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Health and Healthy Lifestyle Habits in Primary Education: An Analysis of Spanish Autonomous Curricular Decrees Under the Current Education Law (LOMLOE)

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Abstract: The Spanish basic education curriculum, specifically the section on primary education, addresses global challenges and recognizes schools as essential in health education. Healthy lifestyle habits are fundamental due to their impact on health and well-being, especially in children. This study analyzes the integration of health and healthy lifestyle habits in Spanish autonomous curricular decrees using a qualitative documentary analysis and a comparative approach with a statistical/descriptive basis. The corpus includes the 17 autonomous curricular decrees derived from the Organic Law 3/2020 (LOMLOE). The data, derived from the 17 autonomous curricular decrees, were examined using lexical and grammatical analyses, then processed with Atlas.ti 23 software. The results reveal that the dimensions and categories related to health and healthy lifestyle habits focus mainly on physical aspects. In common areas or fields, physical education and knowledge of the natural, social and cultural environment are the most relevant areas for integrating health and healthy lifestyle habits into the framework in this study. However, the current curriculum proposal lacks continuity between curricular elements. In summary, this study represents a step forward in the recognition of the extent to which health and healthy lifestyle habits are established in the curriculum.

Keywords: documentary analysis; comparative analysis; curricular continuum; education for health; active and healthy lifestyles; compulsory education; regional curricular decrees; educational legislation; education law

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1. Introduction

Education plays a key role in the development of fundamental skills, attitudes, values, abilities and knowledge in health promotion [1]. The current literature emphasizes this relationship, showing that education is a significant positive determinant of health outcomes [2–17]. Research consistently highlights how education can be used to promote healthy living and general well-being [5,18]. Higher education levels are associated with various positive health outcomes, including lower infant mortality rates, higher rates of childhood immunization, the adoption of healthier lifestyle habits (HLHs) and an extended life expectancy [6,17,19].

The importance of this association has prompted intergovernmental organizations such as the World Health Organization (WHO) and the United Nations Educational, Scientific and Cultural Organization (UNESCO) to address the interdependency between education and health through global initiatives. The WHO, for instance, launched the Health Promoting Schools initiative in 1995, aiming to strengthen health promotion and educational activities at local, regional, national and global levels [20]. Similarly, UNESCO established the Sustainable Development Goals (SDGs) in 2015, with member nations committing to goals including good health (SDG-3) and quality education (SDG-4) as part of the 17 SDGs to be achieved by 2030 [21].

Against this backdrop, many countries have implemented educational legislation and curricular decrees tailored to meet 21st century demands [22–25], with health promotion and HLHs becoming focal points in recent public policy initiatives [6,26–28].

In Spain, the Ministry of Education and Vocational Training and the Ministry of Health, Consumer Affairs and Social Welfare formalized an agreement in 2019 to integrate health education and promotion in schools [29]. This agreement underscores the need for (1) embedding health-related content within the curriculum; (2) promoting health education to encourage healthy lifestyles and life skills; and (3) fostering healthy school environments. Additionally, the approach advocates a comprehensive view of school health encompassing physical, psychological, social and educational aspects [29].

The Organic Law 3/2020, effective since 29 December 2020 (LOMLOE) [30], further reinforces this vision by incorporating health education as a core pedagogical principle across all areas of knowledge, specifically emphasized in the fifth pedagogical principle. This legislation subsequently led to Royal Decree 157/2022, which outlines the organization and essential teachings of primary education, and to various autonomous curricular decrees that now explicitly address health promotion across their provisions.

In previous Spanish education legislation, only general principles were incorporated, with no mention of specific pedagogical principles. Health was addressed solely within the general objectives of the primary education curricula. The Organic Law on the General Organization of the Education System (LOGSE), the Organic Law on the Quality of Education (LOCE) and the Organic Law for the Improvement of the Quality of Education (LOMCE) mentioned a single objective related to health, whereas the LOMLOE addresses it in two objectives (objectives 12 and 14), with the new objective specifically referring to healthy daily habits of active autonomous mobility.

Despite recent analyses of the LOMLOE on topics such as interculturality [31], sustainable development [32–34], arts education [35–37], road safety [38], sex education [39,40] and competences [41–43], research on the impact of Spanish legislation on health education remains limited. Existing studies primarily compare health education policies across contexts, such as between France, Spain and the broader European Union [17,44], and/or analyze shifts across Spanish educational laws [28,45,46]. However, although some of these have studied the autonomous curricular decrees, no comprehensive study has analyzed the common areas or fields (CAoFs) across Spain regarding health or examined primary education CAoFs' curricular elements (specific competences (SCs), basic contents (BCs) and evaluation criteria (EvC)) to evaluate health policy implementation in education.

Therefore, this study, employing a qualitative/descriptive approach, aims to analyze the knowledge domain of health, particularly HLHs, within the curricular elements of Spain's CAoFs in primary education. The following are the specific aims of this study:

- To determine and describe the representation of health and HLHs within the curricular corpus;
- To identify the recurrence of health and HLH dimensions and categories across common areas or fields;
- To determine the curricular coherence (continuum) within the health and HLHs framework.

1.1. The Health and Healthy Lifestyle Habits Framework

Throughout history, the concept of health has evolved significantly, shaped by diverse perspectives and approaches, making it challenging to establish a consistent framework to understand it [47–51]. Until the 1940s, health was seen merely as the absence of physical illness, with an exclusive focus on physical well-being [49,52]. However, in 1948, the WHO introduced a definition that described health as a 'state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity' [53]. This marked a shift towards a holistic and multidimensional view of health [49,54].

In recent decades, the literature has largely endorsed the WHO's multidimensional perspective, with milestones ranging from the Ottawa Charter [3] to studies by Salleras [55], Terris [56] and Devis [57] and, more recently, those by Huber et al. [58], Abachizadeh et al. [59],

Korkut and Demirbas [60], Doyle and Link [50], and van Druten et al. [48]. Nonetheless, this definition has also faced criticism regarding its applicability and relevance across various contexts and populations [47,48,58]. Authors such as Leonardi [47], van Druten et al. [48], Mallee [49], Doyle and Link [50], and Novella-García and Cloquell-Lozano [51] have advocated for a more adaptable and dynamic understanding of health. For example, Huber et al. [58] redefined health as the capacity for adaptation and self-management, while Krahn et al. [61] conceptualized it as a dynamic process involving physical, mental, social and existential well-being, emphasizing adapting to life's conditions and environment. This perspective frames health as a dynamic concept focused on the capacity to adapt to diverse circumstances, emphasizing the health is not static but changes over time. This approach highlights the need to consider health's inherent complexity and to understand the specific definitions associated with its physical, mental and social dimensions.

Under this framework, physical health is understood as optimal functioning in terms of biological, physiological and mental aspects, reflecting the body's capacity to maintain physiological homeostasis amidst changing circumstances [58,62]. Mental health is broadly defined as a state of mental well-being that enables individuals to cope with life's pressures, develop their capabilities, succeed in learning and work, and contribute positively to their communities [63–65]. Good mental health provides the ability to cope with and recover from severe psychological stress and prevent post-traumatic stress disorders [58]. Thus, increased resilience and self-management can lead to improved subjective well-being, as well as a positive interaction between mind and body [66].

Finally, social health is acknowledged as a critical dimension of overall health, alongside mental and physical health [50]. It is defined by these same authors as the balance of both the quantity and quality of relationships an individual maintains within a specific context, fulfilling the essential human need for meaningful connections.

A multidimensional approach requires balancing physical, mental and social health alongside healthy lifestyle choices. Lifestyle choices encompass controllable actions, choices, attitudes, habits and behaviors that define daily living [67–70]. Lifestyle habits are critical to shaping these choices, allowing individuals to engage in health-promoting actions and responses more intuitively without constant planning [71]. Moreover, these habits, often established in early childhood, tend to persist throughout life, underlining the importance of establishing them properly from a young age [16,67,72,73].

Within the health framework, HLHs are defined as a neurological pattern that is initially established through repetition, producing automatic responses that influence health [67,71]. These HLHs provide multiple benefits in cognitive development, memory, attention, self-esteem and health; therefore, there is growing interest in investigating them [74,75]. However, in order to promote HLHs, a clear conceptual definition is essential [71]. Although a definition exists, there is no consensus on the specific elements or habits that constitute HLHs in children. Current research identifies physical activity and nutrition as essential elements or habits [16,76–80], while other critical elements include reduced screen time [81], hygiene habits (hand washing, oral hygiene, sleep hygiene, etc.) [80,82–84] and emotional well-being [63,80].

1.2. The Framework of Spanish Education Legislation

In Spain, the legislation governing primary education has evolved significantly, reflecting the country's social, political, economic and cultural transformations [22,85,86]. This period initiated substantial structural changes, such as the decentralization of curriculum design. With the enactment of the LOGSE, autonomous communities gained the authority to manage and organize educational systems within their respective competences, with the exception of areas under the exclusive competence of the Spanish State [86]. Thus, while the Spanish State retains responsibility for defining the general framework of the education system, the LOMLOE endows autonomous communities with broad competences, including establishing and operating educational institutions, developing curricula aligned with

national standards, managing educational personnel and overseeing the implementation of pedagogical programs and assessments, among others [86].

