



The General Assembly
Atlanta, Georgia 30334

**REPORT OF THE
JOINT STUDY COMMITTEE ON PHYSICAL ACTIVITY
IN GEORGIA SCHOOLS**

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Georgia Dietetic Association
Georgia Association of Education Leaders
Georgia Association for Health, Physical Education, Recreation, and Dance
Georgia Parent Teacher Association
Georgia Coalition for Physical Activity and Nutrition
Georgia Nurses Association
Georgia Partnership for School Health
Georgia Chapter of the American Heart Association
Georgia Chapter of the American Academy of Pediatrics
Georgia Department of Human Resources, Division of Public Health—Chronic Disease
Prevention and Health Promotion Branch
Georgia Department of Education

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I. INTRODUCTION

A. Charge of the Committee

The Joint Study Committee on Physical Activities in Schools was created by Senate Resolution 252 during the 2001 Legislative Session. Senate Resolution 252 authorized the Committee to: study opportunities to increase physical activity in the school setting and the conditions, needs, issues, and problems related to physical activity in Georgia Schools; to make its recommendations; and to report its findings by December 15, 2001.

In accordance with Senate Resolution 252, the Committee was composed of three members of the Senate and three members of the House of Representatives appointed by the Lt. Governor and the Speaker of the House of Representatives, respectively. The Senators serving on the Committee were: Senator Nadine Thomas, Senator Gloria S. Butler, and Senator Mike Beatty. The Representatives serving on the Committee were Representative Nikki T. Randal, Representative Renee S. Unterman, and Representative Sistie Hudson who, as authorized by the resolution, was appointed by the Governor chairperson. Legislative staff assigned to the Committee included: Eden G. Fesshazion with the Senate Research Office, Mary Riddle with the Office of Legislative Counsel, and Phyllis Mitchell with the House Research Office. Pam Wilson with the Department of Human Resources, Division of Public Health-Chronic Disease Prevention, assisted the Committee and collaborated in the writing of this report.

In addition to the legislative membership of the Committee, the resolution provided for advisory membership of the Committee. The Advisory committee was composed of: Donna Gibson, Georgia Dietetic Association; Rendell Stalvey, Georgia Association of Education Leaders; Deborah Baber, Georgia Association for Health, Physical Education, Recreation and Dance; Linda Schultz, Georgia Parent Teacher Association; Lisa Stone, Georgia Coalition for Physical Activity and Nutrition; Myra Carmon, Georgia Nurses Association; Josephine Martin, Georgia Partnership for School Health; Christi Kay, Georgia Chapter of the American Heart Association; Stanley Cohen, MD, and Susan Burns, Georgia Chapter of the American Academy of Pediatrics; Pam Wilson, Georgia Department of Human Resources, Division of Public Health-Chronic Disease Prevention and Health Promotion Branch; and, Paulette Williams, Georgia Department of Education. The Committee held five meetings in Atlanta on the following dates: November 2, November 28, December 6, December 12, and December 19, of 2001.

B. Background: Sedentary Lifestyles and the Declining State of Health in the United States and Georgia

Nation

Over the past few decades, our society has become physically inactive. Lifestyle changes that have come about with the increased use of cable and satellite television, the Internet, and computer-based games have promoted this sedentary behavior. Moreover, increased dependence on the automobile has discouraged walking. This physical inactivity in the general population has resulted in an increasingly overweight society. Currently, more than half of all U.S. adults are considered

overweight, defined as having a Body Mass Index (BMI) of 25 or more.¹ The former U.S. Surgeon General David Satcher recently issued a report stating that 300,000 U.S. deaths a year are associated with obesity.² Physical inactivity, along with poor nutrition, have contributed to many illnesses and deaths nationwide. The total cost of diseases associated with obesity has been estimated at almost \$100 billion per year, or approximately 8 percent of the national health care budget.³

