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National Center for Chronic Disease Prevention and Health Promotion

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Special Focus: *School Health*

Reducing the Burden of Chronic Disease: Promoting Healthy Behaviors Among Youth



In February, the top TV show *Survivor* reached more than 29 million viewers in one night—a huge audience—yet, every school day, our nation’s teachers beat that rating, reaching 53 million children, each with a survival challenge. Taught to make healthy choices, these children improve their chances, not only to survive, but to thrive into healthy adult and senior years. CDC recognizes the school years as an ideal opportunity to reduce the impact of chronic disease and risky behaviors by promoting healthy lifestyles. “If we could increase physical

activity and fruit and vegetable consumption and reduce tobacco use among youth, we would be well on our way to a healthier future in this nation,” said Lloyd Kolbe, PhD, Director, Division of Adolescent and School Health, NCCDPHP, CDC.

Risk Behaviors Lead to Major Chronic Diseases

Cardiovascular disease, cancer, and diabetes, which cause more than 70% of all deaths in the United States, are rooted in

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U.S. DEPARTMENT
OF HEALTH AND
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Centers for Disease
Control and Prevention



Commentary Commentary Commentary

Schools Could Help Prevent Cardiovascular Disease, Cancer, and Diabetes

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In every state of our nation, cardiovascular disease (CVD), cancer, and diabetes are responsible for about two-thirds of all deaths, widespread illnesses, enormous health care costs, and extensive human suffering. Much of the morbidity and mortality from these three diseases results from four risk factors that usually are established during youth: tobacco use, unhealthy diet, inadequate physical activity, and obesity. Once these often interrelated risk factors become established during childhood, they are difficult to modify during adulthood. Unfortunately, by the time they graduate from high school, 40% of our nation's students smoke cigarettes, 73% don't eat enough fruits and vegetables, 43% don't engage regularly in vigorous physical activity, and 25% of our children and adolescents already are overweight or at risk of overweight.

Each generation of Americans attends school for 13 of the most formative years of their lives. Carefully designed and coordinated school health programs—including school health education, school food service, and school physical education—could reduce these risk factors among the 53 million young people who attend school each year, especially if school programs are integrated with related community efforts.

A wide range of public and private national, state, and local agencies are interested in working with schools to reduce one or another of these risk factors separately. During the past decade, CDC has institutionalized four strategies that can help schools and these agencies efficiently and collaboratively identify

and implement effective policies and programs to prevent health problems. These strategies are 1) monitoring critical health events and school policies and programs to reduce those events; 2) synthesizing and applying research to improve school policies and programs; 3) enabling constituents to help schools implement effective policies and programs and 4) conducting evaluation research to improve policies and programs. CDC will use these strategies to enable the nation's schools to simultaneously prevent risks for CVD, cancer, and diabetes, especially among populations with a disproportionate burden of these diseases—notably, African Americans, Hispanics, and Native Americans.

In this issue of *Chronic Disease Notes & Reports*, you will read about some current efforts, including the groundbreaking *President's Report on Physical Activity*, a youth media campaign that will target middle school youth with health messages; and school health activities in Michigan and Utah. Also, we will share how the coordinated school health programs model works.

Improving the education and health of all children within our own communities and across the globe—and especially disadvantaged children—will present opportunities and challenges. Purposeful and focused collaborations among public and private national, state, and local health and education agencies could enable the nation's 117,000 schools to establish the kinds of policies and programs that would significantly reduce the burden of chronic diseases among future generations of Americans. 

Promoting Healthy Behaviors Among Youth

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risk factors that are usually established during youth: tobacco use, unhealthy diet, inadequate physical activity, and obesity. Once poor health habits are adopted, they are difficult to change. Data show that many young people are already at risk for serious chronic diseases and premature death: 70% of high school students have tried smoking at least once, 71% do not attend daily physical education classes, and 25% are overweight or at risk of becoming overweight. Addressing these factors through coordinated school health programs could improve health, spare lives, and reduce the burden on our economy and health care system as this generation reaches adulthood.

Partners Help CDC Prevent Chronic Disease

CDC is providing support to three state professional organizations as part of a new chronic disease prevention initiative: the Society of State Directors of Health, Physical Education, and Recreation (SSDHPER), the Association of State and Territorial Chronic Disease Program Directors (ASTCDPD), and the Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE). CDC's formalized collaboration with these organizations and others, including the American Heart Association and the American Cancer Society, should help bolster resources and coordinate efforts at the state and national levels to support school health programs. CDC recently hosted a meeting with representatives from SSDHPER, ASTCDPD, and ASTDHPPHE to develop plans to equip school health programs with strategies and tools to reduce the risk of cardiovascular

Top 10 Physical Activity, Nutrition, and Tobacco-Use Prevention Priorities for Schools

1. Assess school's physical activity, nutrition, and tobacco-use prevention programs and plan for improvement (i.e., use CDC's *School Health Index*).
2. Review and improve school's physical activity, nutrition, and tobacco-use prevention policies (i.e., use the National Association of State Boards of Education's *Fit, Healthy, and Ready to Learn*).
3. Use research-based health education curriculum.
4. Establish an active School Health Council, with involvement from representatives of all components of the Coordinated School Health Program.
5. Implement quality wellness program for school staff and for students and their families.
6. Implement quality physical education programs.
7. Increase opportunities for physical activity in addition to physical education and interscholastic sports (e.g., recess, intramurals, clubs, fitness trails, and walking to school).
8. Implement quality school meals programs.
9. Establish a healthy school nutrition environment (e.g., healthier food choices outside of school meals).
10. Establish tobacco-free schools.

disease, cancer, and diabetes. CDC is also working with the American Heart Association and the American Cancer Society to build effective national approaches to reduce chronic disease health risk behaviors among young people. The new initiative is intended to help the nation's schools implement effective tobacco-use prevention, physical activity, and nutrition programs that can prevent or reverse unhealthy patterns before they take hold in students' lives. "By working together, we are able to reach a broad range of health professionals to improve chronic disease prevention and health promotion and have a greater impact on the health of our nation's youth," commented CDC health

scientist Pete Hunt, MEd, MPH.

National Plan to Improve Adolescent and School Health

CDC employs four national strategies to improve young people's health:

- Monitor critical health events and school policies and programs.
- Synthesize and apply research to improve school policies and programs.
- Enable constituents to help schools implement effective policies and programs.
- Evaluate to improve policies and programs.

Monitor critical health events and school policies and programs

Key to monitoring chronic disease risk factors among young people is CDC's Youth Risk Behavior Surveillance System (YRBSS; online at www.cdc.gov/nccdphp/dash/yrbs/index.htm). Since 1991 this system has tracked tobacco use, physical activity, dietary intake, and weight control behaviors of high school students. "YRBSS data at the national, state, and city levels are used extensively and typically provide the best, and in many cases the only, source of data on these behaviors," explained CDC health scientist Howell Wechsler, EdD, MPH. In addition to YRBSS, CDC conducts the School Health Policies and Programs Study (SHPPS). SHPPS, which was conducted in 1994 and 2000, provides nationally representative data on various school policies and programs including physical education, food services, and health education. Analyses of SHPPS data, to be published in 2001, will assess all eight components of CDC's coordinated school health program model at the elementary, middle, and high school levels.

Synthesize and apply research to improve school policies and programs

In the mid-1990s, CDC released science-

based guidelines for school health programs on how to promote physical activity and healthy eating and prevent tobacco use. (See "Top 10 Physical Activity, Nutrition, and Tobacco-Use Prevention Priorities for Schools," p. 3.) Two important tools were released in 2000 to help schools implement school health guidelines.

The first is the *School Health Index (SHI) for Physical Activity and Healthy Eating: A Self-Assessment and Planning Guide*, which provides a checklist questionnaire to rate school policies and programs against CDC standards. "The SHI will help schools identify the strengths and weaknesses of their health promotion policies and programs and develop an action plan for improving student health," commented Dr. Wechsler. "It gives them something concrete and specific they can do to improve school programs and services." The SHI is online at www.cdc.gov/nccdphp/dash/SHI.

The second tool, *Fit, Healthy and Ready to Learn*, was developed by the National Association of State Boards of Education with CDC support. This tool is a guide to school health policy development. It focuses on policies related to physical activity, healthy eating, and tobacco-use prevention. Dr. Wechsler said, "This document translates the broad vision of the guidelines into concrete, specific policy language that proponents of school health programs can bring to their school boards." This tool is online at www.nasbe.org/healthyschools/fithealthy.mgi.

Other resources include

- CDC's Healthy Youth Funding Database (HY-FUND), which gives users access to current information on federal funding, state revenue funding, and private sector funding. The database offers examples of how states use federal funds to support adolescent and school health programs. Visit the site at www.cdc.gov/nccdphp/dash, and click the "Funding" button.

YRBSS data provide the best, and in many cases the only, source of data on youth behaviors.

- A database service developed by the National School Boards Association provides sample school district health policies on request. The database also provides advice on getting policies adopted by local school boards. Visit www.nsba.org/schoolhealth/database.htm for more information.
- CDC, as part of the Research to Classroom program, has identified and compiled in *Programs That Work* (PTW) a list of curricula with credible evidence of effectiveness. Two tobacco-use prevention programs have been identified in PTW: *Project Toward No Tobacco* and *Life Skills Training*.

Enable constituents to help schools implement effective policies and programs

CDC helps constituents establish policies and programs to reduce chronic disease risk factors among youth by supporting the development of coordinated school health programs in the education agencies and health departments of 20 states. For example, states are using CDC guidelines to develop model health education curricula or specific instructional objectives that identify precisely what students should know and be able to do after completing a health education course. To improve school health, CDC recently hosted two school-based tobacco prevention workshops for 20 state teams, with representatives from state education and health agencies on each team. In addition, other federal agencies and national organizations are key partners in the fight against cardiovascular disease, cancer, and diabetes and their risk factors. “We expect to work closely with all our partners and envision


providing support one day to all 50 state education agencies and health departments, along with education and health agencies in many of the nation’s large cities,” said CDC health scientist Diane Allensworth, PhD.

Evaluate to improve policies and programs

CDC developed a process evaluation manual as an assessment tool for states with coordinated school health programs and provides support to these states for evaluation. Also, economic evaluation studies are being conducted to identify cost-effective programs.

Other strategies

These four national strategies serve as concrete objectives in the fight against chronic disease. In addition, state-, school-, and district-level guidelines have been outlined. CDC and its partners are emphasizing the need for local districts and states to implement effective strategies to improve school health. For instance, tobacco settlement money is being used in Maine to fund a comprehensive cardiovascular health project. Specific outcomes will include the assessment of health education standards and monitoring of physical fitness of all Maine students and the placement of a health coordinator in 35 school districts. Until all school districts take an aggressive and effective approach to reduce chronic disease risk factors among young people, the number of premature deaths due to cardiovascular disease, cancer, and diabetes will remain high.

To find out more about CDC’s coordinated school health programs, visit www.cdc.gov/nccdphp/dash. 

Coordinated School Health Programs Make a Difference

Coordinated school health not only improves children's health, it improves the learning capacity of children.