The evolution of and differences in the health-related general objectives in Spain's educational laws reflect an increasingly comprehensive approach to health in education. With the introduction of the LOGSE, health education became an explicit component of the educational agenda, progressively evolving with each successive law to align with changing social and educational priorities.

The LOGSE [87], enacted in the 1990s, emphasized knowledge and appreciation of one's own body, as well as the adoption of health and well-being habits, underscoring the impact of certain behaviors on health and quality of life, which have an essential place in education.

Moving forward in time, the LOCE [88], although short-lived, highlighted the value of one's own body, stressing hygiene and health and advocating sports as an integral part of personal and social development. This shift reflects a broader focus on sports as a critical component of student development.

Subsequently, the LOE [89] and the LOMCE [90] continued in this direction, promoting hygiene, health, body acceptance and respect for diversity. These laws reinforced the role of physical education and sport as vital tools for personal and social development, signaling an established commitment to health-related values within holistic student education.

The latest reform, the LOMLOE [30], marks a notable development by incorporating nutrition alongside physical education and sport as key elements in promoting personal and social growth. This broadening of the health concept illustrates an increasingly holistic view, recognizing nutrition as fundamental to both health and personal development.

Aligned with these health-focused objectives, the integration of competences into the curriculum has enhanced the promotion of student health. The LOE [89], introduced the concept of basic competences, in line with European Union guidelines, notablly incorporating the 'competence in knowledge of and interaction with the physical world' which emphasized health-related aspects. This competence sought to 'adopt a disposition towards a healthy physical and mental life in a healthy natural and social environment. It also involves considering the dual dimension—individual and collective—of health, and showing attitudes of responsibility and respect towards others and oneself' (p. 14) [89]. These basic competences persisted in the LOMCE [90] but were notably redefined with the publication of the LOMLOE [30], which rebranded "competences" as "key competences". Under this framework, three key competences stand out for their explicit health focus: Mathematical Competence and Competence in Science, Technology and Engineering (STEM 5); Digital Competence (CD 4); and Personal, Social and Learning to Learn Competence (CPSAA 2) [30]. This change not only reinforces the commitment to health education but expands it to address the complex demands and challenges of 21st-century learners [25,91].

These health-focused key competences reflect a holistic understanding of health. Each of them touches on different aspects of the concept of health. Specifically, STEM 5 emphasizes actions that promote health through scientific and ethical principles, encouraging responsible approaches to environment and personal health [30]. CD 4 addresses health from a technological perspective. It recognizes the health risks associated with digital technology use and promotes measures to safeguard physical and mental health [30]. Finally, CPSAA 2 directly targets personal health, advocating for healthy lifestyle choices and the ability to recognize and manage situations that are potentially harmful for physical and mental health [30].

Together, these legislative changes illustrate how Spain has continually adjusted its educational policies to respond to not only foundational educational needs, but also to a deeper understanding of what health implies in the school environment. The progression of objectives, alongside the evolution of competences, demonstrates a sustained effort to adapt the educational system to the dynamic needs of students and society. This advances

an educational approach that values health as integral to education rather than limiting it to academic achievement alone.

2. Materials and Methods

2.1. Design and Corpus

This study employed a qualitative, descriptive scope and non-experimental design [91,92] based on a comparative document analysis [93,94] (Figure 1). Data collection followed a bottom-up/top-down deductive approach whereby information to identify aspects within the health and HLHs framework was analyzed through careful reading and interpretation [95]. Additionally, the research approach inherently incorporates inductive aspects, drawing on the prior expertise of the research team in this domain [96].

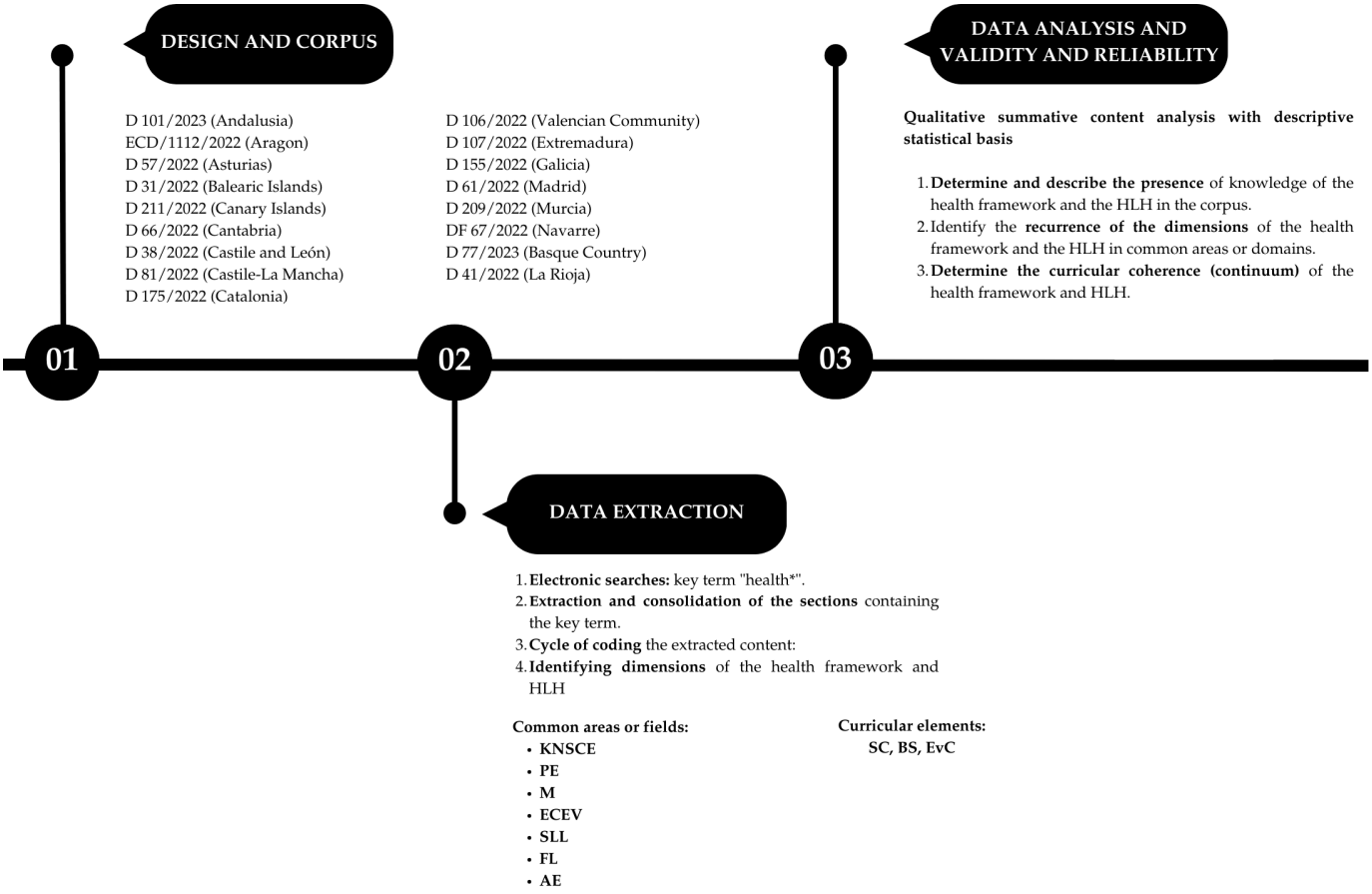

Figure 1. Design of the documentary analysis used in the study. Note. HLHs: healthy lifestyle habits; KNSCE: knowledge of the natural, social and cultural environment; PE: physical education; M: mathematics; ECEV: education in civic and ethical values; SLL: Spanish language and literature; FL: foreign language; AE: art education; SCs: specific competences; BCs: basic contents; EvC: evaluation criteria; *: The asterisk denotes inclusion of all possible endings for the root term.

The analyzed corpus, referred to as ACD-LOMLOE (Autonomous Curricular Documents under the Organic Law of Modification of the Organic Law of Education), comprises 17 autonomous curricular decrees, each corresponding to a distinct autonomous community resulting from Organic Law 3/2020, which modifies the Organic Law of Education (LOMLOE). These communities include Andalusia, Aragon, Asturias, Balearic Islands, Canary Islands, Cantabria, Castile and León, Castile-La Mancha, Catalonia, Valencian Community, Extremadura, Galicia, Madrid, Murcia, Navarre, Basque Country and La Rioja (Figure 1). Document selection adhered to established inclusion criteria, which restricted

the corpus to autonomous communities within Spanish State, and thereby to cities with autonomous status, such as Ceuta and Melilla.

All documents are publicly accessible and meet established standards for corpus analysis, including clear provenance [97], reputation [98], integrity [97], authenticity and representativeness [99].

2.2. Data Extraction

Data were collected through lexical and grammatical analyses and emerged from an inductive/deductive reading of the texts, focusing specifically on the CAoFs of the ACD-LOMLOE texts.

Unlike the previous legislation (LOMCE), the current regulation (LOMLOE) does not categorize areas or fields as core and transversal, but instead presents them as independent domains without classification, that is to say, as areas or fields [30,90]. Consequently, areas such as knowledge of the natural, social and cultural environment (natural sciences and social sciences) (KNSCE); art education (plastic and visual education, and music and dance) (AE); physical education (PE); Spanish language and literature (SLL), as well as, when appropriate, co-official language and literature; foreign language (FL); mathematics (M); and education in civic and ethical values (ECEV) are encompassed. Furthermore, due to the autonomous nature of each educational administration, individual regions have the authority to include additional areas based on specific contextual needs, meaning that not all DCA-LOMLOE documents will provide identical areas or fields.

