven to create an integrated skills-based approach to health and safety instruction. They provide direction for communities and school systems to develop a responsive local health education program that promotes health literacy for all students.

A typical example of the health education curriculum recommended by the state is shown on Table 1 (State Department of Education, Hawaii). The standards are organized into grade level clusters so that a parent, local school board member, classroom teacher, or administrator could quickly review the health learning that is expected at a specific grade level. Grade level clusters are organized K-3, 4-5, 6-8, and 9-12 although this may also be planned for each grade level. Also, the standards and indicators are the same at all levels to provide vertical alignment and continuity in the K-12 curriculum. The benchmarks are conceptually the same, but worded differently so as to be more developmentally appropriate for the various levels. The performance criteria are holistic rubrics that could be used as a summative assessment tool to gauge student achievement/progress. Review of the health education curricula recommended by each of the 50 State Departments of Education revealed that the National Health Education Standards are adopted in the majority of the states, with slight variations depending on the policy and needs of each state (State Departments of Education, 2002).

Health education offers a coherent vision of what it means to be health literate. For students to be health literate, they need to obtain, interpret and understand basic health information and services in ways which enhance health. The content includes the most important and enduring ideas, issues, and concepts related to achieving good health. The skills include ways of communication, reasoning, and investigating which characterize a health-literate person. Both content and skills are essential for effective Health Education.

### Research and Evaluation

Research and evaluation are particularly challenging for CSHE programs. Since these programs

comprise multiple interactive components, it is often difficult to attribute observed effects to specific components or to separate program effects from those of the family or community.

This section summarizes the benefits of health education programs which are claimed in recent literature. However, these need to be viewed with some caution as a justification for health promoting schools. It primarily relates to topic-based interventions, which largely are implemented through only one or two of the building blocks of health promoting schools.

There are some studies that have addressed specific health issues, usually smoking, alcohol, sexuality and physical activity, which indicate major health gains for children will occur if the strategic intervention is multifaceted. Most relate to post-primary schools and are impressive in their findings, e.g. tobacco (Perry et al., 1992; CDC, 2002), alcohol (Ellickson and Hays, 1992; CDC, 2002), and sexuality (Vincent et al., 1987; CDC, 2002).

Recent major reports and studies cite various forms of evidence that suggest that children learn better if they are healthy (Lavin et al., 1992; WHO, 1995). Common themes run through this literature which indicate learning is faster, more comprehensive and is enjoyed by students if they are healthy. The health promoting school appears to offer an approach that increases the learning capacity of students. Evidence in the literature also indicates that the health promoting school approach also appears to enrich classroom-based learning outcomes, e.g. knowledge acquisition and decision making (Lavin et al., 1992; Allensworth, 1995; Collins, 1995).

A fundamental issue involves determining what outcomes are appropriate and reasonable to expect from school health programs. Measures of school