In recent years, reports detailing the declining health of America's youth have been abundant, and it is believed that 20 percent of American children suffer from obesity. Television stories, newspaper articles, and other media sources have been reporting on what seems to be a national epidemic of overweight children and unhealthy lifestyles of the country's youth. This trend of overweight children is primarily attributed to large food portions, less home cooking, more sitting, less physical activity, eating "on the run," and cutbacks in recess and physical education.⁴ Today, children are spending more time inside the home playing games or using the Internet, rather than participating in outdoor activities. Concerns over safety have also kept a number of children from walking to school or playing outside the home. Between 1977 and 1995, simple activities such as walking and bicycling dropped 40 percent by children ages 5 to 15.⁵ In addition, over the last 30 years, the percentage of children ages six to eleven who are overweight or obese has more than doubled, from 4 percent in 1970 to 13 percent in 1999. Sixty-one percent of overweight children ages five to ten have one or more risk factors for developing cardiovascular disease (CVD), and 27 percent have two or more risk factors.⁶ Statistics show that in the U.S. between 1991 and 1997, the percentage of children who participated in physical education classes also declined from 42 percent to 27 percent.⁷ In fact, the increase in obesity occurred during the same period in which many states dropped requirements for daily gym classes in spite of the U.S. Surgeon General's protest.⁸

Georgia

Over the past fifteen years, physical activity in Georgia has declined considerably. Although, the

¹ "US Obesity Trends 1985 to 2000." Center for Disease Control and Prevention. Retrieved on January 29, 2001 from <<http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm>>

² "Obesity in America." National Public Radio. Retrieved on January 29, 2001 from <<http://www.npr.org/index.html>>

³ "Promoting Better Health For Young People Through Physical Activity and Sports," A Report to the President from the Secretary of Health and Human Services and the Secretary of Education, Fall 2000.

⁴ Brochure of The National Association for Sports and Physical Education (NASPE).

⁵ Noreen Seebacher, "Schools Fall Short on Gym Classes, Parents Say," *HealthScout Reporter*, November 4, 2000, p.1.

⁶ American Academy of Pediatrics Statement to the Committee, December 4, 2000.

⁷ 1996 Surgeon General's Report on Physical Activity and Health.

⁸ Noreen Seebacher, p.1.

recommended guideline for activity is 30 minutes of moderate intensity physical activity at least five days a week, only 24 percent of adults are regularly active, while 27 percent would be categorized as sedentary.⁹ This 2001 data shows that 900,000 Georgians are considered obese, and that insufficient physical activity has led to 5,543 deaths, 29,844 hospitalizations, and \$477 million in hospital expenditures in Georgia alone.

Obesity, which leads to cardiovascular disease (CVD), is a primary risk factor for the development of chronic diseases such as heart disease, stroke, diabetes, arthritis, and some types of cancer. CVD is the number one killer in every city and county in Georgia, with one Georgian dying of CVD every 22 minutes.¹⁰ More Georgians die each year from CVD than from all forms of cancer, AIDS, suicides, and traffic injuries combined.¹¹ Furthermore, CVD is a costly disease. According to the Department of Human Resources (DHR) Chronic Disease Prevention, CVD accounted for \$1.8 billion in hospital costs in Georgia in 1997 and \$1.9 billion in 1998. ALTHOUGH CVD DEATH RATES OVER THE PAST 18 YEARS HAVE DECLINED IN BOTH GEORGIA AND THE U.S., the mortality rate in Georgia from CVD is 10 percent higher than the nation's rate for the same disease.¹² Two separate studies by the Centers for Disease Control and Prevention (CDC) have placed Georgia at the bottom of the nation in cardiovascular health. In one study, Georgia had the greatest increase of obesity in the adult population 18 years and older. Similarly, the other study found that while Utah earned the highest activity rate, Georgia was ranked as the most sedentary state.

Evidence of worsening health conditions in children has been circulating within the health community and other concerned organizations for years. To examine the alarming trend of childhood obesity in Georgia, and to provide information and education to primary care providers on the assessment, prevention, and treatment of childhood obesity, the Georgia Department of Human Resources and the Georgia Chapter of the American Academy of Pediatrics have formed "The Obesity Action Network." In 1999, a coalition of more than 80 public and private partner organizations and more than 200 individual members also joined forces to create "The Georgia Coalition for Physical Activity and Nutrition" (G-PAN). In 2000, G-PAN created a ten-year statewide strategic plan for the prevention of cardiovascular and other related chronic diseases. The goal of G-PAN is to increase physical activity and improve nutrition throughout the state.

II. COMMITTEE FINDINGS

⁹Testimony by Pam Wilson, Department of Human Resources, Division of Public Health, Cardiovascular Health Section, September 28, 2001.

¹⁰Ibid.

¹¹Rowe A.K. Powell K.E. Hall V. "The 1999 Georgia State of the Heart Report." Georgia Department of Human Resources, Division of Public Health, Cardiovascular Health Section, and the American Heart Association, S.E. Affiliate, February 1999.

¹²1999 Georgia State of the Heart Report Published by the American Heart Association and Department of Human Resources Division of Public Health.