Every school day, 53 million young people attend the nation's 117,000 schools. What we do to promote their health today will shape the future health of the nation. In addition to reading, writing, and arithmetic, they need to know how to preserve and promote their own health, as well as the health of the generation they will raise, by making healthy choices. School health advocates urge schools to focus on health in a coordinated way, not only keeping health and physical education (PE) in the daily schedule, but including other components needed to make the school a healthy environment supportive of healthy behaviors. These components involve the full spectrum of the school community and address food service, staff wellness, and family and community support (see "A Coordinated School Health Program: The CDC Eight Component Model of School Health Programs," p. 7). The benefits of a coordinated school health program (CSHP) go well beyond improved physical conditioning and health, and they are immediate as well as long-term. "Coordinated school health not only improves children's health, it improves the learning capacity of children," said Lloyd Kolbe, Director of CDC's Division of Adolescent and School Health.

An immediate issue is that children can't learn if they're tired, hungry, on drugs, or worried about violence or domestic problems. CSHPs merge such issues of health and education. Schools with CSHPs report better attendance, less smoking, lower rates of teen pregnancy, increased participation in physical fitness activities, and greater interest in healthier diets. "The reason schools are educating children is so that they can become productive, responsible members of society. Health certainly

has a place in achieving that goal," said Eva Marx, a school health consultant.

"Establishing and maintaining coordinated school health programs and all their components in schools is our primary issue," said William H. Datema, MS, Executive Director, Society of State Directors of Health, Physical Education, and Recreation.

The long-term issue in CSHPs is lifelong health. Research has shown that risk behaviors, often established during youth, account for most of the deaths from chronic diseases: tobacco use, unhealthy diets, and inadequate physical activity. Obviously, equipping young people to resist these behaviors can have a great impact on reducing the toll of illness and death in their future.

Because of competing demands, educators and administrators may not consider the need to make a school health program coherent and complete, but coordinated programs offer many advantages. They increase efficiency, reduce redundancy, and are more cost-effective. "Most schools have many health activities but not in a coordinated, targeted way," said Ms. Marx. "It can be quite haphazard." CDC's coordinated school health program helps educators focus attention and resources on school health, gives them concrete objectives, and shows them how to harness available resources. It supports schools that want to improve their school health programs and empowers them by making them part of a national network of other states with similar programs.

The Need for Standards

Accountability is a requisite of any sound educational system. At the core of accountability are academic standards, which drive curriculum development, instruction, and

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A Coordinated School Health Program: The CDC Eight-Component Model of School Health Programs

The following are the eight components of CDC's model coordinated school health program:

Health Education: A planned, sequential, K–12 curriculum that addresses the physical, mental, emotional, and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It encourages students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices. The comprehensive curriculum includes a variety of topics such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse. Qualified, trained teachers provide health education.

Physical Education: A planned, sequential K–12 curriculum that provides cognitive content and learning experiences in a variety of activity areas such as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. Quality physical education should promote, through a variety of planned physical activities, each student's optimal physical, mental, emotional, and social development, and should promote activities and sports that all students enjoy and can pursue throughout their lives. Qualified, trained teachers teach physical activity.

Health Services: Services provided for students to appraise, protect, and promote health. These services are designed to ensure

access or referral to primary health care services, foster appropriate use of primary health care services, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide optimal sanitary conditions for a safe school facility and school environment, and provide educational and counseling opportunities for promoting and maintaining individual, family, and community health. Qualified professionals such as physicians, nurses, dentists, health educators, and other allied health personnel provide these services.

Nutrition Services: Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the Dietary Guidelines for Americans (published by the U.S. Department of Agriculture and the Department of Health and Human Services; see www.health.gov/dietaryguidelines/) and other criteria to achieve nutrition integrity. The school nutrition services offer students a learning laboratory for classroom nutrition and health education, and serve as a resource for linkages with nutrition-related community services. Qualified child nutrition professionals provide these services.

Health Promotion for Staff: Opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness activities. These opportunities encourage school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the school's overall coordinated health program. This personal commitment often transfers into greater commitment

to the health of students and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism, and reduced health insurance costs.

Counseling and Psychological Services: Services provided to improve students' mental, emotional, and social health. These services include individual and group assessments, interventions, and referrals. Organizational assessment and consultation skills of counselors and psychologists contribute not only to the health of students but also to the health of the school environment. Professionals such as certified school counselors, psychologists, and social workers provide these services.

Healthy School Environment: The physical and aesthetic surroundings and the psychosocial climate and culture of the school. Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and physical conditions such as temperature, noise, and lighting. The psychological environment includes the physical, emotional, and social conditions that affect the well-being of students and staff.

Parent/Community Involvement: An integrated school, parent, and community approach for enhancing the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.

Coordinated School Health Programs Make a Difference

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assessment by precisely and scientifically defining what students should know and do in each subject area and at specified grade levels. Schools, districts, and state education agencies are held accountable on the extent to which students in their respective jurisdictions achieve these standards. Establishing standards and assessments also helps to place health and physical education as equal in importance to other educational disciplines.

Standards reflect the state's educational priorities, and priorities drive resources. That's why it was a victory when Kentucky was recently able to establish a content team that integrates practical living, vocational studies, and cardiovascular health. Previously, content teams were limited to the core academic subjects of mathematics, science, social studies, and language arts. States such as Kentucky, Missouri, and Maine have also succeeded in having health and physical education accepted as core academic subjects that are assessed.

Without standards, overburdened schools with overloaded curricula sometimes try to find more room in the school day by eliminating or reducing requirements for physical education and health. In states like Wisconsin, however, which established a requirement for health education in the 1970s, the place of health and PE in the curriculum has not been challenged. "If health and physical education are in the state standards, they're much more likely to be taught in the schools," said Mr. Datema. Having state standards often enables the state department of education to retain staff who help local districts meet the requirements by offering technical assistance and guidance on program and staff development.

CDC's adolescent and school health program plays a vital role by providing

training and technical assistance to program staff in each funded state and local education agency to help improve policy development and implementation, curriculum design, and teacher training. Specific technical assistance in evaluation assists program staff to continually improve health and physical education in their state.

Coordination Demands Good Communication

What makes school health programs "coordinated" is strong collaboration between state agencies of education and health. "Coordination at the local level is really important, too, but without the state piece, it's very hard to achieve," said Jenny Osorio, MPA, CDC. Funding and organization of states in CDC's coordinated school health program focuses on helping states to establish and run a statewide program for coordinated school health. These programs address a range of health issues. Currently many focus on reducing chronic disease risk factors including tobacco use, poor nutrition, and physical inactivity.

States in CDC's coordinated school health program are encouraged to hire two coordinators: one in the state department of education, one in the health department. In many states the partnership between the agencies is regarded as a unique strength. In New Mexico, for instance, Kris Meurer, PhD, School Health Director, State Department of Education, shares a business card with Laurie Mueller, her counterpart in the Department of Health. People can call either of them to have their concerns addressed. "Our criterion is that projects will go to the agency that can most easily accomplish the task," said Dr. Meurer.

It's important to remember that education agencies aren't health agencies, noted Ms. Marx, who recalls once being advised to "talk and think like an educator." The field of education has its own language,

If health and physical education are in the state standards, they're much more likely to be taught in the schools.

making it difficult for outsiders to communicate with educators. “Health isn’t their priority, but they do realize that health concerns can be a barrier to learning,” said Ms. Marx.

“It’s not necessarily hard for health officials and educators to work together,” said Mr. Datema. “The challenge is for each group to understand the other’s priorities and to find mutual goals. One way CDC has really had an impact is in helping states develop those relationships.”


Another benefit of working with CDC is the cadre of leaders it provides. More experienced states provide models for others. “CDC’s role has been critical,” said Mr. Datema. “Its developmental model has helped states work together.” Another role was in bringing nongovernmental organizations to the table. Said Janet Collins, PhD, Deputy Director, NCCDPHP, CDC, “CDC’s support and funding of national education agencies helped them to support local schools in establishing effective programs.”

States in CDC’s CSHPs also have the opportunity to participate in training programs with their counterparts in other states. Attendees not only learn how to incorporate health messages into their curriculum, they are able to return home and educate others to do the same. In May 2000, teams from 15 states attended training in physical activity, nutrition, and tobacco programs. Each state had one representative from education and one from health. Presentations focused on resources that could be used to promote the need for CSHPs.

A Customized Approach

Statewide planning means careful needs and assets assessments, so that a custom-

ized plan can be developed. In Kentucky, for instance, a private nonprofit group called Kentucky Child 2000 collected data on 30 communities. The information will allow the state to put resources where they are most needed. Funding for the assessment was provided by a collaborative effort of four state agencies: the Department of Education, the Cabinet for Health Services, Cabinet for Families and Children, and the Department of Juvenile Justice. The Kentucky Department of Education, through a cardiovascular health grant funded by CDC, expanded the study to examine the extent to which the eight components of coordinated school health are implemented in these communities. CDC surveillance efforts also support states by gathering information on school health policies and programs and youth risk behaviors [see related articles, “Study Will Strengthen School Health Policies and Programs” and “States Are Using YRBSS Data to Improve the Health of Teenagers,” pp. 24 and 26]. CDC also provides technical assistance to state and local education agencies in evaluating their own programs, with tools such as the School Health Index. The Index is a self-assessment and planning guide that describes how to set up cross-functional teams, and provides worksheets and checklists for evaluating how thoroughly health concepts are being integrated into all areas of school life.

Coordinated school health is “truly primary prevention,” said Ms. Osorio. “We know that it is more difficult to change unhealthy behaviors once they are established. This is where we can really make a difference. This is a good investment for our nation to make.” 

Secretaries Send Youth Physical Activity Report to the White House



Former President Clinton is surrounded by America's Olympic athletes at a White House ceremony at which the former President announced the release of the report Promoting Better Health for Young People Through Physical Activity and Sports.

Unhealthy habits, such as tobacco use, poor dietary patterns, and physical inactivity, are fueling an obesity epidemic and an array of related health problems among the nation's youth. To help address these urgent problems, former President Clinton asked the Secretary of Health and Human Services and the Secretary of Education to produce, within 90 days, a report on strategies to promote better health for our nation's youth through physical activity and fitness.

"By identifying effective new steps and strengthening public-private partnerships, we will advance our efforts to prepare the nation's young people for lifelong physical fitness," Mr. Clinton said.

The request followed the January 2000 publication of *Healthy People 2010*, a listing of the nation's health objectives for the decade. Unlike previous sets of national health objectives, *Healthy People 2010* included a set of leading health indicators—10 high-priority public health areas for enhanced public attention. The fact that the first leading health indicator is physical activity and the second is overweight and obesity speaks clearly to the national importance of these issues.

The Secretaries' report—*Promoting Better Health for Young People Through Physical Activity and Sports*—was released to the public at a White House ceremony on November 29. The directive that the Department of Health and Human Services and the Department of Education would work together in preparing this report underscores the important role that schools can play in reversing the obesity epidemic and promoting the health of our nation's young people. The report focuses strongly on ways to foster the renewal of physical education in our schools and the expansion of after-school programs that offer physical activities and sports in addition to enhanced academics and cultural activities.