# Health Education Content Standards and Grade Cluster Benchmarks

CONTENT STANDARDS	K - 3	4 - 5	6 - 8	9 - 12
1. Students comprehend concepts related to health promotion and disease prevention. All standards must be taught in the following content areas. • Injury & Violence Prevention • Tobacco Use Prevention • Alcohol & Other Drug Use Prevention • Sexual Health • Nutrition • Physical Activity • Mental Health • Personal and Consumer Health • Community and Environmental Health	<ul style="list-style-type: none"> <li>Describe actions individuals can take to promote and protect their own health.</li> <li>Describe ways to help others promote and protect their health.</li> <li>Identify short and long term benefits and consequences associated with the content areas (e.g., short term-looking both ways before crossing streets and wearing seat belts; long term—wearing sun protection and not using tobacco).</li> </ul>	<ul style="list-style-type: none"> <li>Compare and contrast actions individuals can take to promote and protect their own health.</li> <li>Provide reasons to help others promote and protect their health.</li> <li>Describe short and long term benefits and consequences within the content areas (e.g., short term—participating in daily physical activity and asking for help; long term—eating five servings of fruits and vegetables everyday and recycling waste).</li> </ul>	<ul style="list-style-type: none"> <li>Analyze choices individuals can make that promote and protect or that harm their health.</li> <li>Design ways to help others promote and protect their health.</li> <li>Analyze short and long term benefits and consequences within the content areas (e.g., short term—drinking alcohol and fighting; long term—smoking cigarettes and eating high-fat diets).</li> </ul>	<ul style="list-style-type: none"> <li>Justify actions to promote and protect one's own health throughout life.</li> <li>Implement ways to help others promote and protect their health.</li> <li>Evaluate the short and long term benefits and consequences with the content areas that hold greatest importance (e.g., short term—managing stress and driving within speed limits; long term—obtaining from sex and getting enough calcium).</li> </ul>
2. Students access valid health information and health-promoting products and services.	<ul style="list-style-type: none"> <li>Identify appropriate sources of health information.</li> <li>Name school and community health helpers (people).</li> </ul>	<ul style="list-style-type: none"> <li>Describe reasons to access health information.</li> <li>Demonstrate how to locate sources of health information in the home, school and community.</li> </ul>	<ul style="list-style-type: none"> <li>Compare health messages from different information sources.</li> <li>Examine various influence on our decisions in selecting health information.</li> <li>Assess when to access health services for self and others.</li> </ul>	<ul style="list-style-type: none"> <li>Evaluate the validity of different sources of health information.</li> <li>Compare health information provided from home, school and community resources.</li> <li>Demonstrate the ability to access health services (e.g., private insurance, managed care, HMOs).</li> </ul>
3. Students practice health-enhancing behaviors and reduce health risks.	<ul style="list-style-type: none"> <li>Discuss appropriate coping and stress management strategies (e.g., situation-making new friends).</li> <li>Identify behaviors and situations that are safe, risky, or harmful to self and others.</li> </ul>	<ul style="list-style-type: none"> <li>Describe health-enhancing coping and stress management strategies (e.g., situation-changes within the family).</li> <li>Compare behaviors and situations that are safe, risky, or harmful to self and others.</li> <li>Identify and practice steps in assessing risks for injury or disease and making responsible decisions.</li> </ul>	<ul style="list-style-type: none"> <li>Analyze personal preferences for coping and stress management strategies (e.g., situation-peer pressure).</li> <li>Identify barriers to and supports for making health-enhancing decisions.</li> <li>Develop proactive strategies for managing one's own health.</li> <li>Distinguish types and degrees of risk encountered in daily living.</li> </ul>	<ul style="list-style-type: none"> <li>Evaluate personal coping and stress management strategies (e.g., situation-taking a driver's exam).</li> <li>Practice self-management skills to maintain and improve one's own health.</li> <li>Evaluate the effectiveness of positive health practices in overcoming setbacks in achieving health goals.</li> <li>Plan responses to appropriate and inappropriate risk.</li> </ul>
4. Students analyze the influences of media, culture, technology, and other factors to enhance health.	<ul style="list-style-type: none"> <li>Identify internal and external factors that influence health behaviors (e.g., personal, family).</li> <li>Describe how media, technology, and other factors influence health behaviors.</li> <li>Describe how culture influences health behaviors.</li> </ul>	<ul style="list-style-type: none"> <li>Classify the internal and external factors that influence health behaviors (e.g., personal, family, and community into categories).</li> <li>Explain the effects of internal and external factors on health-related decisions.</li> </ul>	<ul style="list-style-type: none"> <li>Analyze internal and external factors that influence health behaviors (e.g., personal, family, and community).</li> <li>Explain how internal and external factors influence health outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>Evaluate the interrelationship and complexity of internal and external factors that influence health behaviors (e.g., personal, family, and community).</li> <li>Generalize the impact of internal and external factors on health outcomes.</li> </ul>
5. Students use interpersonal communication skills to enhance health.	<ul style="list-style-type: none"> <li>Practice effective verbal and nonverbal interpersonal communication skills.</li> <li>Demonstrate non-violent strategies in relating to others and resolving disputes.</li> <li>Identify strategies to avoid inappropriate communication (e.g., name-calling, put-downs, harassment).</li> </ul>	<ul style="list-style-type: none"> <li>Demonstrate a variety of strategies for effective verbal and nonverbal communication in formal and informal group settings.</li> <li>Predict possible consequences of assertive, aggressive, and passive communication.</li> <li>Demonstrate strategies to avoid inappropriate communication (e.g., name-calling, put-downs, harassment).</li> </ul>	<ul style="list-style-type: none"> <li>Identify one's personal values while at the same time maintaining friendships.</li> <li>Evaluate effective verbal and nonverbal communication.</li> <li>Analyze possible causes of disputes connected to personal, family and community health.</li> </ul>	<ul style="list-style-type: none"> <li>Practice maintaining one's personal values while at the same time maintaining friendships.</li> <li>Demonstrate negotiation and collaboration strategies to manage conflict through analyzing the causes of disputes.</li> <li>Demonstrate communication skills necessary to avoid potentially harmful situations.</li> </ul>
6. Students use goal-setting and decision making skills to enhance health.	<ul style="list-style-type: none"> <li>Demonstrate ways to make health-enhancing decisions using decision-making processes.</li> <li>Name persons or places that can help with health-related decisions and goal setting.</li> <li>Identify a personal realistic goal and develop a plan to achieve it.</li> </ul>	<ul style="list-style-type: none"> <li>Demonstrate the ability to apply decision-making processes to health issues and problems.</li> <li>Explain when to ask for help with health-related decisions and goal-setting.</li> <li>Predict possible outcomes, evaluate and/or reflect on decisions made on health issues and problems.</li> </ul>	<ul style="list-style-type: none"> <li>Demonstrate the ability to apply decision-making processes to health issues and problems individually and collaboratively.</li> <li>Predict consequences of decisions for self and others regarding health behaviors.</li> <li>Evaluate personal strengths, needs, and health risks and set personal health goals.</li> <li>Describe a plan to achieve a health goal.</li> </ul>	<ul style="list-style-type: none"> <li>Evaluate processes towards achieving personal health goals.</li> <li>Analyze immediate and long-term consequences, including personal, family, and community consequences.</li> <li>Create a plan for enhancing life long health.</li> <li>Implement strategies for achieving a personal long-term health goal.</li> </ul>
7. Students advocate for personal, family, and community health.	<ul style="list-style-type: none"> <li>Examine and express individual opinions about health issues.</li> <li>Identify people or groups that advocate for healthy individuals, families, and communities.</li> </ul>	<ul style="list-style-type: none"> <li>Apply accurate health information to persuade others to make health enhancing choices as appropriate.</li> <li>Show evidence of personal conviction, awareness of audience, and accurate health information that supports a position that advocates healthy behavior.</li> </ul>	<ul style="list-style-type: none"> <li>Analyze methods that communicate accurate health information and ideas.</li> <li>Develop a plan for persuading others to make healthful choices.</li> <li>Identify barriers to effective communication of information ideas, feelings, and opinions.</li> <li>Demonstrate the ability to influence and support others in making healthful choices.</li> </ul>	<ul style="list-style-type: none"> <li>Evaluate effectiveness of strategies in communicating health information and ideas.</li> <li>Evaluate the effects that health information and opinions have on a particular audience.</li> <li>Defend a position which encourages a health enhancing behavior.</li> <li>Design a health advocacy campaign.</li> </ul>