A. Deterioration of Health in School-Aged Children

1. Obesity and Associated Diseases

Although Georgia schools have been unable to provide health related statistical information on school-aged children, data from the CDC and other sources show that physical inactivity and poor nutritional choices have contributed significantly to the high percentage of overweight school-aged children. The CDC has declared obesity an epidemic and it is estimated that about 20 percent of Georgia's children are obese. According to the CDC, one of the grim indicators of this epidemic is the 10 percent increase in the number of children and young adults who have died of heart attacks from 1989 to 1996. The findings of Dr. John Rowlett, a Savannah pediatrician who has been collecting data on his patients for the past decade, indicate that weight gain and other associated risk factors for chronic diseases are spiraling out of control.¹³

In the past, Type II Diabetes, rarely found in children, was known as "adult onset" diabetes. But today, with poor nutrition and the decline in physical activity, Type II Diabetes is being diagnosed in children at an alarming rate. The increased diagnosis of the disease has forced schools, health organizations and the medical community to pay serious attention to obesity, because the younger the onset of diabetes, the greater the progression of the disease and complications. Today in some U.S. cities, Type II Diabetes accounts for almost half of all new cases of diabetes.¹⁴ In addition, for a disease that can be prevented by maintaining normal weight and regular physical activity, the implications of Type II Diabetes are staggering because diabetes, if not treated properly, can lead to blindness, amputations, and kidney failure. Although genetics plays a role in the development of obesity, the dramatic rise of obesity and Type II Diabetes among young children is linked to factors associated with altered dietary intake and decreased physical activity, not to genetics.

2. Nutrition and Leisure

In order to reverse the trend of obesity, we have to address the poor eating habits of today's children and adolescents. Frequently, the diet of a typical school-aged child consists of fast-food, sugary snacks, and soda, which are high in fat, calories, and cholesterol, but low in nutrients. Dietary changes over the past 30 years that have led to overweight children are attributed to: the use of a microwave; increased fast food consumption; children skipping breakfast; and the increased consumption of soft drinks.¹⁵ According to the CDC, more than 84 percent of children and adolescents eat too much fat and more than 91 percent eat too much saturated fat. In fact, 40 percent

¹³Presentation by Dr. John Rowlett, Director of Pediatric Emergency Medicine and Community Health Initiatives at St. Joseph/Candler Hospitals in Savannah Georgia, December 12, 2001.

¹⁴Angela Stewart Dewitt, MPH, "Are Kids Becoming Super-Sized?" Your Health, November/December, 2001, p.113.

¹⁵Presentation by Dr. Howell Wechsler with the Center for Disease Control and Prevention, Division of Adolescent and School Health, December 6, 2001.

of the average American family's food budget is spent on food consumed outside of the home.¹⁶ Corporations spend billions marketing their products to children and adolescents, especially the fast-food industry, which is one of the biggest advertisers on television. Interestingly, the National Cancer Institute spends only about \$1 million dollars annually to advertise its 5-A-Day (fruits and vegetables) campaign, whereas, McDonald's spends \$1 billion per year, soft-drink companies spend more than \$500 million, and M&M candies spends \$67 million on advertising.¹⁷

A surprising, often overlooked, negative impact associated with television is that television viewing influences the food choices made by children, who are today spending a significant part of their day sitting in front of a television or a computer. In fact, each hourly increment of television viewing by adolescents has been associated with a 2 percent increase in the overall prevalence of obesity within this age group.¹⁸ Television viewing has been associated with inactivity and a lack of physical fitness, which in turn leads to obesity among children, teenagers, and young adults.¹⁹

The Committee heard testimony and discussed the increased availability of unhealthy snacks and soft drinks in schools. The fact is, school administrators make financially motivated decisions when they allow vending machines to supplement their schools' tight budgets.²⁰ On the other hand, testimony was presented that soft drinks and other beverages have their place in a healthy lifestyle, and that children only need to be taught healthy eating habits because there are no "good foods" or "bad foods," just "good diets" and "bad diets." Furthermore, students have a wide variety of healthy beverages to choose from, including sugar-free and caffeine-free soft drinks, bottled water, juices, sports drinks and teas.²¹ However, it is clear that physical activity, dietary behavior, short term health, and academic performance are interrelated, and therefore, it is essential that children and young adults cultivate healthy eating habits at a young age both in school and at home.

