

National  
Center for  
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242 West 30<sup>th</sup> Street, 10<sup>th</sup> Floor • New York, NY 10001-1081 • Tel 212-594-8001 • Fax 212-594-8023 • www.nche.org

## **Testimony**

### **Expanding Funding of the Centers for Disease Control and Prevention's Coordinated School Health Program**

**Statement of John P. Allegrante, Ph.D.\*  
President and CEO  
National Center for Health Education  
Professor of Health Education  
Teachers College, Columbia University  
525 West 120<sup>th</sup> Street  
New York, NY 10027  
Tel 212-678-3960 • Fax 212-678-8259  
E-Mail: [jpa1@columbia.edu](mailto:jpa1@columbia.edu)**

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Good Afternoon. My name is John Allegrante and I am grateful for the opportunity to appear before the Subcommittee. I am the senior professor of health education at Teachers College, Columbia University, where I have been a member of the faculty for over 20 years. I am a past president of the Society for Public Health Education, and last year, I was named the new president and chief executive officer of the National Center for Health Education (NCHE).

The National Center for Health Education, created by a presidential commission under President Richard Nixon in 1975, is a private, non-profit entity whose sole responsibility is to advance the nation's private-sector efforts in health education. Our organization also works in conjunction with the Friends of School Health and the Coalition of National Health Education Organizations, a group of 9 professional associations<sup>†</sup> that represents approximately 25,000 professionals who are especially skilled in the use of health promotion and disease prevention to advance the nation's Healthy People 2010 goals and objectives.

Mr. Chairman and distinguished Members, I want first to thank you for your past support of programs and initiatives that invest in our nation's youth. But, I am also here today on behalf of the National Center for Health Education to sound a "wake-up call" for more substantial federal investment in what are proven, cost-effective coordinated school health programs and comprehensive school health education.

**Specifically, I am here to request that the Centers for Disease Control and Prevention (CDC) be funded at \$35 million for fiscal year 2003 in order to provide the states with infrastructure grants for such programs.**

Perhaps more than at any other time in our nation's history, children and adolescents in our society are facing challenges that can have a profound impact on health. Data from the CDC Youth Risk Behavior Survey<sup>1</sup> and other studies have shown that:

- ? More than 3,000 young people begin smoking each day.<sup>2</sup>
- ? Obesity has doubled among children and adolescents in the last decade, making it now a national epidemic. Ten to 15 percent of children and adolescents are overweight and more than half of these children have at least one cardiovascular disease risk factor, such as elevated cholesterol, hypertension, and risk for Type II diabetes.<sup>3</sup> Yet, daily participation in high school physical education classes dropped from 42 percent in 1991 to 29 percent in 1999.<sup>4</sup>
- ? Two-thirds of eighth-graders have experimented with alcohol and 28 percent have been drunk at least once.
- ? Seven percent of ninth-grade students report carrying a weapon to school in the previous month, with 135,000 bringing a gun to school every day; violent homicide is now the second leading cause of death among people 15 to 24.<sup>5</sup>
- ? Motor vehicle accidents result in over 30 percent of the deaths among young people ages 1 to 24.<sup>6</sup>

Mr. Chairman, the chances are quite high that young people in your district are among these statistics. In Ohio, 73 percent of youth report having smoked cigarettes, 56 percent drank alcohol during the last month, 72 percent did not participate in moderate physical activity, and 81 percent ate fewer than 5 servings of fruits and vegetables daily during the past 7 days.<sup>7</sup> Tobacco use, poor nutrition, lack of physical activity, alcohol use and other drug use constitute major risk behaviors, which when established during youth today, lead to tomorrow's adult premature death and disability, including heart disease, cancer, diabetes, and injuries.<sup>8</sup> Our children and adolescents fall victim to these chronic diseases when we fail to provide them with prevention strategies that we now have in hand and know that work. And we are failing them, Mr. Chairman, in almost each and every community. The cost to the nation of not doing

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<sup>†</sup> American Association for Health Education, American College Health Association, American Public Health Association/Public Health Education & Health Promotion Section and School Health Education & Services Section, American School Health Association, Association of State & Territorial Directors of Health Promotion and Public Health Education, Eta Sigma Gamma, National Commission for Health Education Credentialing, Society for Public Health Education, and the Society of State Directors of Health, Physical Education and Recreation.

more than we are currently doing is intolerable; it is measured both in terms of lives lost to premature death and unnecessary medical expenses. Moreover, the burden of these costs is borne disproportionately in communities where racial minorities predominate.