Table 1 Health Education Content Standards (Hawaii, 1999)

health programs are made on areas as diverse as knowledge, attitudes, health practices and educational gains. It is here in both health practices and educational gains categories where the literature is confused. Allensworth (1997) states that although influencing health behavior and health status is an ultimate goal, reasonable outcomes on which a school health program should be judged are equipping students with the knowledge, attitudes, and skills necessary for healthful behavior. Measures such as improved cardiovascular fitness or a reduction in drug abuse, better traffic behaviors and sexual practices, for example, may also be considered, but the majority of interventions in schools about health for students will probably not be able to produce health outcomes until later life. Lung cancer as a result of smoking, for example, will not manifest itself until well into adulthood. School health has difficulty in clearly demonstrating the health gains at the end of a program. Since the acquisition of health-related social skills—such as negotiation, decision-making, and refusal skills—is a desired end point of the school health program, basic research is needed to develop valid measures of social skills that can be used as measures of program effectiveness.

### Health Education in the USA and Japan

The educational systems and how they are operated are quite different between the USA and Japan. Whereas the subjects taught, the contents of each subject, the textbooks used and the hours of study for all Japanese children in elementary and middle schools are determined solely by the Ministry of Education, Culture, Sports, Science, and technology (hereafter referred to as the Ministry of Education), all these decisions are left to the States and districts in the US, and are dealt in a much more flexible manner, meeting the needs of

the geographical area, culture, and the community. A close investigation of the documents published by each of the 50 State Departments of Education reveals that each State has its own goals for education. The attempt to compare the health education curriculum frameworks between the two countries is therefore not a simple task, with one country having a multitude of different curriculum frameworks. However, with the strong promotion of the WHO, CDC, and many other organizations, the concept of the health promoting school is spread nationwide. As we will see, it can be said without exaggeration that most schools in the US now adopt the policy of the CSHE.