B. Physical Activity and School-Age Children

¹⁶Presentation by Dr. John Rowlett, Director of Pediatric Emergency Medicine and Community Health Initiatives at St. Joseph/Candler Hospitals in Savannah Georgia, December 12, 2001.

¹⁷"Status of Obesity in Georgia 2000," Georgia Department of Human Resources, Division of Public Health, Family Health Branch.

¹⁸Ibid.

¹⁹"When Children's Television Icons Become Advertising Vehicles for Poor Eating Habits," Around the School, Harvard School of Public Health, March 31, 2000, Retrieved February 20, 2001 from <http://www.hsph.harvard.edu/ats/Mar31/mar31_02.html>

²⁰Statement by Dr. Stanley Cohen, with the American Academy of Pediatrics, December 4, 2001.

²¹Statement by Kevin Perry, Executive Director of the Georgia Soft Drink Association, December 11, 2001.

1. Background

Physical activity is defined as any body movement that results in energy expenditure. In contrast, physical education is planned, structured, repetitive, and is designed to maintain or improve fitness.²² Accordingly, several national organizations have guidelines on physical education for school-aged children and adolescents, which is discussed in the next section.

The benefits of physical activity have been well documented. Physical health and fitness are an integral part of high academic achievement, and must be instilled at a young age to create life-long habits. Various data show that replacing physical activity with academic work does not improve academic performance, in fact, physical activity, due to its positive effect on mental health may help increase students' capacity for learning.²³ A sound body enhances a sound mind, which improves a child's mental alertness, academic performance, readiness to learn and enthusiasm for learning.²⁴ The 1996 U.S. Surgeon General's Report on Physical Activity and Health, a landmark comprehensive review on physical activity, unequivocally shows that physical activity contributes to improved self-esteem and lessens symptoms of depression.

Physical activity has also been proven to prevent the development of chronic diseases. Preventing obesity in children is crucial for two reasons: first, obese children and adolescents are more likely to become obese adults; second, discrimination against overweight children often begins early and has a negative long-term effect emotionally and socially. According to one CDC study on children, diet and physical activity resulted in a 58 percent reduction in the progression of Type II Diabetes. Preventing the development of chronic diseases through lifestyle changes is less costly than treating the ensuing diseases at a later stage.

Parents nationwide have become increasingly concerned by the rising rate of inactivity and obesity in children and teens which has coincided with a dramatic drop-off in mandated physical education classes in schools. In fact, parents rate obesity alongside alcohol as the greatest risk to their children's long-term health.²⁵ Another national survey on parents and children regarding physical activity patterns also revealed that about one third of parents said their children are not getting enough physical activity, although 94 percent said that there are supervised programs of sports and physical activities available in their area. In the survey, parents cite lack of interest, competition from television, video games and computers, as the reasons for their children's inactivity, in contrast, the children contend that they do not get enough activity because of homework and lack

²²“How Active are Georgians?” Georgia Physical Activity Report, Georgia Department of Human Resources 2001 Report on Physical Activity.

²³“Promoting Better Health For Young People Through Physical Activity and Sports,” A Report to the President from the Secretary of Health and Human Services and the Secretary of Education, Fall 2000.

²⁴The National Association for Sport and Physical Education Brochure, titled “Maximize your Child's Success, Aim for Balance.”

²⁵Noreen Seebacher, p.1.

of time.²⁶ Although school-age children spend a majority of their time in school, and schools have some responsibility for the health of their students, parents must ensure their children's health through proper nutrition and exercise at home.

2. Recommendations by Various Organizations

- The National Association of Sport and Physical Education (NASPE) recommends that school-aged children accumulate 30-60 minutes of age and developmentally appropriate physical activity on all or most days of the week. The NASPE recommends the following instructional time, which does not include time spent in unstructured play or recess:

Grades K-5: 150 minutes per week/30 minute sessions;
Grades 6-12: 225 minutes per week/45 minutes sessions.

- The National School Boards Association states that, “physical education needs to be offered every day to adequately address the necessary instructional components and provide opportunities for adequate practice and health-enhancing physical activity.”²⁷
- The American Heart Association recommends 30 minutes of moderate intensity activity on most days of the week, and a minimum of 30 minutes of vigorous physical activity at least three to four days per week to achieve cardiovascular fitness.
- The CDC recommends comprehensive daily physical and health education for students grades K-12.