In order to maintain uniformity among the ACD-LOMLOE of the Spanish territory, data extraction in this study was limited to the CAoFs present in all ACD-LOMLOE documents. Otherwise, it would not be possible to carry out a comparison between the curricula of the autonomous communities that are part of the state. Therefore, the CAoFs under this study include KNSCE, AE, PE, SLL, FL, M and ECEV.

Each CAoF is structured through SCs, BCs and EvC, which constitute the curricular elements. In this line, the SCs link the student's exit profile with their basic knowledge of each area, as well as with the EvC. They represent what students are expected to demonstrate when engaging with basic concepts in each area or field. The EvC, in turn, serve as benchmarks for evaluating student achievement in activities aligned with the SCs. Finally, the BCs comprise the knowledge, skills and attitudes within each area or field, supporting the acquisition of SCs.

To identify health-related content and HLHs within CAoF curricular elements, a structured process was carried out. Initially, electronic searches were conducted using the key term 'salud*' (health) to identify any health-related terms. Irrelevant terms, such as the verb 'saludar' (to greet) and its derivatives, were excluded. Extracted sections containing health-related terms were then coded, with six cycles of coding conducted to organize codes into dimensions (Supplementary Files S1 and S2). This process was carried out in Spanish, given that all the ACD-LOMLOE documents were written in Spanish, and subsequently translated into English [100–103].

From this coding, dimensions and categories were stablished for each framework, facilitating a detailed and structured organization. For data processing, the qualitative software Atlas.ti 23 was employed, and coded fragments were consolidated into Excel spreadsheets, organized by relevant sections.

2.3. Data Analysis, Validity and Reliability

A qualitative summative content analysis based on a descriptive statistical basis was conducted to quantify key concepts (codes) and to identify dimensions and categories within the CAoFs of the ACD-LOMLOE corpus [95,104].

First, the presence of the health and HLHs framework in all curricular elements (SCs, BCs and EvC) of the ACD-LOMLOE CAoFs was identified and analyzed. Each curricular element was systematically coded and iteratively categorized until the final dimensions and categories were established [95]. The frequency (absolute value) of each

dimension's occurrence within each curricular element was recorded to calculate the relative frequency of dimensions and categories across both health (Figure 2) and HLHs frameworks (Figure 3) [104].

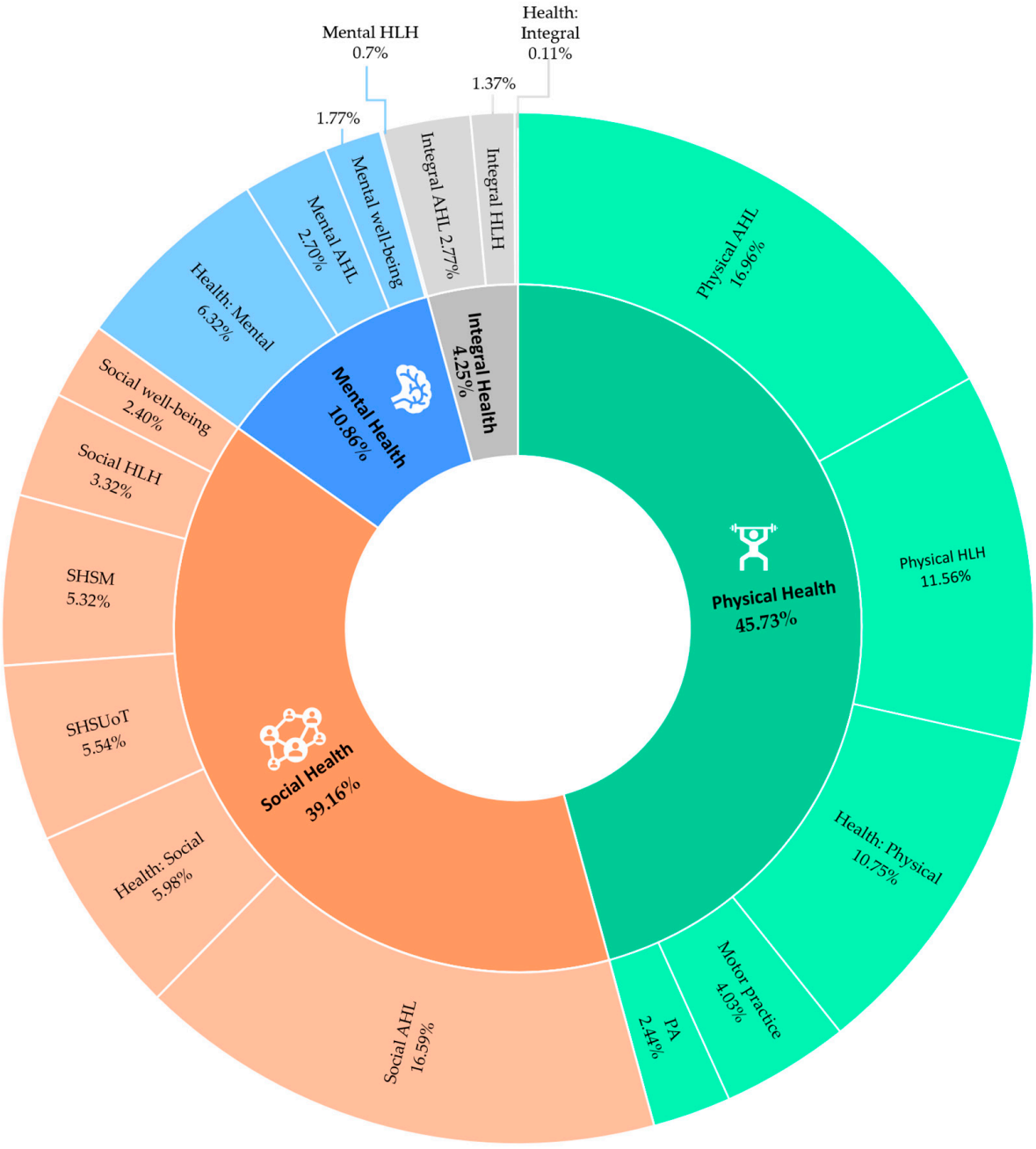

Figure 2. The presence and relative frequency of the dimensions of the health framework. Note: HLHs: healthy lifestyle habits; AHLs: active and healthy lifestyles; SHSM: safe, healthy and sustainable mobility; SHSUoT: safe, healthy and sustainable use of technology; PA: physical activity.

Next, the occurrence of each framework's dimensions and categories was analyzed according to the CAoFs in the ACD-LOMLOE. This analysis involved calculating the relative frequency of the health and HLHs framework dimensions within each CAoF and determining the total relative frequency of curriculum elements across each CAoF. This allowed the study's second objective to be addressed.