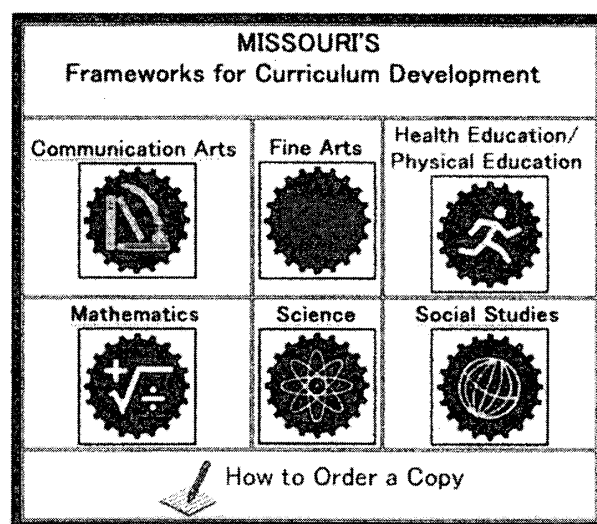


Figure 1 Missouri Department of Education (1999)

Figure 1 (Missouri Department of Education, 1999) is an example of the top page of the Department of Education website showing the subjects taught in the State of Missouri. Health Education and Physical Education were not originally mentioned in the National Education Goal as "core subjects" in which students should demonstrate competence, but with each updated report, the National Education Goals panel has added language emphasizing the importance of these two curricular components, affirming that these two subjects should be an integral part of the school



K12 Curriculum Framework

Curriculum	Grades													
Science	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Mathematics	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Social Studies	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Comprehensive Health	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Physical Education	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Fine Arts-Dance	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Fine Arts-Music	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Fine Arts-Theater Arts	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Fine Arts-Visual Arts	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Language Arts	K	1	2	3	4	5	6	7	8	9	10	11	12	Outline
Business/Technology														Outline
Foreign Language														Outline

Table 2 Mississippi (1999)

States That Have Adopted Health Education (HED) Goals, Objectives, or Expected Outcomes, by School Level

	Has Adopted HED Goals, Objectives, or Outcomes		
	Elementary Schools	Middle/Junior High Schools	Senior High Schools
Alabama	●	●	●
Alaska	●	●	●
Arizona	●	●	●
Arkansas	●	●	●
California	●	●	●
Colorado	○	○	○
Connecticut	●	●	●
Delaware	●	●	●
District of Columbia	●	●	●
Florida	●	●	●
Georgia	●	●	●
Hawaii	●	●	●
Idaho	○	○	○
Illinois	●	●	●
Indiana	●	●	●
Iowa	○	○	○
Kansas	○	○	○
Kentucky	●	○	●
Louisiana	●	●	●
Maine	●	●	●
Maryland	●	●	●
Massachusetts	●	●	●
Michigan	●	●	●
Minnesota	●	●	●
Mississippi	●	●	●
Missouri	●	●	●
Montana	●	●	●
Nebraska	○	○	○
Nevada	●	●	●
New Hampshire	○	○	○
New Jersey	●	●	●
New Mexico	●	●	●
New York	●	●	●
North Carolina	●	●	●
North Dakota	○	○	○
Ohio	○	○	○
Oklahoma	●	●	●
Oregon	●	●	●
Pennsylvania	○	○	○
Rhode Island	●	●	●
South Carolina	●	●	●
South Dakota	●	●	●
Tennessee	●	●	●
Texas	●	●	●
Utah	●	●	●
Vermont	●	●	●
Virginia	●	●	●
Washington	●	●	●
West Virginia	●	●	○
Wisconsin	●	●	●
Wyoming	○	○	○

Table 3 SHPPS (2001)

curriculum (Allensworth *et al.*, 1997). According to a recent Gallup Poll, Americans ranked health education above instruction in language arts, mathematics, and science, when asked to identify what is necessary for students to learn before high school graduation (Marzano *et al.*, 1999). An example of a K-12 curriculum framework is shown on Table 2 (Mississippi Department of Education, 1999). Note that both Health and Physical Education are taught from K-12.