3. Physical Education Requirement in Georgia Schools

Initial physical education requirements in Georgia schools were implemented in the 1920's for military reasons. The required time component was later added in the early 1970's. Georgia law, Section 20-2-142 of the O.C.G.A., authorizes the State Board of Education to prescribe a course of study in health and physical education for all grades and grade levels in public schools, and to establish a minimum time requirement and standards for its administration.²⁸ Until 2001, the rules and regulations of the State Board of Education required physical education curriculum in schools to provide 90 contact hours of instruction at each grade level K-8 which consisted of 30 hours of

²⁶Presentation by Brenda Moore, with the International Life Sciences Institute, September 28, 2001.

²⁷Testimony by Christi Kay, Health and Physical Education Consultant and American Heart Association Board member, December 12, 2001.

²⁸O.C.G.A. Section 20-2-142(c).

health instruction and 60 hours of physical education instruction.²⁹ The comprehensive health and physical education program included instruction in the following areas: alcohol and other drug use, disease prevention, environmental health, nutrition, personal health, growth and development, consumer health, community health, health careers, family living, motor skills, physical fitness, lifetime sports and outdoor education.³⁰ This requirement was, however, revised two years ago in House Bill 1187.

C. Current Law and Concerns

1. Changes to the Physical Education Curriculum due to House Bill 1187

The passage of House Bill 1187, A Plus Education Reform Act of 2000, mandated comprehensive reform in the delivery of education at the pre-kindergarten, elementary, secondary and post secondary levels. The bill revised the instruction time in the core subject areas. Due to this revision, *physical education was removed from the required middle school curriculum in all public schools.* The new law, as stated in Section 20-2-290 of the O.C.G.A., allows local school boards to decide whether to provide physical education classes. In accordance with House Bill 1187, the State Board of Education rule on the Comprehensive Health and Physical Education Program was revised as follows: *K-5 schools must provide a minimum of 90 contact hours of instruction at each grade level in health and physical education; and 6-12 grade schools are authorized to make available instruction in health and physical education.*

The American Heart Association, the CDC, and the Surgeon General's 2010 Objectives for the Nation all concur with the National Association for Sport and Physical Education's minimum recommendation of 30 to 60 minutes of physical education per day for school-aged children during and after school. In Georgia middle schools, beginning with the 2001-2002 school year, the new requirement to teach a minimum of five hours in the core curriculum has encroached on the remaining time in the school day to teach electives or exploratory subjects, which include physical education.

In order to assess the impact of the new requirement on Georgia schools, and the implementation of House Bill 1187, the Georgia Association for Health, Physical Education, Recreation & Dance (GAHPERD) sponsored a survey, Georgia Survey of School Superintendents in 2000. Close to 20 percent of schools responded to the survey, and of those responding, about 90 percent of the K-5 schools anticipated no changes, and 80 percent indicated that they would keep or increase existing physical education teachers.³¹ However, in middle schools, 35 percent said that in 2000 they changed the physical education requirements to comply with House Bill 1187, and another 15

²⁹State Department of Education Rule 160-4-2-.12 (2)(b).

³⁰State Department of Education Rule 160-4-2-.12 (2)(a).

³¹Presentation by Mike Metzler, Kinesiology and Health Department at Georgia State University, December 12, 2001.

percent plan to decrease physical education staff in the 2002-2003 school year. In high schools, 70 percent anticipate no change, 10 percent indicated that they will decrease staffing, while another 10 percent (of metro schools) said that they will increase staffing to accommodate the increased enrollment of students. Georgia's Quality Core Curriculum (QCC) requirement does not allow time for the recommended 30 to 60 minutes of physical education per day for school-aged children. In fact, many schools that realize the importance of physical education are struggling to fund physical education at the local level.

Because of the new requirement for middle schools to teach a minimum of five hours per day in the core curriculum, many schools are struggling to find time in the remainder of the school day to teach physical education. As a result, there is concern that the elimination of health and physical education courses in Georgia could affect federal dollars received by the state, as drug education mandated by the Federal Safe and Drug Free Schools and Communities Fund, is generally taught during many health and physical education courses. Federal dollars from the Federal Safe and Drug Free Schools and Communities Fund, which totaled \$11,594,074 for FY 2001, could be in jeopardy.³²

Although the intent of House Bill 1187 is to improve student academic achievement, health experts believe that this new requirement will contribute to potential weight gain in students, which will negatively affect students' health.³³ In the Middle School Fitness Testing Project 2001, researchers collected cardiorespiratory endurance, body composition, and physical activity data from middle school students throughout Georgia to assess school health fitness. Georgia middle school students report fair physical activity. The average mile run time for Georgia middle school girls and boys was at the 25th percentile or less when compared to the National Children's and Youth Fitness Study (1987).³⁴ Researchers concluded that rather than reduce the amount of physical education in schools, efforts must be made to ensure that physical education remains a daily component of the school curriculum.