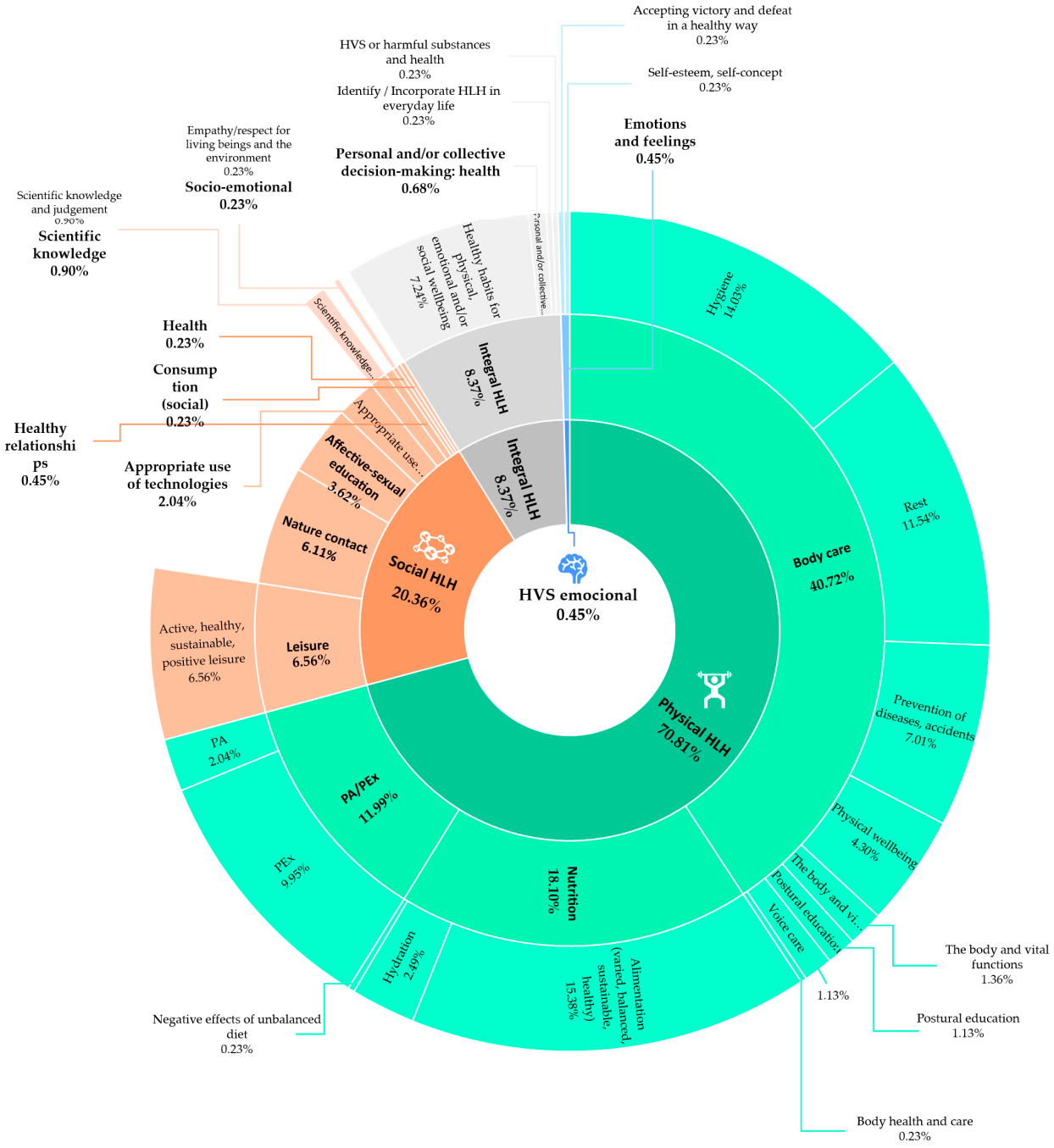

Figure 3. The presence and relative frequency of the dimensions of the HLHs framework. Note: HLHs: healthy lifestyle habits; AHLs: active and healthy lifestyles; PA: physical activity.

Finally, the study examined the curricular continuum of dimensions and categories within the study framework. The curricular continuum refers to the continuity of categories across the three curricular elements. Additionally, the continuum of curricular categories that maintained continuity in at least two of the three elements was also analyzed.

All analyses were conducted with the CAoF as the primary variable for the ACD-LOMLOE. The data were analyzed and visualized using Microsoft Excel.

In this study, coding of the corpus was performed by three researchers, who also triangulated the categorization to ensure validity. Any discrepancies were resolved through consensus. This approach aligns with the strength of qualitative research, validity, which emphasizes the accuracy of findings from different perspectives, such as that of the researcher [92], highlighting the importance of actively incorporating validity strategies [92].

Corpus extraction was carried out using two approaches at different stages. On the one hand, a matrix was created with the contents of all CAoF curricular elements, classified according to CAoF and ACD-LOMLOE. On the other hand, codes relevant to the study framework were extracted into individual Excel sheets. One researcher verified the presence of health-related aspects and HLHs across both extraction methods to confirm the reliability of the results.

3. Results and Discussion

The results have been analyzed according to the following objectives:

- The dimensions and categories in the corpus: the health and HLHs framework;
- The CAoF: the health and HLHs framework;
- The curricular continuum: the health and HLHs framework.

3.1. The Dimensions and Categories in the Corpus: The Health and HLHs Framework

This first section aims to identify the dimensions related to both the health and HLHs framework within the CAoFs of the ACD-LOMLOE.

3.1.1. The Dimensions of the Health Framework

Within the framework of health, four general dimensions are identified—physical, mental, social and integral (Figure 2), which are essential for understanding the influence of various factors on individual health, including the health of children [16,59,81,105–107].

The data reveal a predominant focus on physical health (45.73%), followed by social health (39.16%), mental health (10.86%) and integral health (4.25%). The distribution aligns with the historical conception of physical health, which predominates over the other aspects [49,52]. However, these data also underscore the emergence of a multidimensional perspective of health incorporating social, mental and integral factors (integral health). In this context, the need to address physical, mental and social dimensions of health in an integrated manner within curricular decrees is emphasized. The necessity of this integration is supported by research indicating that early experiences have significant, long-lasting effects on health throughout life [16,18,78].

As shown in Figure 2, these four general dimensions are further associated with 18 specific categories. Active and healthy lifestyles (AHLs) are the most prominent (39.02%), followed by health (23.16%) and HLHs (16.32%), while physical activity (PA) (2.44%) and motor practice (4.03%) appear less frequently.

The results demonstrate the transversality of **AHLs** and **HLHs** across all the dimensions analyzed in this study. Notably, however, the category of well-being is exclusively addressed within the mental and social health dimensions, with no mention in the other dimensions. This omission is significant given evidence of the close relationship between lifestyles/habits and well-being/health [68,105,108]. It is surprising that these three categories do not appear consecutively or do not have the same impact across all dimensions, especially since, as Ródenas-Munar et al. [68] point out, maintaining a healthy lifestyle is crucial for supporting well-being and reducing future health risks. These findings highlight the importance and need of a holistic approach that recognizes the interconnectedness of AHLs, HLHs and well-being in health promotion within education.

Regarding the other dimensions, within the **physical health** dimension, **PA** and **motor practice** stand out as essential categories. Numerous studies support the multifaceted benefits of PA for children's health, including mental benefits such as reduced levels of depression and anxiety, improved self-esteem, enhanced executive and cognitive functioning, and better academic performance [63,109–112]. In addition, physical benefits include a decreased risk of metabolic syndrome, lower adiposity, reduced cardiovascular disease risk, and increased aerobic capacity and muscle strength [106,113]. Social benefits have also been documented, such as improved social and language skills and stronger social support networks [114,115]. Collectively, this evidence underscores the importance of promoting PA and motor practice for not only the physical health but also the mental and social health

of children. Integrating PA programs into the educational environment emerges as a key strategy to enhance students' overall well-being [26]. This approach advocates for a holistic perspective on health promotion within schools, recognizing the interconnected benefits PA offers across multiple areas of child development.

In the **social health** dimension, categories such as safe, healthy and sustainable mobility (**SHSM**) and safe, healthy and sustainable use of technology (**SHSUoT**) are well supported by scientific evidence. Research highlights the benefits of active, healthy modes of transport, such as walking or cycling, for both mental and physical health [116–118]. For example, Aznar et al. [119] highlight the need to promote walkable environments in Spanish neighborhoods, recognizing walking as an effective strategy to promote PA. Thus, integrating SHSM content into the curriculum is essential for developing educational programs that encourage safe and healthy mobility, ultimately contributing to the improved health and well-being of children.

Regarding the **SHSUoT**, numerous studies have identified health risks associated with inappropriate device use in children. These include obesity, overweight, and sleep disorders such as inadequate sleep, poor sleep quality and excessive daytime sleepiness [72,82,120]. In Spain, a study examining trends in PA and screen time from 1997 and 2017 reported increased physical inactivity and screen exposure among children [121]. Additional research on the Spanish population further indicates that prolonged screen time negatively impacts sleep quality and reduces PA levels in children [27,72]. Similarly, another study observed an association between excessive screen time and unrestricted access to devices [73], suggesting the need for moderated or restricted use as recommended by Royal Decree 157/2022 [30]. These findings underscore the importance of addressing SHSUoT in educational curricula, promoting a balanced approach between screen time and PA, and implementing educational programs that foster responsible technology use.

Both dimensions—mobility and technology—require targeted educational strategies that respond to the specific needs and challenges of today's children.

Finally, despite growing recognition of the importance of mental health, evidenced in numerous studies [63,65,105,122], school curricula often do not reflect this priority, tending to emphasize physical or social aspects of health over mental health. This discrepancy highlights the need to review and adjust educational curricula to ensure an equal emphasis across all health dimensions, supporting a more comprehensive approach.

3.1.2. The Dimensions of the HLHs Framework

In the HLHs framework, as in the health framework, physical, mental, social and integral dimensions are identified (Figure 3). In this case, the physical domain—encompassing physical habits—predominates, accounting for 70.81%, followed by social habits, with 20.36%. Notably, within this framework, integral habits are more prominent (8.37%) than mental habits, which constitute only 0.45%.

Specifically, in the **physical HLHs** dimension, which constitutes 70.81%, **body-care**-related aspects are predominant. These include rest, body and postural hygiene, physical well-being, accident and illness prevention, the body and its vital functions, voice care, and postural education. These findings align with those of Montero-Pau et al. [28], who observed that both the LOE and the LOMCE frameworks had a limited emphasis on hygiene, despite this being a critical stage for developing hygienic behaviors.

In addition to body care, **nutrition** and **physical activity/exercise** (**PA/PEx**) are two other categories identified as physical HLHs. These have been widely researched as factors to be considered in the promotion of HLHs in children [16,123,124]. In the context of curricular decrees, it is essential to consider the updated WHO guidelines on PA for this age group, which emphasize the importance of regular, moderate and vigorous PA for improving both physical and mental health in children [125]. Regarding nutrition, concepts such as hydration and nutrition have been the focus of attention in several systematic reviews and studies, particularly those focusing on interventions aimed at improving student health [79,123,126–128].

In the **social HLHs** dimension (20.36%), **contact with nature** and **leisure** emerged as the most frequent dimensions. Regarding **contact with nature**, incorporating it into the school environment seems to provide multiple benefits for children's health and learning. Research shows that exposure to nature increases PA levels, enhances academic performance (facilitates the transfer of knowledge to practical situations, increases students' motivation to learn, etc.), promotes social skills and relationships (self-esteem, self-confidence, trusting relationships, a sense of belonging, and speech, language and communication skills), and contributes positively to mental health [129–134].