What those of us at NCHE and I find so disturbing about these statistics is that something can be done. We are already working in partnership with CDC's Division of Adolescent and School Health (DASH) and other government agencies, as well as health-related voluntary associations and national and state-level school organizations in the private sector, to address these problems and other health concerns of children and their families through the implementation of comprehensive health education and other initiatives in schools throughout the United States. By comprehensive, I mean curriculum approaches that are sequential, age-appropriate, and help young people to apply understandings across a broad range of content areas and behaviors that influence health.

For example, NCHE's *Growing Healthy*<sup>9</sup>, a comprehensive school health education curriculum for Kindergarten through 6<sup>th</sup> grade, helps young people acquire the knowledge and skills they need for good health, academic success, and productive adult lives. Over the past 25 years, *Growing Healthy* has reached over 5 million students in 15,000 schools in more than 40 states in the U.S. and Canada. Through a funded cooperative agreement that enables NCHE to work in partnership with CDC DASH, we are also currently working with teachers, parents, and school leaders across America to coordinate development of locally-based school health councils that can contribute to building community capacity for healthy schools. These councils allow communities to take ownership of their schools and youth, the very youth that will comprise the future workforce.

Our *Growing Healthy* curriculum is an interdisciplinary approach that has been demonstrated effective at giving young people the knowledge and skills they need to avoid health-risky behavior. We can prevent much of the disease burden that is associated with poor health behaviors by exposing young people to such knowledge and skills. *Growing Healthy*, which has been recognized as a promising program for Safe, Disciplined and Drug-Free Schools by the U.S. Department of Education, is especially valuable in this effort because it is one of the few school-based programs that can be easily integrated into other subject areas, allowing students to create, apply, and use knowledge gained in many different situations. In addition to meeting all of the National Health Education Standards,<sup>10</sup> our curriculum meets a generous number of performance objectives in other major subject areas, including Social Studies, Science, Literacy, and Language Arts. Yet, despite the existence of promising and effective programs such as NCHE's *Growing Healthy*, which can not only improve students' health and reduce their participation in harmful activities, but also improve their language and computational skills, health education is often tacked on, taught by teachers with little or no background in health, and taught with few or no resources.<sup>11</sup>

As the chief executive officer of a non-profit entity, behavioral scientist, and parent who has become alarmed by the prevalence of these problems and doing something about them, I know that most schools, most educators, and most communities in America are woefully unprepared to help young people avoid the costly consequences of poor health decisions and complex health problems. Schools look to the states for help with teacher training, curriculum development and selection, and obtaining resources for health education. State-level capacity in the education departments to support such local school programming has been seriously eroded in recent years. Despite generous tobacco settlements and rising rates of obesity and Type II diabetes among youth, fewer than half the states support implementation of school health education programs that target tobacco and promote physical activity and good nutrition because they do not have access to limited CDC infrastructure funds. This is unfortunate because we know that smoking, lack of exercise,<sup>12</sup> and lack of a sound diet constitute the three major risk factors for several preventable chronic diseases.

Although many federal and state programs exist to provide basic services such as immunization, nutritious meals, and physical education programs, most are fragmented and uncoordinated. Funds for such programs come from a variety of federal agencies, including Education, Agriculture, Health and Human Services. Yet, fewer than half of America's schools have the capacity to review, prioritize, and coordinate the diverse programs and services that are available. Expanded funding authorized by Congress could help states strengthen their efforts to establish and replicate local school-community

partnership with state education departments and state public health agencies, as well as organizations in the private sector, to develop and sustain coordinated—rather than piecemeal—school health programs. Coordinated school health programs provide youth with the information and skills, environmental changes, parent and teacher education, and other resources to avoid risky behaviors.<sup>13</sup> In addition, expanded funding would enable CDC to continue monitoring risk behaviors among youth and thus document progress toward meeting the national health promotion and disease prevention objectives for the nation.

For example, in Rhode Island, the State Department of Education has developed a partnership with *Kids First*, a community-based agency dedicated to improving the health and education of children. Together, they have provided nutrition education in schools throughout the state, and helped to address risk factors related to physical activity and obesity. From May 1998 through September 2000, Rhode Island provided nutrition services and programs to more than 40,000 children and their parents, 2,100 teachers, and 700 school food-service staff in more than 220 schools. Through its nutrition education program, Rhode Island is helping its young people establish healthy eating habits at an early age, thus reducing their risk for devastating chronic diseases both now and later in life.<sup>14</sup> This effort could not have been put into place without CDC funds.