The report also highlights a critical need for environmental change. People feel they have few safe or efficient choices for getting around town other than by automobile. They have few destinations within walking distance, limited access to recreational venues, and limited time for recreational activities because of long commutes. Therefore, the report also encourages the development of supportive public policy and describes ways to promote greater coordination of existing public and private resources to shape environments—for example, building more walking and bicycle paths and designing neighborhoods in a grid pattern with connecting streets—that encourage physical activity and sports.

In other words, "Make the healthy choice the easiest choice," said Susan B. Foerster, MPH, RD, Chief, Cancer Prevention and Nutrition Section, California Department of Health Services.

Working together, the Secretaries, their staff members, and their partners in private and nongovernmental organizations identified the following important

factors for helping young people increase their levels of physical activity and fitness:

- **Families** who model and support participation in enjoyable physical activity.
- **School programs**—including quality, daily physical education; health education; recess; and extracurricular activities—that help students develop the knowledge, attitudes, skills, behaviors, and confidence to adopt and maintain physically active lifestyles, while providing opportunities for enjoyable physical activity.
- **After-school care programs** that provide regular opportunities for active, physical play.
- **Youth sports and recreation programs** that offer a range of developmentally appropriate activities that are accessible and attractive to all young people.
- **A community structural environment** that makes it easy and safe for young people to walk, ride bicycles, and use close-to-home physical activity facilities.
- **Media campaigns** that help motivate young people to be physically active.

“This report brings together for the first time in one document a comprehensive agenda for action to promote physical activity among young people,” said Lloyd Kolbe, PhD, Director of CDC’s Division of Adolescent and School Health. It presents 10 strategies (see “10 Strategies for Promoting Lifelong Physical Activity”) and a process for facilitating their implementation that provide a framework for our children “to rediscover the joys of physical activity and to incorporate physical activity as a fundamental building-block of their present and future lives.”

The major role that schools can play is highlighted in strategies 2 through 4. The report recommends that schools

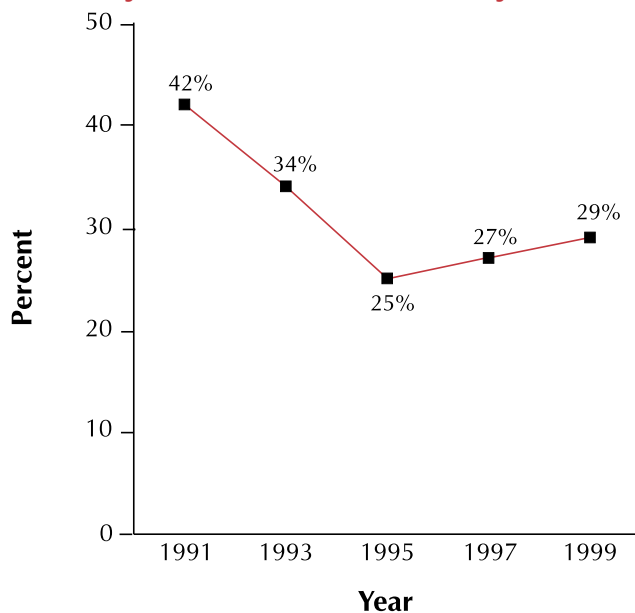
- Provide quality, daily physical education.

10 Strategies for Promoting Lifelong Physical Activity

These strategies emphasize the importance of collaboration at all levels among families, schools, youth-serving organizations, community planners, policymakers, and state-level education and public health officials.

1. Include education for parents and guardians as part of youth physical activity promotion initiatives.
2. Help all children, from prekindergarten through grade 12, to receive quality, daily physical education. Help all schools to have certified physical education specialists; appropriate class sizes; and the facilities, equipment, and supplies needed to deliver quality, daily physical education.
3. Publicize and disseminate tools to help schools improve their physical education and other physical activity programs.
4. Enable state education and health departments to work together to help schools implement quality, daily physical education and other physical activity programs that
 - Have a full-time state coordinator for school physical activity programs.
 - Are part of a coordinated school health program.
 - Have support from relevant governmental and non-governmental organizations.
5. Enable more after-school care programs to provide regular opportunities for active, physical play.
6. Help provide access to community sports and recreation programs for all young people.
7. Enable youth sports and recreation programs to provide coaches and recreation program staff with the training they need to offer developmentally appropriate, safe, and enjoyable physical activity experiences for young people.
8. Enable communities to develop and promote the use of safe, well-maintained, and close-to-home sidewalks, crosswalks, bicycle paths, trails, parks, recreation facilities, and community designs featuring mixed-use development and a connected grid of streets.
9. Implement an ongoing media campaign to promote physical education as an important component of a quality education and long-term health.
10. Monitor youth physical activity, physical fitness, and school and community physical activity programs in the nation and each state.

Percentage of High School Students Who Attended Physical Education Classes Daily, 1991–1999



Source: CDC, National Youth Risk Behavior Survey.

- Schedule classroom health education that complements and reinforces the importance of physical education.
- Have daily recess periods for elementary school students with time for unstructured but supervised play.
- Offer extracurricular physical activity programs—especially enjoyable and inclusive intramural programs and physical activity clubs (dance, hiking, yoga, for example)—that feature diverse choices for students, meet the needs and interests of all students, and emphasize participation without pressure.

The report emphasizes *quality* physical education classes for all students, from prekindergarten through grade 12, *every school day* because physical education is at the core of a comprehensive approach to promoting physical activity through schools. According to the report, quality physical education is not a specific curricula or program; it reflects, instead, an instructional philosophy that emphasizes

- Providing intensive instruction in the motor and self-management skills

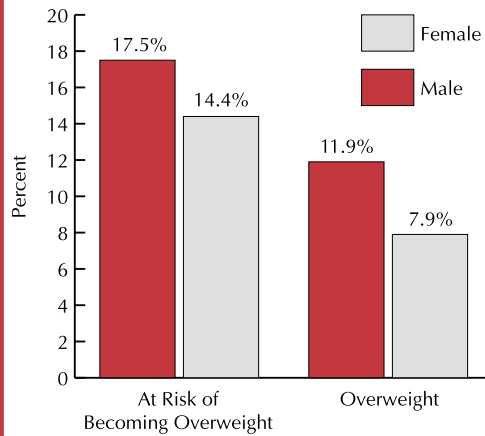
needed to enjoy a wide variety of physical activity experiences, including competitive and noncompetitive activities.

- Keeping all students active for most of the class period.
- Building students' confidence in their physical abilities.
- Influencing moral development by providing students with opportunities to assume leadership, cooperate with others, and accept responsibility for their own behavior.
- Having fun.

In recent years, federal agencies and national organizations have developed a large number of practical tools that can help schools improve their physical education and other physical activity programs. However, according to the Secretaries' report, many school administrators and educators do not have these materials, and only modest efforts have been made to disseminate them. These tools are listed on page 20 of the report, which recommends an ongoing marketing initiative to systematically distribute them to the nation's schools and school districts. The report also recommends the provision of staff development to ensure effective use of the tools.

Another important recommendation in the report is that state education and health departments work together under the leadership of a full-time state coordinator for school physical activity programs. Full-time coordinators would play an important role in implementing the essential staff development, resource dissemination, student assessment, monitoring, and evaluation recommendations made in the Secretaries' report. Without such a coordinator, according to the report, a national initiative to promote physical activity among young people will inevitably fall through the cracks and fail to get the statewide attention needed to make a difference.

Percentage of High School Students Who Were at Risk of Becoming* or Were Overweight,† by Sex, 1999



*Students who were ≥85th percentile but <95th percentile for body mass index by age and sex.

†Students who were ≥95th percentile for body mass index by age and sex.

Source: CDC, Youth Risk Behavior Survey, 1999.

For further reading...

Health, United States, 2000 (with Adolescent Health Chart Book), by the National Center for Health Statistics, CDC. Online at www.cdc.gov/nchs/products/pubs/pubd/hus/hus.htm.

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Current Estimates of the Economic Cost of Obesity in the United States, by A.M. Wolf and G.A. Colditz, in *Obesity Research*, Vol. 6, No. 2, pages 97–106 (1998).

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Full implementation of all the recommended strategies will require the commitment of resources, hard work, and creative thinking from many partners in federal, state, and local governments; nongovernmental organizations; and the private sector. The report further recommends that a broad, national coalition be developed to promote better health through physical activity and sports as an important first step in improving the health of our nation’s children and future adults.

This emphasis on the importance of cooperation among a wide range of partners was reinforced by William H. Dietz, MD, PhD, director of CDC’s Division of Nutri-

tion and Physical Activity. “The vision presented in this report,” he said, “can only become a reality when the public and private sectors come together at the national, state, and local levels to coordinate and reinforce their efforts.”

Copies of the report can be downloaded from the CDC Web site at www.cdc.gov/nccdphp/dash/presphysactrpt or requested by mail from Healthy Youth, P.O. Box 8817, Silver Spring, MD 20907; by telephone at 888/231-6405; or by E-mail at HealthyYouth@cdc.gov. For other related information, you may contact Howell Wechsler by telephone at 770/488-6197 or by E-mail at hwechsler@cdc.gov. 

Reaching and Protecting Young People at Risk for HIV Infection

Researchers studying disease trends note that some subpopulations of young people in the United States appear to be at greater risk for HIV infection than are so-called “mainstream” adolescents. These youth in high-risk situations often have multiple risk factors, and many are especially hard to reach with prevention messages and services. Young people in high-risk situations can be extremely difficult to find. They may be sex workers, migrants, or street kids—homeless or runaways—and many are gay, lesbian, bisexual, transgendered, or questioning youth. They also are more likely than other adolescents to be pregnant, cause a pregnancy, or have HIV and other sexually transmitted diseases (STDs).

Young people who live on the streets, whether by choice or circumstances, often find themselves in situations that place them at great risk for acquiring HIV infection. These young people may trade sex for drugs or money to meet survival needs; others may share needles to inject drugs. If they live in an area with high HIV prevalence, they will be more likely to encounter an HIV-infected partner than other young people.

Minority youth face similar risks because the proportion of AIDS cases reported each year among people of color has grown. Today, in African American communities across the United States, it is not uncommon for local officials to declare a state of emergency in response to the epidemic. Such actions are backed by scientific findings, especially for young people: Through December 1999, in the areas that now report cases of HIV infection among adolescents and adults, more than half (56%) of cases in people aged 13–24 years have occurred among African Americans. This is a much greater proportion than that represented by African

Americans in the general U.S. population (about 13%). Seven percent of HIV infections in people aged 13–24 years have been reported among Hispanics and less than 1% each among Asians/Pacific Islanders and American Indians/Alaska Natives. In the general U.S. population, Hispanics, Asians/Pacific Islanders, and American Indians/Alaska Natives represent 13%, 4%, and 1%, respectively. Just over one-third (35%) of HIV infections in this age-group have been reported among whites, who represent nearly three-fourths of the U.S. population.

Even though the proportion of AIDS cases attributed to heterosexual HIV transmission has increased over time, the largest number of AIDS cases reported each year still occur among men who have sex with men. Young people who are questioning or experimenting with their sexual identity are at great risk for HIV infection and are among the hardest to reach with HIV prevention programs.