School Health Program Report Card

Rhode Island

Health Education			
1.1	Has health education (HED) coordinator	● <sup>2</sup>	
1.2	Requires or encourages districts or schools to follow HED standards or guidelines	● <sup>3</sup>	
		Elementary Schools	Middle/Junior High Schools
1.3	Has adopted HED goals, objectives, or expected outcomes	●	●
1.4, 1.5, and 1.6	Requires schools to teach:		
	Accident <sup>4</sup> or injury prevention	●	●
	Alcohol or other drug use prevention	●	●
	Consumer health	●	●
	Cardiopulmonary resuscitation (CPR)	○	●
	Death and dying	●	●
	Dental and oral health	●	○
	Emotional and mental health	●	●
	Environmental health	●	●
	First aid	●	●
	Growth and development	●	●
	Human immunodeficiency virus (HIV) prevention	●	●
	Human sexuality	●	●
	Immunizations or vaccinations	●	●
	Nutrition and dietary behavior	●	●
	Personal hygiene	●	●
	Physical activity and fitness	●	●
	Pregnancy prevention	○	●
	Sexually transmitted disease (STD) prevention	○	●
	Suicide prevention	○	●
	Sun safety or skin cancer prevention	●	●
	Tobacco use prevention	●	●
	Violence prevention	●	●
1.7	Requires students to be tested on health topics	●	●
1.8	Has developed own HED curricula	○	○
1.9	Requires undergraduate or graduate training in health education for newly hired HED teachers	○	●
1.10	Offers and requires certification, licensure, or endorsement for newly hired HED teachers	○ <sup>5</sup>	○ <sup>5</sup>

Table 4 SHPPS (2001)

Going through the curriculum frameworks and verifying the status of health education in each of the 50 States would be a very interesting as well as meaningful task. However, the space allowed for this paper is much too limited to make any reference to the findings from the extensive investigation. Reviewing the reports published by the CDC would be another alternative. The School Health Policies Programs Study (SHPPS) is a national survey periodically conducted by the CDC to assess

school health policies and programs at the state, district, school, and classroom levels (CDC, 2001). According to this report, nearly 90% of the states require the schools to teach health education (Figure 2, CDC, 2001). The Health Education goals, objectives, or expected outcomes have been adopted by the majority of the states, with few exceptions (Table 3). School Health Program Report Cards showing the topics taught in each state are also published (Table 4). The evaluation reports are used to provide feedback to administrators and teachers and gain their active participation in defining solutions to improving the country's program.

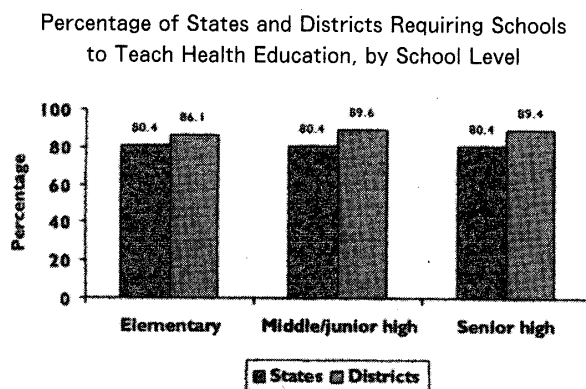


Figure 2 SHPPS (2001)

Health education in Japan started during the late 1950s by utilizing some of the hours planned for physical education (Mori, 1997). It was in 1989 that the first health education textbook was approved by the Ministry of Education. Today, under the new Educational Reform, a total of 8 class hours are taught in grades 3 and 4; 16 hours in grades 5 and 6; and 48 hours during the 3 years of middle school (Ministry of Education, 2002). The goals for 3rd and 4th graders are to: 1) understand the importance of health, and how to lead a healthy lifestyle, and to 2) understand the development of the body. The 5th and 6th graders learn: 1) injury prevention and first aid, 2) mental health problems and ways to deal with them and 3) knowledge of diseases. The goal of health education in middle

school is to: 1) understand the development of the body and mind, 2) understand the relation between health and environment, 3) prevention of accidents, and to 4) understand the causes of disease and to lead a healthy life.