In contrast, in Illinois, the Cook County Department of Public Health has utilized the CDC model of the coordinated school health program to plan a bold initiative to bring about systemic change in an effort to improve child health in an economically depressed African-American community in south suburban Cook County. With the support of visionary school superintendents and the Illinois Board of Education, two county tax-supported health educators with a \$30,000 grant from the state human services agency created *The Healthy Schools Partnership*. The first activity was to begin implementation of comprehensive, age-appropriate and sequential health instruction. The grant paid for teachers in three schools to receive training to use NCHE's *Growing Healthy*, and enough curriculum materials for one school year. But, when the grant ended the following year, there was neither infrastructure nor funds to support further implementation of the curriculum. Without CDC school health program funds, Illinois was unable to leverage the state and local resources to support this important school health initiative.<sup>15</sup>

That is why the expansion of infrastructure grants to establish school health programming that can effectively promote healthy behavior aimed at preventing tobacco use, fostering physical activity and improving nutrition is so important. Doing so is especially important if we are to expand such programs in the early grades and in economically disadvantaged communities. In short, implementation of high-quality school health programming, coordinated by certified health education specialists, is critical if we want to make a difference.<sup>16</sup>

In FY 2002, CDC provided 20 states with support to facilitate coordinated school health programs. These programs resulted in improvements to the health environment in schools, including healthier food choices and tobacco-free schools, delivery of effective health education, and opportunities for physical education that promote the recommended levels of physical activity. Yet, none of these 20 states have had sufficient funds to support implementation of effective programs such as NCHE's *Growing Healthy*, and many states, including Ohio, receive no funding. Moreover, the CDC school health program, which was funded at a level of \$9.7 million in FY 2002, is virtually unchanged from the \$9.6 million appropriated in FY 2001, which is about the level of funding that has occurred in the last 10 years. Failure to provide an increase is tantamount to sliding backwards.

With increased dollars, CDC would be able to increase funding to at least 2 of the currently funded states to establish physical activity, nutrition, and tobacco evaluation programs; fully fund the remainder of the 18 existing states; and fund an additional 6-9 states to do what Illinois and Rhode Island have begun to do. This would result in a total of 26-29 states receiving funding. These funds would foster critical partnerships between departments of education and health and other related agencies in states, allowing high-level, state-directed coordination across programs. This would help ensure that students not only receive effective health instruction in nutrition, physical activity, and prevention of tobacco use, but also the necessary health services, quality physical education, nutritious school meals, and counseling and

social services that, when integrated into a coordinated school health program, can contribute to students' overall learning and academic success.

In addition to enabling CDC to provide infrastructure support for school health programs in additional states, funding for CDC's school health initiative can serve as a foundation for other federal categorical funding programs as well as state-specific funding. For example, in Tennessee, funding for coordinated school health provided the basis for a \$1 million appropriation from the state legislature for school health in rural, underserved areas. In states that also receive CDC school health funding, coordination of various categorical programs eliminates duplication of services, more effectively allows states to leverage resources to fill gaps, and maximizes each program's effectiveness by ensuring that students receive consistent messages and exposure across programs and services.

I am not alone in my view that we need to do this. Independent surveys have consistently demonstrated that the public supports school health programs; a recent Gallup poll found 7 of 10 adults rated health information as important for students to learn before graduating from high school.<sup>17</sup> School health programs have the potential to reach 53 million young people in schools across America and have been demonstrated to be cost-effective in promoting healthy behaviors.<sup>18</sup> Thus, we are only scratching the surface of the number of schools in America that should be implementing coordinated school health programs and comprehensive school health education. That is why NCHE supports a FY 2003 appropriation of \$35 million for the CDC DASH school health program, separate from DASH HIV/AIDS funding. In addition to expanding the funding base for coordinated school health programs at the state level, this \$25 million increase would help state and local agencies that receive these monies to leverage local tax-based funding to better coordinate the many categorical health education programs that are offered in schools and by other community agencies.

This is an investment in our future. Limiting the burden of chronic disease for our nation's health care system will pay enormous dividends in federal dollars saved in coming decades. Improving health outcomes for children and youth can also improve their educational success as students, providing the educational foundation that fosters productive citizens. Finally, ensuring a healthy start for our young people lessens the eventual physical and emotional burden of chronic disease on our citizens and their families.

In closing, Mr. Chairman, I want to say that I understand the constraints under which all of the agencies of our federal government must operate. But, I believe that, when it comes to the health of our children, the diagnosis is clear and a treatment is readily at hand. Expanding funding of school health programs is a prescription for the health of our children, one that will ensure our nation's future.<sup>19</sup> It is a prescription that this committee should write for the American people.

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