Young people in the juvenile justice system also are at high risk for HIV infection, as well other STDs and hepatitis. Their risk appears to be greater for a number of reasons. Some of these young people have used drugs; others have traded sex for drugs or to meet basic survival needs on the street. They often come from inner-city areas where HIV prevalence is greater than in other communities, so their risk of encountering an infected sex or needle-sharing partner is higher.

School health education to prevent the spread of HIV infections and AIDS.

CDC provides assistance to education departments in all 50 states, 19 major cities, and 7 U.S. territories to plan, establish, and evaluate school health programs to help prevent HIV/AIDS. The agency also supports several projects that

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Avoiding HIV Infection: CDC's 1999 HIV/AIDS Surveillance Report

Editor's Note: The data in this summary are from CDC's HIV/AIDS Surveillance Report, 1999, Volume 11, Number 2.

Through December 1999, more than 430,000 people in the United States had died with AIDS (acquired immune deficiency syndrome). Most of these deaths (nearly 75%) were among persons under the age of 45, many of whom were likely infected with human immunodeficiency virus (HIV) in their teens and 20s. At least half of all new HIV infections in this country are believed to occur among people under age 25.

With the advent of highly active antiretroviral therapy (HAART) for HIV-infected persons, the number of AIDS cases reported in the United States has declined. However, while young people aged 13–24 accounted for only 4% of all AIDS cases reported through the end of 1999, they accounted for 17% of the reported HIV cases in areas with confidential HIV infection reporting (not all U.S. states currently report cases of HIV infection, including some states with high rates of AIDS).

Scientists believe that cases of new HIV infection diagnosed among 13–24-year-olds probably are indicative of overall trends in HIV incidence (the number of new infections in a given time period, usually a year) because people in this age-range have more recently initiated high-risk behaviors. A disturbing finding in this age-group is the growing

proportion of young women who are infected with HIV—in 1999, in areas with confidential HIV reporting systems, girls and women accounted for almost half (49%) of all reported infections in people between the ages of 13 and 24. Even more alarming, girls accounted for 64% of all new HIV infections reported among adolescents (13–19 years) in 1999.

CDC uses a comprehensive approach to preventing further spread of HIV and AIDS that incorporates the following broad strategies:

- Monitoring the epidemic to target prevention and care activities.
- Researching the effectiveness of prevention methods and translating findings for use in community settings.
- Funding local prevention efforts for high-risk communities.
- Fostering linkages with care and treatment programs.

CDC is an active participant in helping young people avoid HIV infection. By providing funding and technical support, the division assists national, state, and local education agencies and other organizations that address adolescent health in identifying and preventing HIV risk behaviors.

Collaborative efforts first concentrated on HIV prevention education within the comprehensive school health education program. Today, increasing infection rates in many youth

subpopulations have prompted concerned officials to increase their efforts to find ways to reach young people at highest risk, both in and outside of school.

CDC works closely with many other public and private partners at all levels to carry out, evaluate, and further develop and strengthen effective HIV prevention efforts nationwide. CDC also provides financial and technical support for the following prevention activities:

- Disease surveillance.
- HIV antibody counseling, testing, and referral services.
- Partner counseling and referral services.
- Street and community outreach.
- Risk-reduction counseling.
- Prevention case management.
- Prevention and treatment of other sexually transmitted diseases that can increase risks for HIV transmission.
- Public information and education.
- School-based education on AIDS.
- International research studies.
- Technology transfer systems.
- Organizational capacity building.
- Program-relevant epidemiologic, sociobehavioral, and evaluation research.

More data is available online at www.cdc.gov/hiv/dhap.htm.

Reaching and Protecting Young People at Risk for HIV Infection

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train teams from these states, cities, and territories to continuously improve HIV prevention programs. The major strategies that education agencies employ include implementing HIV prevention policies, conducting staff development programs, incorporating HIV prevention lessons and activities into the school's formal and informal curriculum, and developing targeted programs that address the needs of youth in high-risk situations. To assist with the policy and resource development, as well as the training of professional staff, CDC funds approximately 40 national organizations representing professional staff in health, education, or youth-serving organizations that promote HIV prevention programming in school or community sites. In addition, funding is provided to eight national organizations that are helping postsecondary institutions set up a national system of integrated activities to prevent HIV/AIDS and other serious health problems among students in our nation's colleges and universities.

What do we know about young people in high-risk situations? At a November 1990 meeting, the CDC Advisory Committee on the Prevention of HIV Infection characterized young people in high-risk situations as feeling invulnerable, lacking adult supervision, having a history of abuse, feeling distrustful of adults, and being disenfranchised from the usual institutions that could offer them help (schools, for instance). Attendees at that meeting concluded that prevention programs focusing on this group may not succeed unless attention is first given to meeting their basic needs.

"You can never really generalize about youth in high-risk situations," said Leah Robin, PhD, a CDC health scientist. "We use labels like gay or lesbian or 'young men who have sex with men' because we are interested in their risk behaviors, but it is

important to try to understand the adolescent's particular situation." Dr. Robin believes that providers of services for young people in high-risk situations need to know that it is important not to make assumptions about behaviors. For example, primary care providers may not realize that young women who self-identify as lesbian need information about birth control; a recent study revealed that they were more likely than other young women to have had a pregnancy.

Another obstacle to providing needed services is that many of these young people are difficult to find. "Where you find them depends on the context," said Dr. Robin. For example, there was a high rate of homelessness in New York in the early 1990s, and many shelters viewed adolescents as troublemakers and sent them to other locations. This often caused families to be divided by age groups. Some of these families never reunited, and many young people ended up on the street.

Many community-based organizations serve runaway and homeless youth. Most of these groups have outreach programs to help locate young people in need of services. Some street youth go to public health clinics for medical care, but these clinics are unable to do enough, and many young people receive no medical services at all. Alternative schools are another location where young people at risk can be found—some of these schools serve targeted youth populations such as pregnant adolescents and teen mothers, young people from the juvenile justice system, those who would not otherwise graduate, or gay or lesbian youth. Young people who are incarcerated have recently become a focus of more intensive prevention efforts.

In many of the places where young people in high-risk situations are found, critically needed HIV prevention and other social and health services may be provided. Alternative schools serving young women who are pregnant or have small children, for example, can provide assistance with child care and nutrition.

Other activities, called “resiliency-based” programs, do not focus specifically on risk behaviors, but help young people develop their strengths. These programs teach young people problem-solving skills and help them form attachments to caring adults and their communities. Such activities enhance the development of healthy relationships and promote self-efficacy and hopefulness for the future.

“Most programs for nonmainstream kids have not been evaluated,” Dr. Robin said, “so we don’t really know yet which are most likely to succeed.” For example, a current study includes a component designed to help students in alternative schools learn to be useful by performing community service, but it is unclear at this time how such programs will affect HIV risk in this population. Dr. Robin also is helping to evaluate an HIV prevention program, called *Power Moves*, for institutional placements of all kinds. In this study, researchers are working with 337 participants aged 12–19 years who were incarcerated at a juvenile justice facility in Colorado. The HIV prevention lessons used in this *Power Moves* program are designed to stand alone because young people in the justice system tend to be moved around a lot between institutions, or be pulled out of classes due to changes in facility schedules. Lessons learned from such evaluation studies will be shared with CDC constituents who work with incarcerated young people.

In the juvenile justice system, according to Dr. Robin, “we usually try to intervene with a narrowly defined group, and what we can do varies from state to state. For these kids,” she said, “it may be our last chance to intervene.”

To help meet the health-related needs of incarcerated young people, CDC’s **Cross-Center Corrections Work Group** (CCCWG) included a juvenile justice portion in a series of 1-day in-service trainings sponsored by the CCCWG for CDC staff members last year. In addition, CDC has been working over the last 2

years with a **Juvenile Justice Work Group** (JJWG) made up of representatives from the CCCWG, the federal Office of Juvenile Justice and Delinquency Prevention, several key juvenile justice organizations, and grantees (ETR Associates and the National Commission on Correctional Health Care) who are funded to provide training in HIV prevention strategies to juvenile justice staff around the country.

The JJWG has met several times since its inception and currently is working to develop a series of workshops to be offered to state teams in 2002. The purpose of the upcoming training is to strengthen collaboration between public health and juvenile justice organizations to prevent and treat HIV, STDs, and hepatitis among young people in the juvenile justice system and to ensure continuity of prevention and care efforts in the communities to which they return.

“Historically, the public health system and the juvenile justice system have had competing priorities and different missions,” said Jim Martindale, MSW, a CDC health education specialist. “The top priority for a public health agency is preventing health problems, but the top priority for any correctional facility is security. We know that young people in the juvenile justice system are at high risk in terms of health issues, and there are great unrealized opportunities to reach them through comprehensive and better coordinated public health practices in these settings. When public health and juvenile justice are working well together, there is a respect for each other’s missions.” Public health services that may be offered in correctional settings range from group education or individual counseling on HIV/STD prevention, to clinical services such as STD screening or HIV testing and counseling, to ensuring continuity of care in the community for those who are released.

HIV prevention activities focusing on the juvenile justice system are just one example of the many programs that CDC


coordinates to help slow the spread of HIV and AIDS among young people.

Programs for young people at greatest risk for HIV infection. CDC assists a number of agencies that serve areas with high HIV prevalence in coordinating activities to reach young people at high risk, including minority youth, indigent youth, or young people in difficult life situations—for example, runaways, men who have sex with men, recent immigrants, and those who are homeless, incarcerated, pregnant, or in need of drug or alcohol rehabilitation. The division also supports many projects across the country that are designed to assist professional educators, health professionals, parents, and organizations that serve minority populations and young people who are not in school to establish effective programs to prevent the spread of HIV infection and AIDS.

“CDC is systematically promoting collaborative programming among agencies in order to reach youth at high risk,” said CDC health scientist Diane Allensworth, PhD. These programs, she said, follow a pattern established for all target groups. A work group conducts internal staff development activities.

Constituents funded to provide programming to targeted populations are asked to work collaboratively. The expertise of these funded constituents is then used to provide professional development opportunities for teams from funded state and local education constituents and key community members who can assist them and advocate for HIV prevention in the respective target populations. Constituents and their community advocates work together to develop action plans for the targeted population. CDC project officers provide technical assistance to help funded constituents implement the prevention plans in their communities. This process is repeated continuously as new information about the most effective programs becomes available.

For further information about CDC programs to prevent HIV infection among young people, visit the Web sites at www.cdc.gov/nccdphp/dash or www.cdc.gov/hiv/dhap.htm.

CDC has released its new HIV prevention and control plan, *HIV Strategic Plan Through 2005*, which can be viewed online at www.cdc.gov/nchstp/od/news/prevention.pdf. 

Asthma: 10 Million School Days Lost Each Year

Asthma, a chronic condition that is triggered by allergens or irritants in the environment, is a major health problem of increasing concern in the United States. Between 1980 and 1994, the prevalence of asthma increased 75% overall and 74% among children 5 to 14 years of age. “Today asthma affects 15 million people, including nearly 5 million under the age of 18, and it accounts for an estimated 10 million lost school days annually,” said CDC health scientist Mary Vernon-Smiley, MD, MPH. Of special concern, she

added, is the impact of asthma on minority children. Death from asthma is 2 to 6 times more likely among African Americans than in the general population.