It is evident that health education is not given a crucial role in the Japanese curriculum framework. In many schools, health education hours are combined with physical education and are not always guaranteed. They are secured only through the efforts of dedicated teachers. In a recent study performed on health education, topics on "community and health" were completed by 86%, but "environment and health" were not taught at all by 20% or more of the teachers, and some 21% answered that they could not find the time to teach (Omichi et al., 2001). Moreover, only 10~20% of the teachers who taught health considered their class to be meaningful (Takahashi, 1997). Many people who are now adults hardly remember what they were taught in health classes, or even the fact that such classes existed when they were in school.

Another problem is that the teachers have not been trained to teach the subject. Many of the teachers who teach health are physical education teachers who earned degrees in sports, and are far from being knowledgeable about the subject. It is difficult to teach a subject that one is weak in, and there is a tendency to avoid this situation if possible. Much have been argued about teachers not qualified enough to teach health under the present educational system, and suggestions for teacher training have been made (Ieda, 1997; Yamanashi, 1997; Ozawa, 1997; Watanabe *et al.*, 2001; Sakamoto *et al.*, 2001). Clearly for health education to be effective, students need more than isolated health messages delivered by a single teacher on a rainy afternoon.

The content of the subject is also an issue. Statements have been made that the gap between what the students are expected “to know” and what they are expected to be able “to practice” is too wide, and that the goal should be “to have the knowledge and the capacity to practice” (Takakura, 1999). For example, it makes one wonder whether it is meaningful to have all the knowledge of how the traffic rules were legislated, without learning how to prevent traffic accidents (Ieda, 1997). Topics that the students find truly meaningful need to be selected (Yamanashi, 1997).

Many argue that the children will benefit more from the subject if they started earlier, and suggest health education from K-12 rather than the present 3-12 (Kawabata, 1997; Wato, 2002). Negative behaviors can be changed later in life, but it is more effective to encourage positive behaviors at the earliest age possible. Ieda *et al.* (1999) proposed 151 items as contents of school health education, and claims that it is necessary to have one school hour of health education per week from at least 3rd grade to cover the material. Kitamura (1999) claims that health education should be valued as much as the Japanese Constitution, and should not be treated as a minor subject. The Ministry of Education (1998) states that health-related topics are ideal topics to be chosen for “integrated study.” However, considering the nature of “integrated study” that values the students’ interest and willingness, this would at the same time mean that those who are not interested would miss the chance to learn. Health should be equally taught to each and every student.

At the turn of the new century, the educational policies of the two countries seem to be aiming for opposite goals. In January 2002, President Bush signed into law the ‘No Child Left Behind Act of 2001.’ This new law represents his education reform

plan and contains the most sweeping changes to the Elementary and Secondary Education Act (ESEA) since it was enacted in 1965. The Act contains the President’s four basic education reform principles: stronger accountability for results, increased flexibility and local control, expanded options for parents, and an emphasis on teaching methods that have been proven to work (Bush, 2002). In Japan, the Ministry of Education (2002) states that “the educational contents will be limited to the very basics necessary for daily life,” and that “a student’s academic ability should not be measured by the quantity of knowledge acquired.”

It would not be possible for the children of our nation to “cultivate rich humanity”, “think independently”, “grow one’s individuality” and “show ingenuity” (Ministry of Education, 2002), without preparing them with the massive knowledge essential to survive in this rapidly changing world. This is an era where each one of us needs to be equipped with the knowledge of the effect of environment on health, life sciences, medicine, nutrition, and healthy lifestyles, to be involved in important and demanding decision-making processes such as treatment options, organ transplants, gene testing, terminal care, and much more. Children need to build up their life skills and learn how to deal with stress. Bullying, school refusal, and suicides among elementary and secondary students continue to increase. It is clear that we do not have the luxury to “develop educational activities without pressure of time or stress” (Ministry of Education, 2002). We should not be relieved that “the academic achievement of Japanese children is satisfactory overall” (Ministry of Education, 1998), since becoming a health-literate individual means much more than being smart in math and science.

Many countries in the world are actively participating in international conferences related to health

in efforts to improve the health of their people as there is much to learn from the attempts and suggestions of other countries. It is truly regrettable that Japan was not among one of the 87 countries that signed the *Mexico Ministerial Statement for the Promotion of Health* (WHO, 2000). This incident in itself can be one proof that our nation lacks the important life-skills to improve the present state.