In terms of **leisure**, systematic reviews, including those by Eime et al. [135] and Hulteen et al. [136], consider PA as a form of leisure, particularly emphasizing the benefits of team sports for physical, psychological and social health. These findings support promoting community sports as a valuable form of PA during children's leisure time.

Lastly, the category of **emotions** and **feelings**, corresponding to **mental HLHs** (0.45%), is less frequently mentioned in the curricula. Prior research, including studies by Zalve and Talavera [137] and Sáenz and Medina [138], highlights the limited integration of emotional education within the curriculum. These studies emphasize the importance of embedding emotional education across all subjects, given that curriculum content directly influences classroom instruction. Consequently, school curricula should prioritize emotional education, as numerous studies highlight the critical role of developing these skills from an early age [63,65,105,122].

3.2. Common Areas: The Health and HLHs Framework

This second section aims to analyze the dimensions and categories associated with the health and HLHs framework within the CAoFs of the ACD-LOMLOE, considering the curricular elements (SCs, BCs and EvC).

3.2.1. The Health Framework in Common Areas or Fields

PE (48.87%) and KNSCE (37.42%) are the CAoFs that encompass the most health-related aspects and are the only areas addressing all health dimensions. AE omits the social health dimension and includes the fewest health-related aspects (0.41%), while ECEV and M focus solely on social health aspects (Figure 4) (Supplementary File S3).

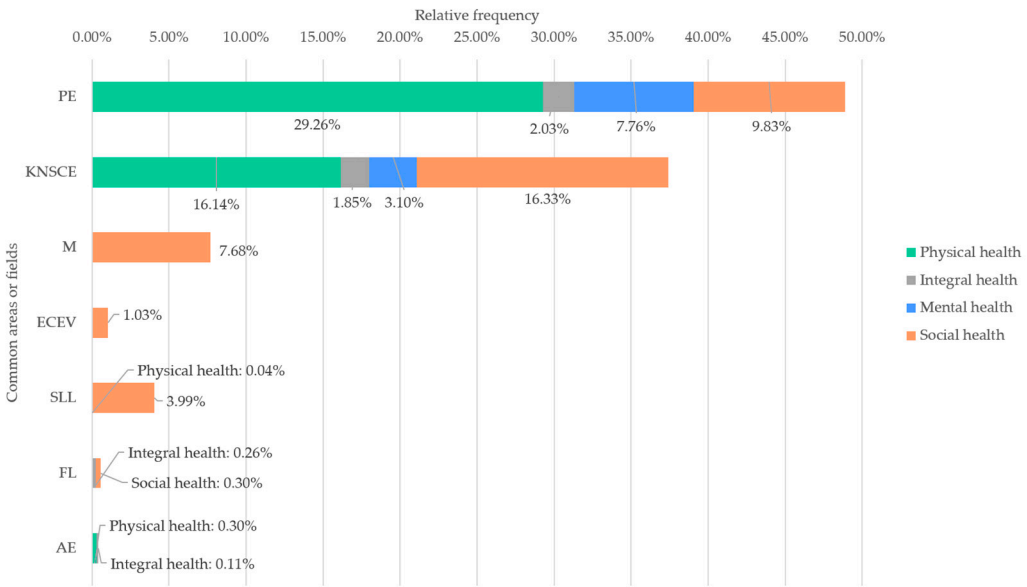

Figure 4. Relative frequency of the dimensions related to the health framework according to the CAoFs of the ACD-LOMLOE. Note: PE: physical education; KNSCE: knowledge of the natural, social and cultural environment; M: mathematics; ECEV: education in civic and ethical values; SLL: Spanish language and literature; FL: foreign language; AE: art education.

3.2.2. The HLHs Framework in Common Areas or Fields

KNSCE (77.83%), PE (21.04%) and AE (1.13%) are the only CAoFs that include aspects related to HLHs. It is noteworthy that KNSCE not only presents the highest frequency of HLHs but also covers the greatest diversity of dimensions associated with these habits. In contrast, AE has both the lowest presence and the least diversity in HLHs dimensions (Figure 5).

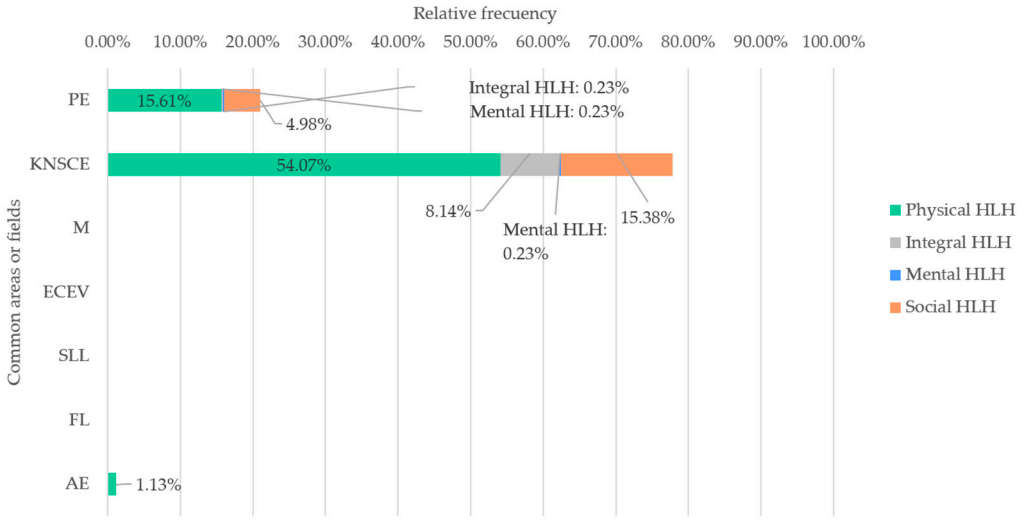

Figure 5. Relative frequency of the dimensions related to the HLHs framework according to the CAoFs of the ACD-LOMLOE. Note: PE: physical education; KNSCE: knowledge of the natural, social and cultural environment; M: mathematics; ECEV: education in civic and ethical values; SLL: Spanish language and literature; FL: foreign language; AE: art education.

At the national level, PE and KNSCE emerged as the CAoFs with the highest degree of relevance within the health and HLHs frameworks. This finding aligns with the conclusions of Montero-Pau et al., who identified these areas as central to health education when comparing the LOE and LOMCE frameworks [28].

Several studies support the role of **PE** in promoting healthy habits and lifestyles, overall health, and cognitive and individual skill development [139–141]. Ramires et al. conducted a review [141] of PE's benefits for children's health and identified positive impacts across physical, social, cognitive and affective levels. These align with the health dimensions included in PE within the LOMLOE, which addresses physical, mental, social and integral health, alongside mental and integral HLHs dimensions.

For **KNSCE**, López and Felices [142] argue that it should help students to understand social realities and address critical issues. In line with WHO guidelines and other studies, children today face global health challenges, including inactivity and sedentary behavior, and non-communicable diseases like type 2 diabetes, hypertension, and social and psychological problems, among others [119,143,144]. This urgency is reflected in the inclusion of all health and HLHs dimensions within KNSCE under the LOMLOE. However, López and Felices [142] note that primary school teachers in Almería tend to prioritize content such as the environment, gender equality and family violence over public health and HLHs. This finding raises questions about how teachers prioritize curricular content and whether they are really addressing all the content or BCs in this area.

These results suggest that health education still lacks a fully transversal approach, with PE and KNSCE remaining the primary carriers of health-related content. Although Montero-Pau et al. [28] highlighted the importance of **ECEV** in health education, our findings show that ECEV ranks fifth in health-related content, following PE, KNSCE, M, and SLL, and is not present within the HLHs framework.

Alongside PE and KNSCE, **AE** is also linked to the health and HLHs framework, specifically in addressing aspects of physical and integral health, as well as physical HLHs.

This contrasts with Navarro's findings, which underscore art's potential for regulating psycho-physical states and fostering critical thinking [145]. This result suggests that artistic disciplines impact not only physical health but may also contribute to mental health, expanding one's perspective on and understanding of the interaction between artistic disciplines and health.

All the other CAoFs (**SLL**, **FL**, **M** and **ECEV**) reference the social health dimension, with SLL also including physical health. While previous studies, such as Montero-Pau et al.'s study, found no relationship between health education and the CAoFs of SLL, FL and M, this study reveals how the new educational law places greater importance on health education [28]. As noted in this study's introduction, the LOMLOE's fifth pedagogical principle stresses the importance of promoting health education across all knowledge areas or fields [30]. In this context, the language-focused areas are associated with SHSUoT, while ECEV aligns with SHSM. Notably, all CAoFs except SLL include references to AHLs, underscoring the transversal role of health across the curriculum [26,145,146].

3.2.3. The Health and HLHs Framework in the CAoF Curriculum Elements

At the national level, 5.60% of the SCs, 3.38% of the BCs and 5.26% of the EvC refer to aspects related to the health and HLHs framework.

Analyzing the distribution of these health-related (Figure 6) and HLH-related aspects (Figure 7) across curricular elements reveals notable differences between the frameworks. Specifically, only 4.69% of the health aspects and 4.30% of the HLH aspects are integrated into the SCs. In contrast, the majority of these aspects appear in the BCs and EvC, with 50.57% and 44.74% for health, and 47.74% and 47.96% for HLHs, respectively. This distribution underscores the greater emphasis on health and HLHs frameworks within knowledge-based and evaluative curricular elements compared to SCs.