CDC has launched a pilot effort involving four local education agencies serving large, urban school districts and capable of targeting racial or ethnic minority groups. An asthma wellness manual is in development and will become available in about 16 months. In the interim, a helpful

Michigan Gets Moving With Exemplary Physical Education Curriculum

When Michigan Governor John Engler took up the problem of obesity in the state, he found himself confronting a dilemma familiar to policymakers. Although school physical education (PE) programs were clearly part of the solution, classes in PE and health were being squeezed out of the curriculum by competing demands. Furthermore, he hesitated to mandate time for PE until an effective program was available. He resolved the dilemma by founding the Michigan Governor's Council on Physical Fitness, Health and Sports and charging it to develop a curriculum that would help schools to equip children with the knowledge, skills, and motivation necessary to live a physically active lifestyle now and as adults. The result is the Exemplary Physical Education Curriculum (EPEC), a public health initiative that addresses the crushing burden of chronic disease attributable to physical inactivity. EPEC is being carried out completely in the education arena.

"Improved levels of physical activity represent a crucial step toward the prevention and reduction of a number of chronic diseases, such as obesity, diabetes, and cardiovascular disease. The Michigan efforts are an important step in this direction," said William H. Dietz, MD, PhD, Director, Division of Nutrition and Physical Activity, NCCDPHP, CDC.

The Michigan Fitness Foundation provides funding and staff to carry out the initiatives of the Governor's Council. The Council and Foundation Boards comprise educators, physicians, policymakers, business owners, and other professionals from the field of health and sports. Collectively, they are working in an innovative way to make systemic change, reverse the trend toward sedentary living, and positively affect many risk factors for serious health problems.

EPEC has sound scientific grounding in chronic disease prevention and uses state-of-the-art educational theory. The result is an exciting curriculum for grades K–5 and 6–8 that equips students to understand the importance of physical activity and to obtain the fitness, knowledge, motor skills, and personal and social skills they need to be active for life. "What EPEC gives children is the alphabet of movement on which they can build a lifetime of physical activity," said Glenna DeJong, PhD, Director of Educational Programs for the Governor's Council.

EPEC breaks with traditional approaches and teaches toward specific, highly valued objectives in a systematic way to create lasting change. Instruction based on clearly stated outcomes is at the heart of the EPEC mission.

"Programs that give students the knowledge, attitudes, motor skills, joy, and confidence to participate in physical activity may help young people establish active lifestyles that continue throughout their lives," said Lloyd Kolbe, PhD, director of CDC's Division of Adolescent and School Health. EPEC lessons promote lifelong physical activity by providing developmentally appropriate instruction that is perceived to be valuable in developing students' knowledge and mastery of motor, behavioral, and fitness skills. Dr. DeJong said the response from teachers has been "fantastic. In approximately 2 years, we've reached 53% of our Michigan market and trained more than 900 teachers." EPEC materials have been praised for their effectiveness, ease of use, and clear learning objectives.


Other states that wish to provide quality physical education programs are looking to EPEC as a solution. Hawaii, Indiana, Ohio, and New York have all shown great

interest in adopting EPEC for their schools.

In 1997, 100 elementary school physical education teachers taught and evaluated the EPEC K-2 lessons. More than 95% of the teachers found the EPEC lessons to be clearly written, easy to communicate and implement, and developmentally appropriate.

Other study findings show that EPEC is effective. Two of nine factors investigated contributed significantly to school differences in student performance: whether the teacher was certified with a major in physical education and whether the teacher used EPEC lessons. In addition,

EPEC students had better scores on a field test of physical fitness and better self-reported personal/social behaviors than non-EPEC students.

EPEC offers Michigan the potential to improve the health of nearly 1.7 million school children each year. In addition to the curricula for grades K-5 and 6-8, materials are being prepared for use in high schools. For more information on EPEC, the Governor's Council on Physical Fitness, Health and Sports, or the Michigan Fitness Foundation, please call Glenna DeJong at 800/434-8642 or visit the Web site at www.michiganfitness.org. 

Utah Takes a Unique Approach to School Health



Utah students enjoy a Gold Medal break: a walk outdoors.

With schools under tremendous pressure to increase standardized test scores, motivating schools to adopt environmental and policy changes to improve health is a constant challenge for public health professionals. Utah's Department of Health is meeting this challenge by linking school health with the biggest event to hit the state in decades: the 2002 Winter Olympics. The department is implementing the Gold Medal Schools Project to encourage students and faculty in Utah elementary

schools to participate in the Olympic spirit by making their school and community a healthier place.

Schools will be given a menu of criteria to implement that will qualify them for gold, silver, or bronze medal school awards. CDC health indicators for environmental and policy supports for schools were the basis for the criteria (see "Gold Medal School Project" p. 21). The state health department worked with the state Office of Education and others to decide which criteria were the most important and the most doable. "Using the criteria gives schools credit for what they have already accomplished," explained Joan Ware, MSPH, Director, Cardiovascular Health Program, Utah Department of Health.


"We're very impressed with the program because it's taking a creative, innovative approach to letting schools know about the most important policies and practices

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Gold Medal School Project Guides Policies to Promote Health

The Gold Medal School Project assists schools in creating an environment that promotes healthy lifestyle choices for both students and teachers. Schools are given a menu of criteria to implement that will qualify them for gold, silver, or bronze medal school awards.

Sample criteria for Gold Medal Schools:

- Establish a tobacco- and drug-free policy, and ensure awareness of the policy among faculty and students.
- Establish a policy that discourages withholding physical education or recess as a punishment.
- Establish a policy that requires classroom instruction on nutrition, and ensure faculty awareness of this policy.
- Establish a policy that provides an adequate amount of time for students to eat school meals—at least 10 minutes for breakfast and 20 minutes for lunch from the time students are seated.
- Establish a faculty and staff wellness program, and ensure faculty awareness of this policy.
- Establish a policy that elementary students will participate in at least 90 minutes of structured physical activity each week, and ensure student and faculty awareness of the policy. 

A Healthier You 2002 Moves Utahans to Physical Activity

The Gold Medal School Project is part of a larger effort to inspire Utah to catch the Olympic spirit. A Healthier You 2002™ provides information, opportunities for participation, and motivation to begin and maintain healthy habits in schools, communities, and worksites. Physicians and health care providers were given prescription pads to encourage them to prescribe physical activity for their patients. Thirty-seven communities have conducted a Gold Medal Mile Event, 1-mile walks designed to encourage Utahans to become more active. Participants who complete the event receive the Gold Medal Olympic commemorative pin (valued at \$20), which is available only to participants.

“We wanted to let people know how healthy it would be to walk a mile and that they could do it,” said Scott Williams, MD, MPH, Deputy Director, Utah Department of Health. “We wanted them to see how short a mile really is.” The project also involves the construction of permanent Gold Medal Mile courses. CDC has provided funding for 20 courses; the state plans a total of 30. The courses must be accessible to the elderly and disabled.

More than 50% of Utah’s population is overweight or obese. Despite having the lowest rate of cardiovascular disease and smoking in the nation, Utahans spend \$342 million annually on hospital stays. A Healthier You 2002™ uses the Olympic legacy of athletic health and fitness to improve and motivate Utahans to embrace a life of health and wellness. The initiative promotes five sets of behaviors:

1. Physical Activity: 30 minutes of any type of physical activity 3–5 days per week.
2. Nutrition: Lower dietary fat and increase fruit and vegetable consumption.
3. Healthy Behaviors: Quitting tobacco use and low-risk alcohol use.
4. Safety: Regular seat belt and helmet use (for future implementation).
5. Prevention: Getting all recommended early detection screening such as Papanicolaou (Pap) tests, mammograms, and blood pressure checks, as well as immunizations.

Healthier Smiles: States Focus on Children's Oral Health



Although great strides have been made in preventive oral health since mid-century, many children continue to be at risk for dental decay, one

of the most common chronic infectious diseases. Nearly 80% of children have had at least one cavity by the time they are 17 years old. Poor and under-served children aged 2–9 years have twice as much untreated dental decay as other children. Permanent first molars that erupt at about age 6 are most susceptible to decay. Dental sealants, a plastic coating placed into the pits and grooves of molar teeth, are a cost-effective and proven prevention method, but only 23% of 8-year-olds—only 3% among poor 8-year-olds—have had their first molars sealed. Children of some ethnic and racial groups, such as Mexican Americans and African Americans, may experience even greater disparities in untreated tooth decay and sealant use, and often have less access to dental care.

One strategy for reaching these and other at-risk children is through school-based programs that support linkages with health care professionals and other dental partners in the community. In FY 1998, CDC awarded cooperative agreements to education agencies in three states—Ohio, Rhode Island, and Wisconsin—to develop models for school-based programs to improve access to oral health education, prevention, and treatment services for school-aged children. This effort builds on the coordinated school

health programs (CSHPs) funded by CDC. Activities for the initial planning year included assessing children's oral health status in the respective states and forming oral health coalitions with broad representation from the state education agency, health department, school administration and staff, child advocates, foundations, nongovernmental organizations, and other partners. In FY 1999, these three states as well as South Carolina were awarded 3-year cooperative agreements to implement the approaches selected. In FY 2000, another state, Maine, received a 2-year cooperative agreement under this initiative.

During the initial planning year, most of these states conducted surveys of school administrators, school nurses, and health educators to assess the level of school-based oral health programs, determine how schools identified and dealt with children who needed dental care, and examine current policies governing school-based oral health delivery systems. These surveys revealed the need for enhanced oral health education and screening in schools. For example, a survey of elementary school nurses conducted in Ohio found that 10% of students had dental problems serious enough to affect a student's attendance and ability to learn. In addition, only half of those students referred for care actually receive the needed dental treatment. In Rhode Island, only 18% of public schools and 8% of private schools currently had oral health promotion programs. And in South Carolina, 59% of the lead health educators surveyed reported that not enough emphasis was being placed on oral health topics in the school curriculum.

After their initial planning year, the four current grantee states are using various approaches to improve the oral health of

their school children. For example, the “Healthy Smiles for Wisconsin” program for children is focusing on increasing sealant use, oral health education, and youth oral health surveillance. The kick-off for the program, held in the rotunda of the state capitol in Madison before an audience that included then-Wisconsin Governor Tommy G. Thompson (now Secretary of Health and Human Services), state lawmakers, and legislative staff, was a demonstration of dentists and dental hygienists applying sealants to school children’s molars. As part of the Healthy Smiles program, five projects are directed toward the urban poor in Milwaukee, and others are being implemented widely in all regions of the state. More information on this program is available on the program’s Web site, www.healthysmilesforwi.org.


The Rhode Island initiative “Healthy Schools! Healthy Kids!” is focusing on school- and community-based services, family outreach and education, and oral health education and policies for schools. A unique result of this project, which currently is being implemented in poor urban neighborhoods in Providence, involves changes in state policies that regulate how mandated oral health screenings are performed. In one of the program’s pilot projects, children requiring dental services are assigned a caseworker who is responsible for linking the child and family with appropriate services (e.g., Medicaid or the Children’s Health Insurance Program) and for finding the child a “dental home.” The child, as well as family members, subsequently will be referred for

oral health care services.

The South Carolina Healthy Schools Oral Health Care Program has formed a Children’s Oral Health Coalition, with representation from school districts, school nurses, state dental and dental hygiene societies, the state’s dental school, successful oral health programs, and state agencies. During the program’s first year, the group identified a particular need in that state for enhanced training on general oral health education for school nurses. In addition to supporting these training seminars, the project is developing and testing a classroom oral health curriculum for grades 3, 4, and 5.

The newest grantee, Maine, is working to strengthen linkages between the state departments of education and health and to develop a multidisciplinary statewide steering committee to address oral health issues, including increased coordination of school sealant programs.

An evaluation tool for these projects is currently being designed and will be implemented during FY 2001.


“The goal of these programs is to develop comprehensive, integrated, and sustainable approaches to address the oral health needs of school-aged children in the United States,” said William R. Maas, DDS, MPH, Director, Division of Oral Health, NCCDPHP, CDC. “These models will provide information about different school-based or school-linked approaches and serve as guides for those states that are developing programs targeting oral health for vulnerable children.” 



Asthma: 10 Million School Days Lost Each Year

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resource is the Environmental Protection Agency’s publication, *IAQ Tools for Schools: Managing Asthma in the School Environ-*

ment (Publication EPA 402-K-00-003; to view online or to order, go to www.epa.gov/iaq/schools/incentiv.html). 

Study Will Strengthen School Health Policies and Programs

The School Health Policies and Programs Study (SHPPS) is the largest assessment of school health programs ever undertaken.

In fall 2001, CDC will release data from the School Health Policies and Programs Study (SHPPS), providing a detailed look at school health activities at the state, district, school, and classroom levels nationwide. The data were collected in spring 2000 and will be used to improve school health policies and programs throughout the United States.


“This is the largest assessment of school health programs ever undertaken,” said Laura Kann, PhD, Chief of the Surveillance and Evaluation Research Branch, Division of Adolescent and School Health, NCCDPHP. “SHPPS 2000 is a bigger and better version of the survey we did in 1994. This time, we’re covering all eight components of school health programs at the elementary, middle/junior high, and senior high school levels. SHPPS 2000 data will be used to measure eight *Healthy People 2010* objectives,” she noted. Following are the eight components and examples of topics covered.

- **Health education.** What are students being taught about health, and how many hours of instruction are required? What materials and methods do teachers use to teach health education? What kinds of health education goals and objectives are states and school districts setting for schools?
- **Physical education and activity.** What is being taught to students during physical education? How many hours of instruction are required? What types of facilities are available for physical education classes and for community use? What credentials and certifications are required of physical education teachers?
- **Health services.** What health screenings and immunizations are required for students? What policies are in place to maintain students’ health records? What types of health services are available to students at the school and through arrangements with providers in the community? How much time do school nurses and other health services personnel spend at the school?
- **Mental health and social services.** What types of mental health or social services are available to students at the school and through arrangements with providers in the community? What is the required ratio of students to mental health or social services staff? What credentials and certifications are required of school guidance counselors, school psychologists, and school social workers?
- **School policy and environment.** What policies are in place regarding fighting, weapon possession, gang activities, harassment, and use of tobacco, alcohol, and other drugs? What policies are in place to promote school safety and prevent injuries?
- **Food service.** Are schools offering breakfast and lunch to children? What variety of foods are offered? Do states and districts have any policies on junk food? Are school meals in compliance with the U.S. Dietary Guidelines for Americans? Is staff development provided to food service personnel?
- **Faculty and staff health promotion.** Are health or mental health services provided to school faculty and staff? Are employee assistance programs or wellness workshops offered? What about health screenings and physical activity programs?
- **Family and community involvement.** How are students, parents,

guardians, and community members contributing to school health policies? Are faculty and staff collaborating with community agencies on school health education, physical education, and nutrition projects? Are schools promoting community awareness of their health, physical education, food service, and mental health and social services programs?

The SHPPS data were collected for CDC by Research Triangle Institute of North Carolina. Surveys were mailed to all states and to a nationally representative sample of school districts to find out about their school health policies for children in kindergarten through 12th grade. Data also were gathered during on-site inter-

views with principals, health education teachers, physical education teachers, food service directors, nurses, counselors, and other personnel in a nationally representative sample of elementary, middle/junior high, and senior high schools. Students were not interviewed. The next SHPPS probably will be conducted in 2006, according to Dr. Kann.

For more information about SHPPS, contact Nancy Brener, PhD; Surveillance and Evaluation Research Branch, DASH, NCCDPHP, Mail Stop K-33; CDC; 4770 Buford Hwy.; Atlanta, GA 30341-3717; telephone 770/488-6184; E-mail nad1@cdc.gov. Information also is available at www.cdc.gov/nccdphp/dash/shpps. 

Utah Takes a Unique Approach to School Health


► *CONTINUED FROM PAGE 19*

they can implement to promote physical activity and good nutrition," said Howell Wechsler, EdD, MPH, a health scientist in CDC's Division of Adolescent and School Health.

Having the three levels of excellence allows schools to set their own goals for the project. The bronze level is the most basic; at the gold and silver levels, additional criteria must be met. Schools will receive an award of \$500 for physical activity equipment if the criteria are achieved. Mentoring packets will be provided to help schools find resources, and schools will be given access to college students majoring in physical education to help them figure out how to meet the criteria related to

physical education. The goal is to get all 500 Utah elementary schools, public and private, working toward some kind of award.

The school administration will be charged with observing whether policies on nutrition, physical activity, and tobacco are being followed. The program won't go away after the Olympics, Ms. Ware promised. Other plans for Utah's school children include soccer leagues that play during school lunch, and structured hopscotch and jump-rope activities.

For more information on the Gold Medal School Project, contact Karen Coats, telephone 801/538-6227, E-mail kcoats@doh.state.ut.us. 

How States Are Using YRBSS Data to Improve the Health of Teenagers



The Youth Risk Behavior Surveillance System tracks health risk behaviors in children and adolescents.

A decade ago, public health and education officials had mostly anecdotal evidence of the health threats facing teenagers. Today, the Youth Risk Behavior Surveillance System (YRBSS) provides a much clearer picture of teenagers' health behaviors, both good and bad ("YRBSS Data for 1990s," p. 30). "We're 10 years into the YRBSS now, and the real proof of its worth is in

how the data are being used," said Laura Kann, PhD, a CDC health survey research specialist who oversees the YRBSS.

"In San Diego, we share the YRBSS data between health agencies, community agencies, and schools to help with program development and planning; to show where our greatest needs are and justify requests for grants; and to see where we are in relation to other districts, states, and the nation," said Jack Campana, MEd, director of Health and Intervention Services for the San Diego Unified School District.

When San Diego's YRBSS data revealed that suicide attempts among adolescents had increased dramatically, education and public health officials used the data as evidence of the urgent need for interventions. "Because of the YRBSS data, \$2 million was provided for after-school programs to keep children active during some of the most critical hours when high-risk behaviors are most likely to occur,"

Mr. Campana noted.

Another YRBSS success story involved tobacco use. "We looked at our YRBSS data and saw that smoking rates had gone up steadily from 1991 through 1995. So we established an early intervention program in 1996. We've since had a 20% drop in substance abuse on campus, as reported by the YRBSS, and a 20% drop in suspensions for students using or possessing tobacco or marijuana or alcohol," Mr. Campana said.

Until San Diego began participating in the YRBSS, "we had no surveillance data to see what the extent of high-risk behavior was among adolescents," he said. "Now, the YRBSS data give us a much more accurate account of where they're at, and it gives us the opportunity to cross-reference behaviors. For example, what other risk behaviors do binge drinkers have? We looked at the data and found that binge drinkers were less likely than other students to use seat belts or condoms. Suicide attempts were about the same, but in all other categories, binge drinkers were more likely to exhibit high-risk behaviors."

Focus on What's Needed Most

Montana has participated in the YRBSS since 1991, and "our biggest hot issue right now is tobacco," noted Richard Chiotti, Director, Coordinated School Health Programs, Montana Office of Public Instruction. But funding for interventions should be driven by need and not hot issues, he said. "Say a school district has a rate of tobacco use that's below the national rate, but their violence indicators far exceeded the national rate. We can use the data to really focus on what's needed most—in this example, that would be violence prevention."

The YRBSS data also can be used to design a program to meet a need that is specific to a school, Mr. Chiotti said. “One of our schools had a significant problem with marijuana use, and school officials used YRBSS data to make their case when requesting support from the Safe and Drug-Free School’s Greatest Needs grant funds, which we provide to schools. The school then used the money to develop a campaign for marijuana use prevention and social norms marketing,” he said.

Social marketing campaigns and the YRBSS go hand in hand, Mr. Chiotti added. The data from Youth Risk Behavior Surveys show teenagers “that not all of their peers are out there having sex, drinking, or using other drugs—not nearly as much as kids or their parents think. The norm is to not be involved in risk behaviors, and once kids find this out, some of the pressure is removed for them to have sex, smoke marijuana, drink, or practice these other behaviors,” he explained.

YRBSS data are also helping to dispel myths about school violence. “You hear about Columbine, and it’s very sad,” said Mr. Chiotti, “but if you look at schools nationwide, they’re very safe.” About 6 years ago, Montana changed the name of its Drug-Free Schools Program to the Safe and Drug-Free Schools Program. “We wanted schools to look at fighting, both on and off school property, as an indicator for violence, and to also look at conflict resolution and character development issues,” he explained. “Montana schools and other schools across the country are making a sincere and dedicated effort to reduce violence in schools, and the YRBSS is helping us do this.”

One Size Does Not Fit All

In Michigan, the 1998 National Alternative High School Youth Risk Behavior Survey has provided strong evidence of the need for health education programs tailored to help students in the state’s alternative schools. “The national data were powerful in making the case that with

health education programs, one size does not fit all,” said Laurie Bechhofer, MPH, HIV/STD Prevention Consultant, Michigan Department of Education, Lansing, Michigan. “The data showed that about half of students in regular high schools had ever had sex [in 1997], compared with about 90% of high school students in alternative education programs [in 1998].”

Recognizing the urgent need to help students in alternative schools, the state education and health departments held several forums for educators and policy-makers, “and we used the YRBSS data as a springboard to get people thinking about what are the risks and needs of these students,” Ms. Bechhofer said. State officials gave attendees a YRBSS chart showing that students in alternative high schools are far more likely than students in regular high schools to drink and drive, carry a weapon, fight, attempt suicide, smoke, use illegal drugs, and have four or more sexual partners.

When they saw how Michigan schools compared with schools nationwide, some attendees were surprised. “Everyone likes to think their community looks different from the state and that their state looks different from the nation. The YRBSS data showed us that we are not that different in many of the categories of risk behaviors, and that was a surprise,” said Ms. Bechhofer.