The author would like to end this paper with a quote from the School Health Work Group (2000): “Only when schools consider coordinated school health programs to be as essential as history, social studies, or language arts will they be able to maximize academic achievement and positive health outcomes among children and youths they serve.”

## Bibliography

- Allensworth, D. and Kolbe, L. (1987) The Comprehensive School Health Program: exploring an expanded concept. *Journal of School Health*, 57, 409-412.
- Allensworth, D. (1995) The Comprehensive School Health Programme: essential elements. Feeder paper to the WHO Expert Committee on Comprehensive School Health Education and Promotion, WHO, Geneva.
- Allensworth, D., Lawson, E., Nicholson, L., and Wyche, J. eds. (1997) *School and Health—Our Nation's Investment*, National Academy of Sciences Institute of Medicine, The National Academy Press.
- Bush, G. (2002) *No Child Left Behind Act of 2001*, US Department of Education.
- CDC (1998) Surveillance for Characteristics of Health Education Among Secondary Schools—School Health Education Profiles, *Morbidity and Mortality Weekly Report*, August 18, 2000; 49 (SS08):1-41.
- CDC (2001) Overview-School Health Policies and Programs Study 2000, *Journal of School Health*, Vol, 71, Number 7, September 2001.
- CDC (2002a) *Healthy Youth: An Investment in Our Nation's Future*, 2002, Division of Adolescent and School Health, CDC.
- CDC (2002b) *School Health Program Report Cards For Each State: Summary from the School Health Policies and Programs Study 2000*, Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2002.
- Collins, J. (1995) *School Health Research*, Feeder paper to the WHO Expert Committee on Comprehensive School Health Education and Promotion, WHO, Geneva.
- Ellickson, P.L., and Hays, R.D. (1992) On becoming involved with drugs: modeling adolescent drug use over time, *Health Psychology*, 11, 377-385.
- Ieda, Shigeharu (1997) School Health Education and Behavior Sciences, *Japanese Journal of School Health*, 39: 1997; 104-106. (Japanese)
- Jackson, S.A. (1994) Comprehensive school health education programs: innovative practices and issues in standard setting, *Journal of School Health*, 64, 177-179.
- Joint Committee on National Health Education Standards (1995) *National Health Education Standards: Achieving Health Literacy*, American Association for Health Education/Alliance for Health, Physical Education, Recreation and Dance.
- Kawabata, Tetsuro (1997) Future Directions of Life Skills-based Health Education in Japan, *Japanese Journal of School Health*, 39:1997; 121-124. (Japanese)
- Kitamura, Akihide (1999) Critical Mental Health of School Children and Students, and Task of School Health, *Japanese Journal of School Health*

- 41: 1999; 410-414. (Japanese)
- Lavin, A.T., Shapiro, G.R., and Weill, K.S. (1992) Greeting an agenda for school-based health promotion: review of 25 selected reports, *Journal of School Health*, 62,212-229.
- Marzano, R., Kendall, J., and Cicchinelli, L. (1999) *What Americans Believe Students Should Know: A Survey of U.S. Adults*, Aurora, Colo.: McREL.
- Ministry of Education, Culture, Sports, Science and Technology (1998) *Synopsis of the Curriculum Counsel's Midterm Report*.
- Ministry of Education, Culture, Sports, Science and Technology (2002) Official Website, <http://www.mext.go.jp>
- Mori, Terumi (1997) Looking ahead: School Health Education in the 21st Century, *Japanese Journal of School Health*, 39: 1997; 6-13. (Japanese)
- National Professional School Health Organization (1984) Comprehensive school health education: a definition, *Journal of School Health*, 45, 312-315.
- Omichi, N., Koyama, K., Shiraishi, T., and Gotoh, A. (2001) The Study of Health Education in High School (The 2nd Report), *Japanese Journal of School Health*, Vol. 42. Supplement 2001. Selected Papers from the 47th Annual Meeting of Jash.114-116.
- Ozawa, Haruo (1997) Some Problems in School Health Education Viewed from Lower and Upper Secondary Schools, *Japanese Journal of School Health*, 39: 1997; 107-109.(Japanese)
- Perry, C., Kelder, S.H., Murray, D.M., and Klepp, K.I. (1992) Community wide smoking prevention: long term outcomes of the Minnesota Heart Health Program and the Class of 1989 Study, *American Journal of Public Health*, 82, 1210-1216.
- Sakamoto, T., Nozu, Y., Watanabe, M., Iwata, H., Fujiyama, H., Nomura, Y., Munakata, T., Fujisawa, K. (2001) How Teacher Training Should be for Promotion of "Health Education at Elementary School" Based on New Course of Study—Results from the survey among elementary school teachers in I Prefecture, *Japanese Journal of School Health*, Vol. 42, Supplement 2001. Selected Papers from the 47th Annual meeting of Jash, 117-119.
- School Health Work Group (2000) *Building Infrastructure for Coordinated School Health—California's Blueprint*, California Department of Education and California Department of Health Services.
- State Departments of Education (2002) Website search page linking to the state departments of education. <http://education.rootsweb.com>
- St Leger, L.H. (1999) The opportunities and effectiveness of the health promoting primary school in improving child health—a review of the claims and evidence, *Health Education Research*, Vol. 14, No. 1, 51-69.
- Takahashi, Hiroyuki (1997) What Should Schools Health Education Do Now?, *Japanese Journal of School Health*, 39:1997; 110-112. (Japanese)
- Takakura, Minoru (1999) On the enrichment of the School Health Education—prevention of drug abuse, Ryukyu University Department of Medicine. <http://www.cc.u-ryukyu.ac.jp>
- US Department of Health, Education, and Welfare (1979) *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, US Government Printing Office, Washington, DC.
- US Department of Education (2002) <http://www.ed.gov>
- Vincent, M.L., Clearie, A.F. and Schuchter, M.D. (1987) Reducing adolescent pregnancy through school and community based education, *Journal of the American Medical Association*, 257, 3382-2386.
- Watanabe, M., Nozu, Y., Iwata, H., Fujiyama, H.,

- Nomura, Y., Munakata, T., and Fujisawa, M. (2001) Development of Teacher Training Program for Health Education in Elementary Schools in Japan: A Preliminary Evaluation in Tsukuba Health Education (THE) Study, *Japanese Journal of School Health*, Vol. 42, Supplement 2001. Selected Papers from 47th Annual Meeting of Jash. 92-94.
- Wato, Masakatsu (2002) Past and Future of School Health Education in Japan, *Japanese Journal of School Health*, 43:2002; 455-458. (Japanese)
- WHO (1951) Technical Report Series 30: Expert Committee on Health Education of the Public, WHO, Geneva
- WHO (1966) Planning for Health Education in Schools, WHO, Geneva.
- WHO (1978) Primary Health Care: Report on the Conference of Primary Health Care, WHO, Geneva.
- WHO (1986) *Ottawa Charter for Health Promotion*, WHO, Geneva.
- WHO (1991) *Sundsvall Statement on Supportive Environment for Health*, Third International Conference on Health Promotion, Sundsvall, June 1991.
- WHO (1995) WHO Expert Committee on Comprehensive School Health Education and Promotion, WHO, Geneva.
- WHO (1997) *The Jakarta Declaration on Leading Health Promotion into the 21st Century*, Fourth International Conference on Health Promotion, Jakarta, 21-25, July, 1997.
- WHO (1998a) WHO's Global School Health Initiative: Helping Schools Become "Health-Promoting Schools", Fact Sheet No. 92.
- WHO (1998b) Health Promotion: milestones on the road to a global alliance, Fact Sheet No. 171.
- WHO (2000) Health Promotion: Bridging the Equity Gap, The Fifth Global Conference on Health Promotion, 5-9 June 2000, Mexico City.
- WHO (2002) School Health Education related

website: <http://www5.int/school-youth-health>  
 Yamanashi, Yaeko (1997) The Prospects of School Health Education in the 21st Century, *Japanese Journal of School Health*, 39: 1997; 116-120. (Japanese)

## 要旨

学校健康教育は WHO により強く推奨され、世界中の国々で実施されている。本稿では健康教育の概念の変遷過程、プログラムの構成要素について概説し、アメリカの50の州政府の教育担当部門と日本の文部科学省が提案しているそれぞれのカリキュラムを比較検討する。この領域の論文とともに、健康教育プログラムの有効性と有益性についての検討も行われる。日本の健康教育プログラムはアメリカと比較して大きく遅れを取っており、日本のすべての子どもたちが受けることのできるプログラムの開発が望まれる。

(2002. 10. 31. 受稿)