D. Lack of Participation by Georgia's Schools for Data Collection

Statistics on Georgia schools are insufficient in comparison with data from other states. Throughout the years, Georgia state schools have failed to participate in information-gathering models. During

³²Georgia Coalition for Physical Activity and Nutrition Position Statement.

³³Statement presented by Dr. Stanley Cohen, Chair of the Committee on Nutrition, American Academy of Pediatrics, December 4, 2001.

³⁴Presentation by Dr. Barry Joyner and Dr. Frank Spaniol with Georgia Southern University and Georgia Southwestern State University, December 12, 2001.

the 1999-2000 school year, DHR's Epidemiology Branch mailed a survey on physical activity programs in Georgia schools to all public school physical education teachers. Few schools, however, responded to the survey, and although further effort was made by district health personnel to increase the responses to the survey, no statewide conclusion could be drawn. Statistics-wise, the only reliable data for Georgia comes from the Women, Infant, and Children (WIC) program.³⁵ WIC data, which represents less than 5 percent of Georgia's child population ages one to five, shows an upward trend in overweight children and obesity from 7.7 percent to 9.4 percent between 1989 and 1999. Although the sample is small, the information gathered is consistent with national data.

The Youth Risk Behavior Survey System (YRBSS) is a national health survey conducted by the CDC through public schools. The YRBS determines the health risk behavior status of youth and young adults. However, Georgia's data has not been included in the CDC's report since 1993 due to inadequate response from its schools. Statewide assistance and incentives could help schools gather the data needed for assessment. Grants of up to half a million dollars are also available from the CDC's Division of Adolescent and School Health (DASH) for data collection and coordinating school health. According to Ms. Christi Kay with the Georgia Chapter of the American Heart Association and the Georgia Association of Health Physical Education Recreation and Dance (GAHPERD), Georgia has not had the infrastructure required to make application for the CDC grant because there is no staff person at the Department of Education to oversee and carry out those functions. Tennessee, Florida, and South Carolina have all been recipients of the CDC grant in past years.

Another assessment tool developed by the CDC is the School Health Index, which assists school personnel identify barriers and opportunities to improving overall school health and provides a system for prioritizing opportunities for improvement. It assesses school health in all areas, including health education, nutrition services, counseling services, family and community involvement, and health promotion for staff.

E. The Need for a Physical Education Coordinator at the State Level

Several years ago, Georgia was ranked as one of the top five states with a well-rounded physical education curriculum and a state-level physical education curriculum coordinator. The position no longer exists. Reinstating this position which oversees the pressing issues of establishing standards and guidelines and coordinating with local boards to produce a physical education curriculum would help Georgia meet or exceed the national standards.

F. Shortage of School Nurses

School nurses play a vital role in child health and community emergency preparedness. School nurses promote health and safety by intervening in actual and potential health problems. They also assist students with disabilities, diabetes, asthma, cerebral palsy, and medication administration. In

³⁵“Status of Obesity in Georgia 2000”, Georgia Department of Human Resources, Division of Public Health, Family Health Branch.

1999, membership in the Georgia School Nurse Association was 200 and increased to over 400 in 2001. Currently, there are approximately 1,000 licensed school nurses, RN's and LPN's in Georgia schools. Approximately, 127 nurses are provided by local public health departments. The current ratio of school nurses to students is 1:1,474, double of what it should be.³⁶ It should be noted that the ratio within school districts varies from 1:441 to 1:31,000. The ratio of school nurses to students must be increased to meet the standard of 1:750, as required by the National Association of School Nurses.

G. The Need for a School Nurse Program Coordinator at the State Level

In addition to the shortage of school nurses, the Department of Education, DOE, has failed to staff a position to coordinate health issues with a counterpart in the Department of Human Resources. Due to this staffing vacuum, issues which could have been addressed between DHR and DOE personnel have gone unresolved. A state coordinator for School Health Services, in collaboration with DHR, would provide training, technical assistance, and ensure timely communication to all schools and school physical education teachers.