Michigan officials are trying a new approach this year to disperse state YRBSS findings to an even broader audience. They are hosting a series of monthly lunch meetings, each focusing on a particular health threat facing adolescents and each geared to reach a different group of professionals. “For the lunch meeting about nutrition in January 2001, we invited people from the Dairy Council, team nutritionists, food service staff, representatives of voluntary agencies, health department people, epidemiologists, and program people,” Ms. Bechhofer explained. Attendees reviewed YRBSS data on nutrition issues and discussed what is being done to address the nutritional needs

Facts About the YRBSS

- Has four components: state and large city school-based surveys of students in grades 9–12; national school-based surveys of students in grades 9–12; a national household survey of young people 12–21 years old; and a national mail survey of college students in 2- and 4-year institutions.
- First conducted in 1990 and conducted every other year since 1991.
- Monitors six categories of risk among adolescents: violence and unintentional injury, tobacco use, alcohol and other drug use, sexual behaviors, dietary behaviors, and physical activity.
- Is linked to 16 of the *Healthy People 2010* objectives and three of the 10 leading health indicators.
- Forty-one states, four territories, and 17 large cities participated in 1999. Thirty-seven sites had weighted data
- More than 12,000 students completed national YRBS questionnaires in 1999.
- Surveys in states and large cities are conducted by education and health agencies, which are funded through cooperative agreements with CDC.
- Participation is voluntary, and responses are anonymous.

of adolescents. Other topics to be covered during the lunch meeting series include smoking, sexual activity, violence, safety, alcohol use, drug use, depression and suicide, and physical activity.

Montana's YRBSS data also are widely used outside the state's Office of Public Instruction. Reports summarizing the statewide data are sent to a multitude of recipients, such as schools, churches, libraries, state and local health departments and their constituents, the department of transportation, department of justice and their constituents, and Native American organizations, Mr. Chiotti noted. Reports also are shared with the Healthy Mothers/Healthy Babies Program and Blue Cross/Blue Shield of Montana, which are among nine partner agencies that support the Montana Youth Risk Behavior Survey. Funding from these public and private partner agencies allows

the state to print and distribute thousands of copies of its YRBSS reports. The state prints 5,000 copies of its YRBSS summary report alone and also produces specialized reports that present data separately for students in grades 7–8 and 9–12 and for subgroups, including American Indians attending schools on the reservation, those attending schools off the reservation, students in alternative schools, and students in special education programs.

“We also have a Web site that allows you to view state-level response percentages for every survey question ever asked during the 1991, 1993, 1995, 1997, and 1999 Youth Risk Behavior Surveys,” said Mr. Chiotti. But the site includes much more than just state-level percentages. “Visitors can view several analyses of the data—for example, comparing responses from students who smoke vs. those who do not, students from high-performing vs. low-performing schools, and students from high-economic well-being vs. low-economic well-being areas,” he explained. (Check out the Web site at

www.metnet.state.mt.us. Select *Office of Public Instruction*, under *Services of OPI* select *Health Enhancement*, and select *Youth Risk Behavior Survey*.)

In San Diego, YRBSS reports are prepared for elected officials, parents, advisory groups, and health coalitions. Education staff make YRBSS presentations to the media, school board, county health advisory board, health agencies, advisory boards, and Healthy Start staff. “Also, many of the six priority health behaviors are highlighted in our county health report card for 2010. It's our local version of *Healthy People 2010*, and in it we talk about our progress in meeting local goals,” explained Mr. Campana.

The ways in which YRBSS data can be used are limited only by the resources that states can invest. If Ms. Bechhofer had the time and money, her hope would be to develop model lessons for students that would integrate survey techniques, tech-

nology, math, civics, and health education, in effect making these subjects come alive with actual challenges facing young people. “Health education has always had to compete with the core academic subjects, such as English, language arts, and math,” she said. So why not use health education—and the YRBSS—as a cross-cutting theme to teach core subjects? In a civics lesson, for example, students could use the YRBSS data to prepare a report showing how certain social factors have influenced adolescent health. Students could also prepare a school board presentation aimed at influencing school health policy and programs. To enhance math skills, teachers could ask students to look at YRBSS trends for Michigan and determine which changes are statistically significant. They could also learn about weighting data. “If math used more real-world examples that applied to the lives of young people, it would be interesting and more relevant to them,” she predicted.

The Power of Weighted Data


Dr. Kann is pleased with the innovative ways in which states and cities are using YRBSS data to promote the health of adolescents, and her goal is to have all 50 states in the system, collecting high-quality data. “We’ve come a long way. The surveillance system has more participants today, and it is of a better quality than in years past. We started out with 23 states participating in 1990. In 1999, 41 states participated, but only 22 of them had weighted data. We need to do better,” she affirmed. Weighted data allow health and education officials to estimate rates for the entire state.

To have weighted data, a state must have an overall participation rate of at least 60%.

San Diego, Montana, and Michigan are among the 22 participating areas that have weighted data. Michigan has an 82% overall participation rate (calculated by multiplying the percentage of participating schools times the percentage of participating students). “We’ve had weighted data since 1997, and it means the difference between having data that apply only to the students who participated versus being able to generalize your findings to the entire state,” explained Ms. Bechhofer. “For us, the weighted YRBSS data have been very powerful.”

Another goal of Dr. Kann’s is to see more collaboration between education and health agencies. “The surveys are always better when health and education work together to implement the survey and use the data that come out of it. This is happening in a lot of places. For instance, in some states—such as Alaska, Florida, and Mississippi—the health department actually conducts the survey,” she said.

Dr. Kann has been involved in the YRBSS since it began. “In 1990, few states had good data to help develop programs for kids, and now many do, and that’s great. Being able to base program and policy decisions on data is always better than just guessing what kids need,” said Dr. Kann. “We really hope that the YRBSS has made a difference in the quality of school health programs available to kids today.”

YRBS data can be viewed online at www.cdc.gov/nccdphp/dash/yrebs/index.htm. 

YRBS Data for 1990s Show How Adolescents Are Faring

The national Youth Risk Behavior Survey (YRBS) is conducted every other year to assess the prevalence of health risk behaviors among high school students. CDC combined survey responses into one data set to examine trends in risk behaviors during the 1990s. Measures were taken to control for grade, sex, and race/ethnicity. YRBS data are not included in the tables for risk behaviors that did not change significantly or that had inconsistent patterns of change during the 9-year surveillance period.

Risk Behaviors That Improved¹—National Youth Risk Behavior Surveys, 1991–1999

	1991	1993	1995	1997	1999
Injury-related behaviors					
Never or rarely wore a seat belt	25.9	19.1	21.7	19.3	16.4
Never or rarely wore a bicycle helmet ²	96.2	92.8	92.8	88.4	85.3
Rode with a drunk driver ³	39.9	35.3	38.8	36.6	33.1
Carried a gun ⁴	NA	7.9	7.6	5.9	4.9
Carried a weapon on school property ⁴	NA	11.8	9.8	8.5	6.9
Involved in a physical fight ⁵	42.5	41.8	38.7	36.6	35.7
Involved in a physical fight on school property ⁵	NA	16.2	15.5	14.8	14.2
Seriously considered suicide ⁶	29.0	24.1	24.1	20.5	19.3
Tobacco use					
Current smokeless tobacco use ⁴	NA	NA	11.4	9.3	7.8
Sexual behaviors					
Ever had sexual intercourse	54.1	53.0	53.1	48.4	49.9
Had four or more sexual partners	18.7	18.7	17.8	16.0	16.2
Used a condom at last sexual intercourse ⁷	46.2	52.8	54.4	56.8	58.0
Had been taught about HIV/AIDS in school	83.3	86.1	86.3	91.5	90.6
Physical activity					
Participated in strengthening exercises ⁸	47.8	51.9	50.3	51.4	53.6

NA Data not collected.

¹ Significant linear change; $p < 0.05$

² Among students who rode bicycles during the 12 months preceding the survey.

³ > 1 times during the 30 days preceding the survey.

⁴ On > 1 of the 30 days preceding the survey.

⁵ > 1 times during the 12 months preceding the survey.

⁶ During the 12 months preceding the survey.

⁷ Among currently sexually active students.

⁸ On > 3 of the 7 days preceding the survey.

Risk Behaviors That Worsened¹—National Youth Risk Behavior Surveys, 1991–1999

	1991	1993	1995	1997	1999
Tobacco use					
Frequent cigarette use ²	12.7	13.8	16.1	16.7	16.8
Alcohol and other drug use					
Episodic heavy drinking ³	31.3	30.0	32.6	33.4	31.5
Lifetime marijuana use	31.3	32.8	42.4	47.1	47.2
Current cocaine use ⁴	1.7	1.9	3.1	3.3	4.0
Lifetime illegal steroid use	2.7	2.2	3.7	3.1	3.7
Sexual behaviors					
Used birth control pills at last sexual intercourse ⁵	20.8	18.4	17.4	16.6	16.2
Physical activity					
Attended physical education class daily	41.6	34.3	25.4	27.4	29.1

¹ Significant linear change; $p < 0.05$.

² On > 20 of the 30 days preceding the survey.

³ Drank > 5 drinks of alcohol on at least one occasion on > 1 of the 30 days preceding the survey.

⁴ > 1 times during the 30 days preceding the survey.

⁵ Among currently sexually active students.

CDC Supports International School Health Activities


In an increasingly global economy and environment, the health of every citizen depends on the health of neighbors in other countries. Around the world, nations are becoming aware of the value of school health education and school health programs in reaching not only students, but teachers and families as well. CDC is often called upon for technical advice, assistance, and support of such efforts.

In the United States, CDC is the federal focal point for school health education, providing guidance and support for school health education and health promotion activities to state and local education agencies throughout the country. CDC offers formal international support of school health through a cooperative agreement with the World Health Organization (WHO), and informal support through collaborative efforts with several countries. For example, CDC participates in WHO's Mega Country Health Promotion Network, which aims to enhance health and health promotion strategies in countries with populations of 100 million or more. The "Mega" countries are China, Bangladesh, India, Nigeria, Brazil, Mexico, Russia, Pakistan, Indonesia, and the United States." WHO characterizes a Health-Promoting School as a school that is "constantly strengthening its capacity as a healthy setting for living, learning, and working." Four United Nations agencies—WHO, UNICEF, UNESCO, and the World Bank—are working together as part of FRESH to help schools around the world improve the health, and consequently the education, of young people.

Additional technical assistance is provided through the FRESH (Focusing Resources on Effective School Health) program, "A FRESH Start to Improving the Quality and Equity of Education."


FRESH focuses on four components that are used as a model, at the option of the participating countries: health-related school policies, a core framework for action, health and nutrition services, and provision of safe water and sanitation. It is hoped that this model will be effective in both developed and developing nations. CDC also recently participated in the National Conference on Health-Promoting Schools in Beijing, People's Republic of China, where one important focus of school health programs has been elimination of helminth (parasites such as hookworms and pinworms) infections, which occur at a very high rate, especially in China's river regions.

Among other countries that have asked for or been offered technical assistance are the Russian Federation, South Africa, Australia, and Vietnam. CDC offers technical assistance to Russia through the U.S.–Russia Joint Commission on Economic and Technical Cooperation on School Health, and has sent representatives to two forums focused on Russia's move toward health-promoting schools and other school health initiatives. CDC is a member of the U.S.–South Africa Binational Commission on School Health. Because HIV infection rates in South Africa are among the highest in the world, the technical assistance provided to this country for its school health programs focuses on HIV prevention in schools.

For more information on the Mega Country Health Promotion Network and the Global School Health Initiative, visit the Web site of WHO's Department of Health Promotion, Noncommunicable Disease Prevention and Surveillance on the Internet at www.who.int/hps. More information about CDC's school health programs may be found online at www.cdc.gov/nccdphp/dash. 

Media Campaign Planned to Improve the Health of America's Children

Using new funding first provided by Congress for fiscal year 2001, CDC is mounting a campaign that employs the best principles of marketing and communication strategies to influence America's children to develop habits that foster good health over a lifetime—including physical activity. Young people today are a multimedia generation with high rates of media consumption. These media sources, which include television, radio, music, print, and Internet use, offer a tremendous opportunity to

market healthy behaviors to young people. The campaign, titled by Congress the National Campaign to Change Children's Health Behavior, will involve young people in all aspects of campaign planning and implementation, and will enlist the support and involvement of parents and other role models. CDC will work with marketing and media experts to design and implement a successful media campaign. For more information, call Faye Wong, RD, MPH, Project Director, at 770/488-5131, or E-mail fwong@cdc.gov. 

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Conferences

Plan for Success: Strengthening the Public's Health Through Health Promotion 19th National Conference on Health Education and Health Promotion

You are invited to join the Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPE), the Centers for Disease Control and Prevention (CDC), and public health professionals from across the nation for the 19th National Conference on Health Education and Health Promotion. The conference will be held April 25–27, 2001, in Atlanta, Georgia, at the Crown Plaza Ravinia. Take advantage of this opportunity to share successful health education and health promotion programs for a variety of settings, levels, diverse populations, and public health issues. For more information or to register, contact Rose Marie Matulionis, Executive Director, ATDHPPE, at 202/312-6460 or fax 202/336-6012 or visit www.astdhppe.org/conf19/19confindex.htm.

CDC's Diabetes Translation Conference 2001

CDC's Division of Diabetes Translation (DDT) will be hosting its annual conference April 30–May 3, 2001, in Seattle, Washington. This year's theme is Diabetes Across the Life Stages. The conference will bring together a wide community of local, state, federal, territorial, and private-sector diabetes partners to explore science, policy, and education as they relate to diabetes in every life stage. For more information, call toll-free 877/CDC-DIAB, E-mail diabetes@cdc.gov, or visit DDT's Web site at www.cdc.gov/diabetes.

CDC's 2002 National Leadership Conference

CDC's 2002 National Leadership Conference will convene February 8-13, 2002, at the Renaissance Hotel in Washington, D.C. Each year this conference offers an outstanding opportunity for learning and networking among dedicated professionals in the fields of HIV/AIDS prevention and school health, including those from state and local education, health and social service agencies, national nongovernmental organizations, federal

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agencies, colleges and universities, and philanthropic organizations. Information about the 2001 Leadership Conference and the program for the 2002 Leadership Conference will be posted in the coming months at www.cdc.gov/nccdphp/dash.

National Oral Health Care Conference

“Dental Public Health: Enhancing Health, Access, and Partnerships” will be the theme of the next National Oral Health Conference to be held April 30–May 2, 2001, at the Marriott Hotel Downtown in Portland, Oregon. The program will focus on Medicaid and access issues, national oral health initiatives, health promotion and disease prevention, utilization cost-effectiveness and benefits of programs, education of health personnel, and innovative program evaluation. The meeting is sponsored by the Association of State and Territorial Dental Directors, the American Association of Public Health Dentistry, CDC, the Health Care Financing Administration, and the Health Resources and Services Administration. More information about the conference is available at the following Web sites: www.astdd.org or www.aaphd.org.

First National CDC Prevention Conference on Heart Disease and Stroke

CDC, the American Heart Association, and the National Heart, Lung, and Blood Institute are cosponsoring the First National CDC Prevention Conference on Heart Disease and Stroke to be held August 22–24, 2001, in Atlanta, Georgia, at the Westin Peachtree Plaza. The goal of the conference is to increase knowledge and provide opportunities for information sharing, networking, and skill building for state health department staff and cardiovascular health (CVH) partners to build and expand comprehensive CVH state programs. More information about the conference is available at www.cdc.gov/nccdphp/cvd.

2001 Cancer Conference

CDC’s 2001 Cancer Conference will be held September 4–7, 2001, in Atlanta, Georgia, at the Marriott Marquis Hotel. The theme is “Using Science to Build Comprehensive Cancer Programs: A 2001 Odyssey.” The conference will explore evidence-based science and how it applies in a public health setting. Short courses will be held September 4 as part of the preconference activities. Abstract submission deadline is March 19, 2001, and the registration deadline for the CyberExpo, exhibit booths, and tabletop exhibits is June 27, 2001. To be added to the mailing list for the conference, write Laura Shelton at PSA, 2957 Clairmont Road, Suite 480, Atlanta, GA 30349, or call 404/633-6869, extension 214. For more information, E-mail Kathleen Carey, Conference Co-Chair, at kcarey@cdc.gov or visit www.cdc.gov/cancer/conference2001.

16th National Conference on Chronic Disease Prevention and Control

The National Center for Chronic Disease Prevention and Health Promotion will host its 16th annual conference February 27–March 1, 2002, at the Sheraton Atlanta Hotel in Atlanta, Georgia. Participants will learn about emerging chronic disease issues, data applications, and intervention research; network with health and other professionals; develop new working relationships; and discover what others are doing in communications, training, policy, and partnership. For more information, E-mail Dale Wilson at dnw3@cdc.gov or visit www.cdc.gov/nccdphp/conference.

Communications

Second Annual National Colorectal Cancer Awareness Month—March 2001

Colorectal cancer is the second leading cancer killer in the United States. The risk of developing this disease increases with age; 93% of cases occur in people aged 50 years or older. However, most Americans in that age-group are not screened for colorectal cancer. Therefore, the National Colorectal Cancer Awareness Month was

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established to increase awareness and encourage prevention and early detection through screening. March 2000 was the first National Colorectal Cancer Awareness Month, and 34 leading organizations, including CDC, joined as collaborating partners. The Cancer Research Foundation of America (CRFA) spearheaded the drive to have the month of March officially designated as National Colorectal Cancer Awareness Month. To learn more about CRFA and future planning for National Colorectal Cancer Awareness Month 2001, call 1-877-35-COLON or visit www.preventcancer.org.

Information Sources

National Oral Health Surveillance System Now Available

The National Oral Health Surveillance System (NOHSS) is a new policy resource available online. The NOHSS Web site is designed to provide national and state information on oral health indicators including the percentage of the adult population reporting a dental visit during the past year, the percentage of adults who had their teeth cleaned during the past year, the percentage of senior population with complete tooth loss, and the percentage of a state's population on a community water system whose water is fluoridated. NOHSS also includes selected information from the Synopses of State Oral Health Programs, which contains state-specific information on demographics, as well as oral health infrastructure, administration, and program activities. Additional oral health data will be added each year as they become available. For more information, visit www.cdc.gov/nohss.

Sample Medicaid Dental Purchasing Specifications

Sample Purchasing Specifications for Medicaid Pediatric Dental and Oral Health Services are now available. These specifications describe comprehensive oral health care services for children and adolescents and are especially useful for State Medicaid agencies, State Children's Health Insurance Programs (SCHIPs), and insurance providers that develop contracts for dental services for low-income children. To learn more about these specifications, visit www.gwu.edu/~chsrp/sps/dental.

NCCDPHP News

Elizabeth Majestic Selected as NCCDPHP Associate Director

Elizabeth Majestic, MA, was named Associate Director for Planning, Evaluation, and Legislation, Office of the Director, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) and began her new assignment on February 1. Since 1997, Dr. Majestic has served as Deputy Director, Office on Smoking and Health (OSH), NCCDPHP, and, since September, Acting Director, OSH, while a search was under way for the Director position. Before joining OSH, she served for 6 years as Chief, Special Populations Program, Division of Adolescent and School Health, NCCDPHP.

Congressman Porter Recognized as "Champion of Prevention" at 15th National Conference on Chronic Disease Prevention and Control

At the 15th National Conference on Chronic Disease Prevention and Control held November 29–December 1, 2000, in Washington, D.C., CDC Director Jeffrey P. Koplan, MD, MPH, presented CDC's Champion of Prevention Award to U.S. Congressman John E. Porter of Illinois in recognition of his work in promoting and

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protecting the health of all Americans, particularly the underserved. Dr. Koplan praised Congressman Porter as a “true advocate of public health” and for being the first House Appropriation Subcommittee Chairman to visit CDC. In addition to presiding over significant funding increases in CDC’s budget for improved facilities, Congressman Porter supported public health programs for breast and cervical cancer, polio eradication, domestic violence, oral health, immunizations, obesity and physical activity, school health programs, cardiovascular diseases, and tobacco control. “It is because of efforts of leaders like Congressman Porter that scientists can continue to open doors that will lead to longer, healthier, and more satisfying lives for people with chronic disease,” said James S. Marks, MD, MPH, Director, National Center for Chronic Disease Prevention and Health Promotion, CDC.

CDC Honors HIV/AIDS Education Leaders

CDC—in association with the U.S. Department of Education; the Society of State Directors of Health, Physical Education, and Recreation; and the Rollins School of Public Health of Emory University—presented the following awards at the National Leadership Conference to Strengthen HIV/AIDS Education and Coordinated School Health Programs, January 22–25, 2001, in Washington, D.C.:

Leadership Award (Coordinated School Health Programs):

Patricia Nichols, Department of Education, Michigan (retired)

Leadership Award (HIV):

Joyce Johnson, Department of Education, New Hampshire

Award of Excellence:

Brenda Z. Greene, National School Boards Association

Simon A. McNeely Award:

Marshall Kreuter, Division of Adult and Community Health, NCCDPHP, CDC

Director’s Special Award

Gordon Ambach, Council of Chief State School Officers

Director’s Special Award:

William Datema, Society of State Directors of Health, Physical Education, and Recreation

Diabetes Stamp

The United States Postal Service will issue a diabetes stamp March 16 in Boston at the Joslin Diabetes Center; the stamp will go on sale nationwide the same day. The Boston event will feature celebrities and officials from the postal service and their partners from the Centers for Disease Control and Prevention, the American Diabetes Association, the Juvenile Diabetes Research Foundation International, and the National Institutes of Health. The event will be an all-day symposium and workshop series with diabetes screening and informational booths. The diabetes stamp encourages everyone to “Know More About Diabetes” and will help promote awareness about the need for early detection and for continued research and education to help find a cure for this devastating disease. Designed by James Steinberg, the stamp includes two elements associated with diabetes testing and research—a microscope and a test tube containing blood. To see an image of the stamp, visit the CDC Diabetes Public Health Resource Web page at www.cdc.gov/diabetes or call toll-free 1-877-CDC-DIAB.

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