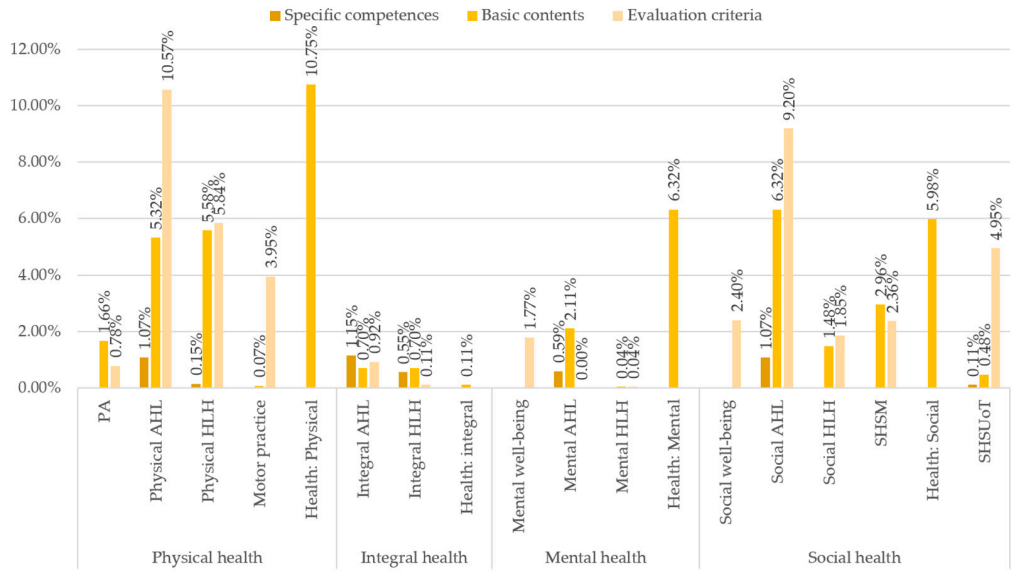

Figure 6. Relative frequency of the health framework in the curricular elements (SCs, BCs and EvC). The presence and relative frequency of the dimensions of the HLHs framework. Note: SCs: specific competences; BCs: basic contents; EvC: evaluation criteria; PA: physical activity; HLHs: healthy lifestyle habits; SHSM: safe, healthy and sustainable mobility; SHSUoT: safe, healthy and sustainable use of technology.

Regarding CAoFs, PE exhibits the highest absolute percentage of aspects related to the study framework across all curricular elements (2.10% SCs, 2.29% BCs and 1.86% EvC), followed by KNSCE (1.87% SCs, 0.9% BCs and 1.71% EvC) and mathematics (1.63% SCs, 0.00% BCs and 0.79% EvC) (Figure 8). However, when examining the relative frequency within each area, mathematics (10.14%) shows a higher percentage in SCs compared to the

KNSCE (8.89%) (Figure 9). Although the remaining CAoFs do not include aspects related to the study framework within the SCs, they do incorporate them within other curricular elements. Supplementary Files S4 and S5 provide detailed information on the presence of health and HLHs framework aspects in each CAoF according to curricular elements.

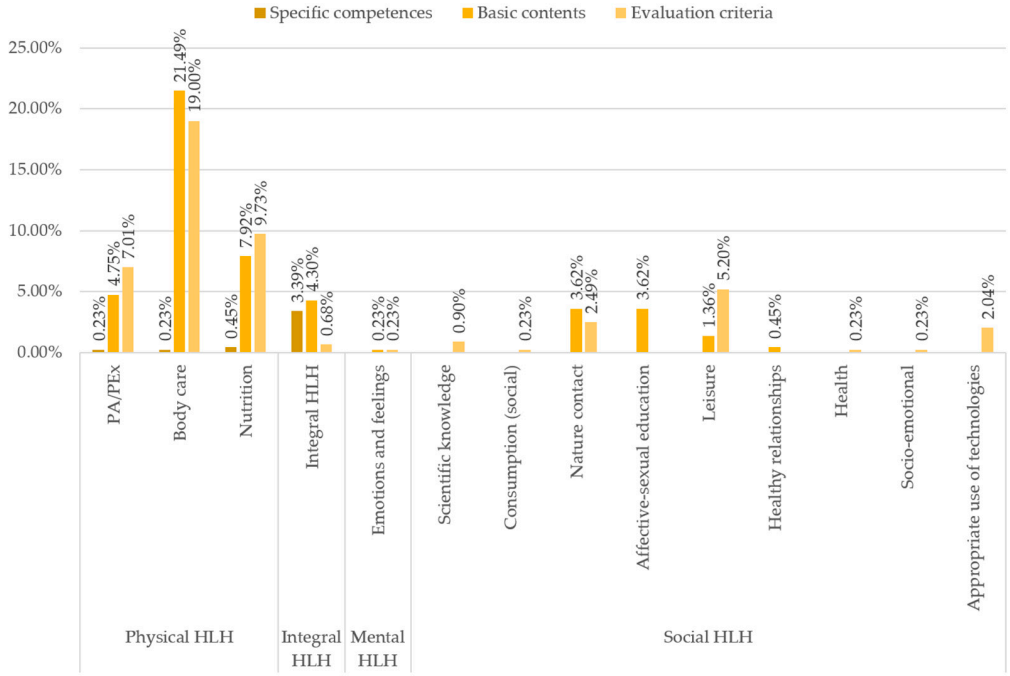

Figure 7. Relative frequency of the HLHs framework in the curricular elements (CSSC, BCs and EvC). Note: SCs: specific competences; BCs: basic contents; EvC: evaluation criteria; PA: physical activity; HLHs: healthy lifestyle habits.

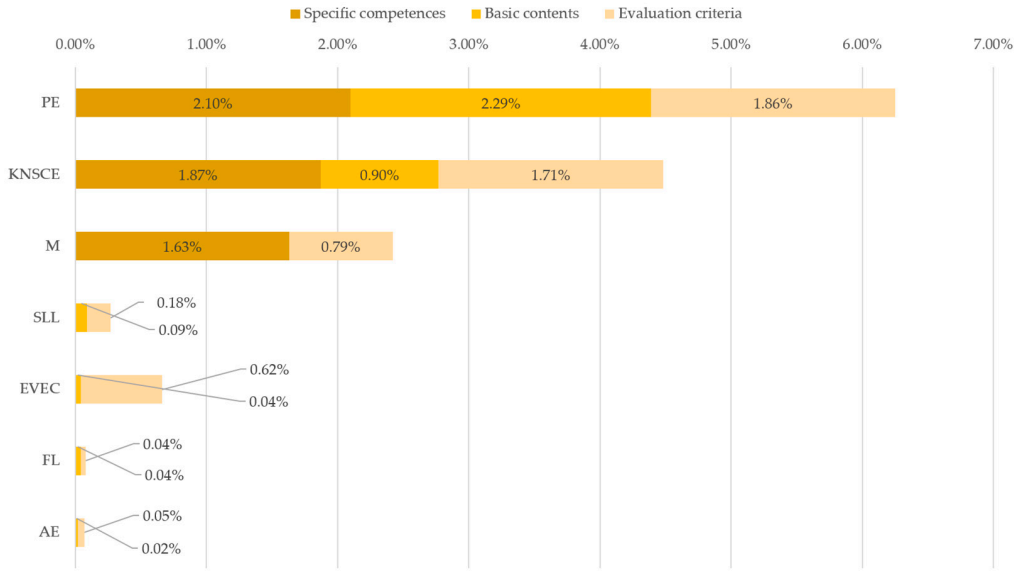

Figure 8. Total relative frequency of each CAoF based on the SCs, BCs and EvC related to the health and HLHs framework. Note: CAoF: common area or field; SCs: specific competencies; BCs: basic contents; EvC: evaluation criteria; HLHs: healthy lifestyle habits; PE: physical education; KNSCE: knowledge of the natural, social and cultural environment; M: mathematics; ECEV: education in civic and ethical values; SLL: Spanish language and literature; FL: foreign language; AE: art education.

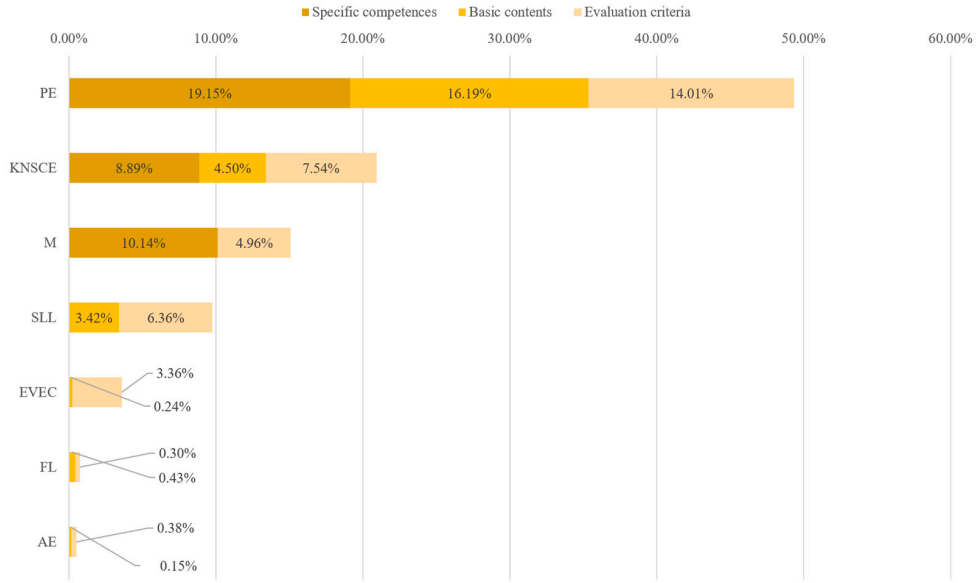

Figure 9. Relative frequency of each CAoF based on the SCs, BCs and EvC related to the health and HLHs framework. Note: CAoF: common area or field; SCs: specific competencies; BCs: basic contents; EvC: evaluation criteria; HLHs: healthy lifestyle habits; PE: physical education; KNSCE: knowledge of the natural, social and cultural environment; M: mathematics; ECEV: education in civic and ethical values; SLL: Spanish language and literature; FL: foreign language; AE: art education.

3.3. Curriculum Continuum: The Health and HLHs Framework

After identifying the presence of the health and HLHs framework within the curricular elements of the CAoF, the continuum of the identified categories related to the health framework (Supplementary File S6) and HLHs framework (Supplementary File S7) was analyzed.

3.3.1. Health Framework Curriculum Continuum

Within the health framework, the curricular continuum is predominantly observed in the CAoF of PE and KNSCE (Supplementary File S6). Specifically, the KNSCE area demonstrates complete curricular integration in the dimensions of physical health—through physical HLHs—and social health, represented by SHSUoT. In contrast, the PE area maintains this continuum primarily within the physical health dimension, represented by the physical AHLs (Figure 10).

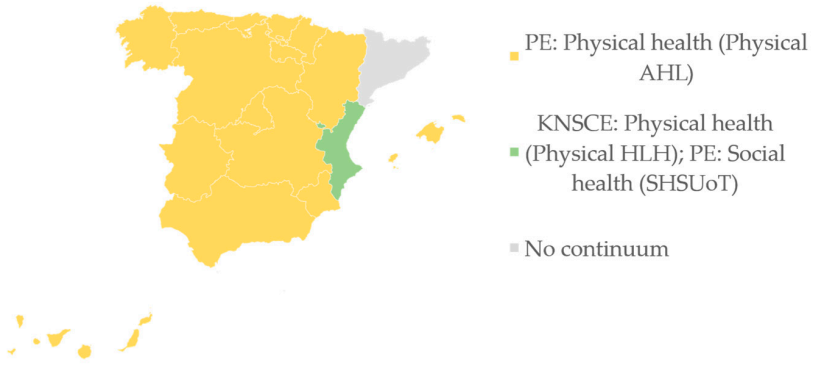

Figure 10. Typology of ACD-LOMLOE which maintains a complete curricular continuum in the dimensions related to the health framework in the CAoFs. Note: ACD-LOMLOE: regional curriculum decree in the LOMLOE; CAoF: common area or field; PE: physical education; KNSCE: knowledge of the natural, social and cultural environment; AHLs: active and healthy lifestyles; HLHs: healthy lifestyle habits; SHSUoT: safe, healthy and sustainable use of technology.

Although a complete continuum is not observed in the CAoFs of KNSCE, PE, SLL and ECEV, coherence and continuity have been observed in some categories between at least two of the curricular elements. In this context, PE stands out as the only area that demonstrates coherence across all health dimensions, underscoring its integral role in health promotion. KNSCE maintains this coherence within the physical and social health dimensions, whereas SLL and ECEV focus solely on the social health dimension. Consequently, 14 ACD-LOMLOE typologies maintain curricular coherence in relation to the health framework within their CAoFs (Figure 11).

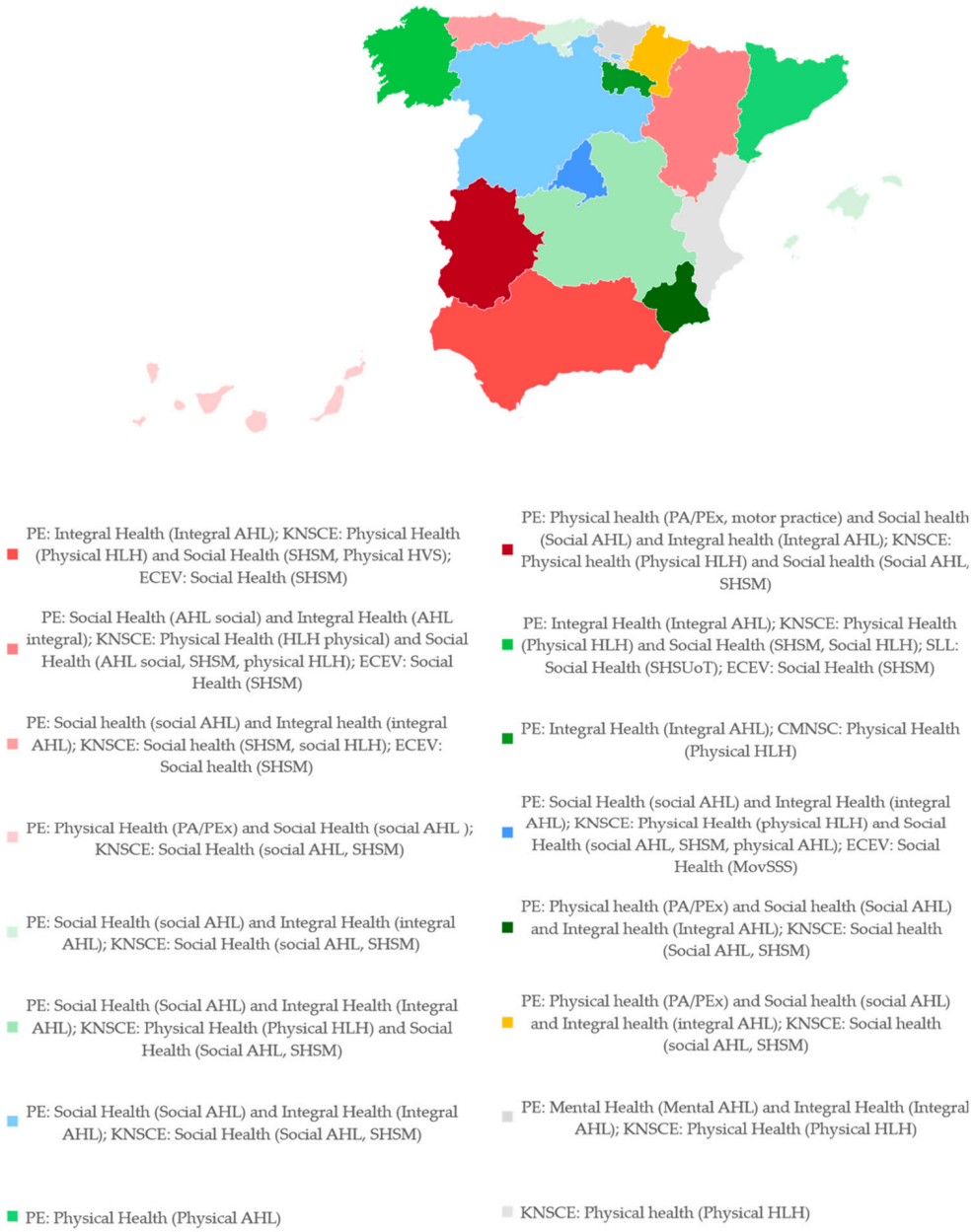

Figure 11. Typology of ACD-LOMLOE which maintains coherence and continuity between categories in at least two of the curricular elements related to the health framework in CAoFs. Note: ACD-LOMLOE: regional curriculum decree in the LOMLOE; CAoF: common area or field; PE: physical education; KNSCE: knowledge of the natural, social and cultural environment; SLL: Spanish language and literature; ECEV: education in civic and ethical values; AHLs: active and healthy lifestyles; HLHs: healthy lifestyle habits; SHSM: safe, healthy and sustainable mobility; SHSUoT: safe, healthy and sustainable use of technology; PA/PEx: physical activity/physical exercise.

3.3.2. Curricular Continuum of the HLH Framework

In the HLHs framework, the curricular continuum is exclusively observed in the KNSCE area, specifically within the Valencian community (Supplementary File S7). This autonomous community maintains coherence in physical HLHs, with aspects related to PA/PEx habits, body care and nutrition mentioned in SCs, BCs and EvC (Figure 12).

Figure 12. Typology of ACD-LOMLOE which maintains a full curricular continuum in the dimensions related to the framework of HLHs in CAoFs. Note: ACD-LOMLOE: regional curriculum decree in the LOMLOE; CAoF: common area or field; HLHs: healthy lifestyle habits; KNSCE: knowledge of the natural, social and cultural environment; PA/PEx: physical activity/physical exercise.

Analyzing the coherence between BCs and EvC or between SCs and EvC reveals their presence in the areas of PE and KNSSC. In KNSCE, coherence is evident across all categories within the physical HLHs dimension, as well as in the social HLH categories of contact with nature and leisure. In PE, coherence is observed in the integral HLH category and in the physical HLH categories of body care and nutrition.

Seven typologies of ACD-LOMLOE are identified that demonstrate curricular coherence in their CAoFs: (1) physical HLHs (PA/PEx, body care and nutrition) and social HLHs (contact with nature) in KNSCE; (2) physical HLHs (PA/PEx and body care) in KNSCE; (3) physical HLHs (body care and nutrition) in KNSCE; (4) physical HLHs (body care and nutrition) in PE; (5) physical HLHs (PA/PEx, body care and nutrition) in KNSCE; (6) physical HLHs (PA/PEx, body care and nutrition); and social HLHs (leisure) in KNSCE; and (7) physical HLHs (PA/PEx, body care and nutrition) in KNSCE and physical HLHs (body care and nutrition) and comprehensive HLHs in PEx (Figure 13).

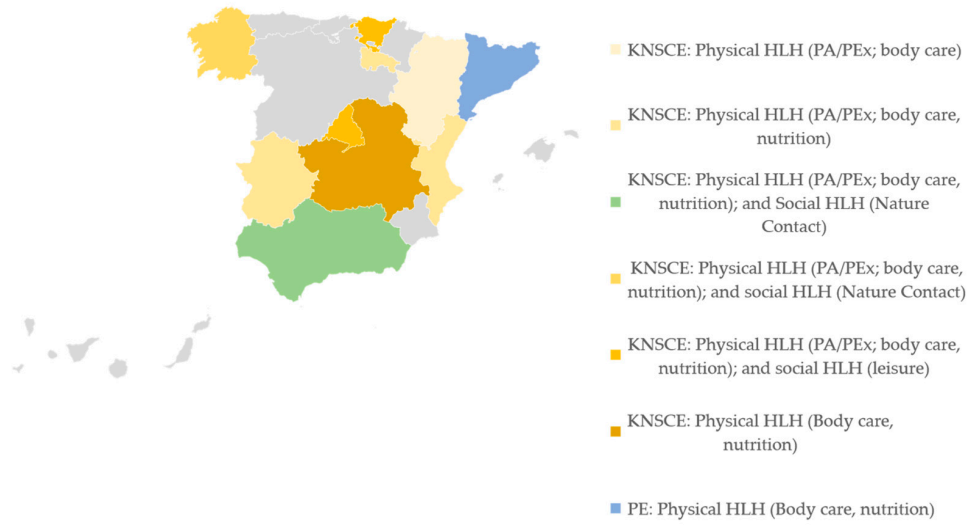

Figure 13. Typology of ACD-LOMLOE which maintains coherence and continuity between categories in at least two of the curricular elements related to the HLHs framework in CAoFs. Note: ACD-LOMLOE:

autonomous curricular decree in the LOMLOE; CAoF: common area or field; PE: physical education; KNSCE: knowledge of the natural, social and cultural environment; HLHs: healthy lifestyle habits; PA/PEx: physical activity/physical exercise.

4. Limitations

This study presents a series of limitations that require consideration. On the one hand, cases were detected in which synonyms were used to refer to concepts related to the health and HLHs framework, without considering the differences in their meanings. For example, several of the ACD-LOMLOE indistinctly used terms such as styles, habits, behaviors, conduct and decision making, although these are not actually synonyms. This issue of terminological interpretation was also identified in another study conducted by Vicente-Nicolás et al. [36].

In addition, the search method focused on the term "salud*" (health in English) in order to identify the health and HLHs knowledge framework established by the Spanish educational legislation LOMLOE [30]. One of the study's objectives was to find the dimensions and categories related to the framework of health and HLHs. However, after analyzing these dimensions and categories, it was identified that this search may not have provided a complete representation of the health and HLHs framework. This is because there are instances where aspects related to health or HLHs are addressed without explicitly using these terms. An example of this is mental health, which may be included in the curriculum without being explicitly labeled as such. In other words, emotions and feelings are addressed, but without directly referring to mental health. Therefore, it would be interesting for future research, building on the framework created by this study, to analyze aspects related to these dimensions and categories in the ACD-LOMLOE. This approach would allow for a more precise understanding of all the elements related to the study frameworks and enable a more accurate definition of the presence of health and HLHs in the ACD-LOMLOE.

On the other hand, an additional limitation of this study is that the representation of certain aspects is not always significant, appearing in only one or two of the ACD- LOMLOE. Furthermore, this research has focused only on the CAoFs of the ACD- LOMLOE, and therefore, does not provide a comprehensive view of the state of the health and HLHs framework in the primary education curriculum. For example, it is possible that some of the ACD-LOMLOE, such as those of the Canary Islands and La Rioja, which include areas or fields dedicated to emotional and creativity education, reflect a broader integration of the study framework.

Finally, although this study aimed to analyze the reality of the health and HLHs framework in the CAoFs of Spanish territories according to the latest primary education law in force, we acknowledge that it has not covered the entire curricular spectrum.

In light of these limitations, it would be interesting for future research to focus on the presence of this framework in the primary education cycles in order to determine whether there are differences in the acquisition of aspects related to health and HLHs according to the educational stage. In addition, it would be interesting to investigate the variability in the integration of the health and HLHs framework among different DCA-LOMLOE documents and how this diversity affects educational and health equity. An additional future research direction could involve replicating this study within the curricula of other countries. Such a comparative analysis would offer a broader understanding of the role of health and HLHs in primary education internationally and could provide insights into the societal adherence to these health-promoting habits. Likewise, it would be essential to address the methodological limitations observed in this study, such as the analysis of all curricular areas or fields of Spanish educational legislation.

5. Practical Implications

This study provides valuable insights into how health and HLHs are being promoted in the context of primary education. By understanding the specific dimensions and categories that encompass both health and HLHs, teachers will be better able to focus their efforts on promoting health and HLHs. Additionally, the study examines the presence of health and HLHs in common areas of primary education, which will facilitate a more integrated and cross-disciplinary approach to teaching health and HLS in schools. While the study reveals that physical education is the area in which health and HLHs are most frequently addressed, it also highlights opportunities to incorporate health education into other areas of the curriculum. This broader perspective allows for a more comprehensive and cross-cutting approach to addressing health and HLHs in the education system.

6. Conclusions

First of all, this work presents an in-depth analysis of the inclusion of concepts of health and HLHs in the Spanish educational legislative framework in the CAoFs of primary education. Indeed, this analysis represents a significant step forward in recognizing the extent to which health education is established as a core axis in the curriculum. In this regard, the analysis reveals the conditions in which this axis is deployed through the different curricular elements (SCs, BCs and EvC).

Thus, we conclude that there is a clear prevalence of physical aspects in both the overall health and HLHs framework (with the social domain emerging in the background), with less attention given to health and mental HLHs. This reflects a traditional understanding of health. However, the inclusion of the mental, social and integral domains indicates progress in defining the dimensions and categories of the health framework and, specifically, HLHs.

Secondly, the study reveals that the AHLs and HLHs constitute two elements with significant importance in the health framework. The presence of HLHs is particularly noteworthy, as they are represented in the four identified dimensions: physical, mental, social and integral. In physical HLHs, PA/PEx, body care and nutrition prevail, while in mental HLHs, emotions and feelings are predominant. Social HLHs take on several dimensions: scientific knowledge, substance consumption, contact with nature, affective-sexual education, leisure, healthy relationships and health (social health, socioemotional health and the appropriate use of technologies). Lastly, integral HLHs do not indicate any additional dimension.

Thirdly, regarding CAoFs, it is observed that PE and KNSCE constitute the two preponderant spaces in the integration of the health and HLHs framework. However, in the rest of the CAoFs, they are still very minor concepts. Therefore, from this study, we conclude there is a need to review and strengthen the transversality of health education in the school curriculum, with the aim of ensuring a more equitable coverage of aspects related to the health and HLHs framework of all CAoFs in Spanish legislation. This transversal perspective on health can have a positive impact on the promotion of HLHs and on the comprehensive training of primary school students, as it can contribute to a more complete and well-being-focused education.

Fourthly, this study concludes that the current curricular proposal does not exhibit a continuum that ensures logical coherence from the SCs to the EvC for the analyzed dimensions and categories. This situation underlines the need to review the primary education curricular legislation in Spain.

In summary, this study highlights the strengths and gaps within the Spanish primary education curriculum regarding the integration of health and HLHs. Our findings call for a more balanced and transversal approach to health education across all curricular areas, ensuring that health and HLHs are consistently and comprehensively addressed throughout the curriculum. This approach would not only improve the curricular coherence of the health dimensions and HLH categories within the curriculum, but it would also

contribute to the integral development of students, providing them with the knowledge and skills necessary for good health and well-being throughout their lives.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/educsci14111220/s1, Supplementary File S1: Definition and examples of the dimensions and categories related to the health framework in the curricular elements of the common areas of the DCA-LOMLOE.; Supplementary File S2: Codes of the dimensions and categories related to the HVS framework in the curricular elements of the common areas of the DCA-LOMLOE.; Supplementary File S3: The dimensions and categories of the health framework according to common areas or fields.; Supplementary File S4: Presence of the health framework in common areas or fields according to curricular elements.; Supplementary File S5: Presence of the HLHs framework in the CAoF according to the curricular elements.; Supplementary File S6: Curricular continuum of the health framework.; Supplementary File S7: Curricular continuum of the HLHs framework.

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Conflicts of Interest: The authors declare no conflicts of interest.

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