III. COMMITTEE RECOMMENDATIONS

- 1. Require health and fitness to be a focus area for school councils, and require an additional health oriented member for each council.** House Bill 1187 created school councils to provide advice, recommendations, and assistance to local boards of education and school leaders, and to represent the community of parents and businesses. Councils are composed of seven members which include the principal as chair, two parents, two teachers, and two business or industry representatives. The eighth member could be the school physical education, health, nutrition, or home economics teacher, the school nurse, or school cafeteria manager, as determined by the local school board. As an alternative, one of the seven members designated by House Bill 1187 could fulfill this role, if that member has a background in health, medicine, nursing, chiropractics, pharmaceutical, dietetics, nutrition, physical education, physical fitness, or a related occupation.
- 2. Create a School Health Advisory Committee.** One of the functions to be carried out by this new School Council member would be to work with school administrators and the school nurse to create and serve on a School Health Advisory Committee. Other members of the School Health Advisory Committee should include: school administrator(s), student leaders (School Council, Beta Club, etc.), school nurse, school cafeteria manager, local community members, parents, and teachers. The first task of the School Health Advisory Committee would be to conduct the School Health Index.

³⁶This data was obtained from three different surveys: a survey of superintendents by the Georgia Health Policy Center; a telephone survey of 96 school district nurses by Children's Healthcare of Atlanta; and a survey of public health school nurses conducted by DHR.

The Georgia PTA expressed concern over mandating one member of the Health Council to have a specific background in health, nutrition, or physical activity. The reason cited was that many existing local school councils are having difficulty recruiting parents and community members to participate in schools, and that the School Health Advisory Committee would also focus attention on a specific issue to the detriment of other issues such as school safety and substance abuse, which might be of more pressing importance locally.

3. **Provide financial incentives to schools to help address top health or fitness priorities identified by the Health Advisory Committee after conducting the School Health Index.**
4. **Fund a state level position within the Department of Education with responsibility for the coordination of the physical education and health curriculum in public schools.** The goal of the coordinator would be to:
 - Form a public/private council to focus on child health;
 - Align the current QBE curriculum for physical education classes with the National Standards for Physical Education established by the National Association for Sport and Physical Education;
 - Create staff development courses and provide statewide training for health and physical education specialists and other educators involved in physical activity initiatives;
 - Create a system of assessment, evaluation, and accountability to promote better practices within the standard curricula; and,
 - Disseminate information and resources to support health and physical education professionals in their work.
5. **Fund a state level position with the Department of Education with responsibility for the coordination of the school nurse program in public schools.** A state coordinator for school nurses in collaboration with DHR would provide training, technical assistance, and ensure timely communication to all schools and school nurses.

The goal of the coordinator would be to:

- Participate on a public/private council to focus on child health;
- Provide statewide training and technical assistance regarding school health and emergency preparedness;
- Create a system of assessment, evaluation, and accountability to promote best health practices within the school setting; and

- Disseminate information and resources to support school nurses in their work.
6. **Increase the number of school nurses in Georgia schools to meet the national guidelines of one nurse per 750 students or one nurse per school.**
 7. **Recommend that the Youth Risk Behavior Survey be conducted in Georgia high schools to allow the state to assess the greatest areas of need and to successfully apply for federal funds to address student health problems.**
 8. **Implement strategies to increase and enhance physical activity in schools.** In the absence of physical education, other means to increase physical activity in the school day should be implemented and carried out within the school setting, either before or after school. Some programs discussed were as follows.
 - (1) The CDC’s Nutrition and Physical Activity Program developed the “Kids Walk-to-School” Program to increase the opportunity for daily physical activity, which could be achieved by ensuring safe sidewalks and pedestrian crossing signals in residential areas and near schools.
 - (2) The 10K-A-Day Program, the goal of taking 10,000 steps in a day. Ten thousand steps is roughly equivalent to the Surgeon General’s recommendation to accumulate 30 minutes of activity most days of the week.³⁷ The goal is to measure one’s steps in a week by using a pedometer (also called digiwalkers), to reach 10,000 steps a day.
 - (3) The “Kids Health” Program which, in partnership with Rollins School of Public Health of Emory University, the CDC, and Children’s Healthcare of Atlanta, provides young people with the information, skills, resources and motivation necessary to assist them in taking responsibility for their own health. Program topics include nutrition and fitness, injury prevention and violence, human growth and development, drug prevention education, and general health. In its first year, Kids Health plans to reach at least 32,500 students in the Atlanta area.³⁸

According to Ms. Brenda Moore with the International Life Sciences Institute (ILSI), the following is an overview of some classroom-based physical activity programs designed to complement physical education programs and reduce periods of inactivity during the school day.

PROGRAM NAME	TARGET GROUP	PROGRAM GOAL	ACCOMPLISHMENTS
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³⁷“Fit Walking Into Your Life: Shoot for 10K a Day” Walking Magazine Pamphlet.

³⁸Kids Health, Inc, The Center for School Health Education Program Outline.

Take 10!	Grades K-5 150 schools in Georgia	Reduce sedentary time by incorporating 10 minutes of physical activity into the school day.	Students enjoy the program, 80 percent of teachers recommend the program. Activities are in the moderate-to-vigorous range. Sustained use after 1 year in 60-80 percent of teachers (3 or more times per week).
SPARK (Sports, Play, and Active Recreation for Children)	Grades 3-6 (Phase 1) Grades K-2 (Phase 2)	Improve the extent to which physical education contributes to achieving the health objectives for the nation. Provide training to teachers to enhance physical education in elementary schools.	Doubled student physical activity during physical education classes. Improved the quality of teaching; maintained for at least 1.5 yrs after the study. Improved academic achievement. Improved sports and activity skills. Improved muscular endurance and cardiorespiratory fitness in girls.
Eat Well & Keep Moving	Upper elementary school-aged children (4 th and 5 th Grade)	Behavior targets include: Increase fruit and vegetable intake, decrease total and saturated fat, increase moderate to vigorous physical activity, decrease television viewing.	4 hours less television time per week, increased fruit and vegetable consumption, decreased total and saturated fat intake. Implemented in 40 of Baltimore's 122 grade schools.
CATCH	Grades 3-5 4 Sites: Texas, Minnesota, California, Los Angeles Follow up in Grades 6-8	Reduce total fat, saturated fat, and sodium content of food served in school to 30 and 10 percent of calories, and 600-1000mg/serving, respectively. Increase the amount of physical education class time that students spend in moderate to vigorous physical activity to 40 percent. Reduce total cholesterol by 5mg/dl (in individual cases).	Increased moderate to vigorous physical activity during physical education, and increased out-of-school vigorous physical activity. No change in fitness. Follow-up in students who participated in first intervention: Self-reported daily intake was identical in control and intervention groups; intervention group self-reported higher daily physical activity; no change in serum cholesterol, and gap is closing between control and experimental schools in follow-up.
Planet Health	Adolescents 6 th & 7 th Grades	Obesity reduction as primary outcome, decrease television viewing, increase fruits and vegetable intake, decrease fat intake, increase physical activity.	Significant reduction in the prevalence of obesity, (defined as BMI and triceps skinfold greater than the 85 th percentile) was observed for girls / none in boys. Effects of intervention on adiposity were largely due to changes in television viewing.

The Committee discussed the need for schools to focus on providing quality physical education programs. Based on the NASPE's recommendations, committee members agreed that a quality physical education program would help students to develop the positive attitudes necessary to help lead productive lives. The program should: (1) be based on the national standards; (2) provide students with a variety of physical activities; (3) feature cooperative as well as competitive activities, and provide the opportunity to practice at different skill levels; (4) meet the needs of all students, especially those not athletically gifted, and assess students on their progress towards achieving personal fitness goals; (5)

encourage and promote a positive environment, and eliminate practices that have the potential to humiliate students; and (6) be taught by certified personnel.

9. Recommendation by the Georgia PTA to continue the Study Committee with additional research in the following areas:

- The impact of the elimination of the middle school health and physical education requirement (data presented during the Study Committee was preliminary.)
- The level and amount of recess offered in elementary schools. Recess which allows students an opportunity for unstructured physical activity is being phased out in some schools.

V. CONCLUSION

Physical inactivity is one of the many challenges facing Georgia's schools. Physical inactivity, along with the alarming trend of rising obesity rates in Georgia, have increased the need for a mandated physical education curriculum in all grades. Prevention is the key to addressing the pressing issues facing schools, the state and the nation. The Committee strongly believes that a state-of-the-art health and physical education curricula based on national standards, as well as support and coordination at the state level are two of the crucial steps necessary to effectively address the problem. The CDC quotes newspaper columnist, Art Popham as saying, "If you think American business struggles to control health care costs now, just wait a few years when today's cholesterol-clogged overweight adolescents join the work force." The need for balance among physical fitness, mental health and acumen is as old as time. Herophilus, physician to Alexander the Great, was quoted in 325 B.C. as saying, "When health is absent, wisdom cannot reveal itself, art cannot become manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied."