

# School Health Education Primer

## FOREWORD

Understanding school health education can be helpful in advancing sexuality education in public schools because sexuality education is often, though not always, a part of a broader health education curriculum and/or coordinated school health program.

This primer is intended to provide an overview of the public schools' role in health education, the relationship between school health and sexuality education, existing infrastructure to advance health education, and federal involvement and funding to support health education. It also offers a guide to understanding school health at the state and local levels given the wide variation that exists not only from state to state but also school district to school district in the same state.

## BACKGROUND

From the earliest days of formal education, public schools were recognized as important vehicles for promoting health.<sup>1</sup> When public education became a requirement in the mid-1800's, schools became the primary delivery mechanism for treating and informing children and their families about infectious diseases and physical "defects" (which, at the time, included vision and hearing impairment). These efforts, in concert with medical advances (e.g., antibiotics and vaccinations), were so successful that school health education evolved and now focuses primarily on the six major behaviors that result in 70 percent of adolescent mortality and morbidity: injury, pregnancy and disease, poor nutrition, lack of physical activity, smoking, and alcohol and other drug use.<sup>2</sup>

In 1997, the Institute of Medicine released a report entitled *Schools and Health: Our Nation's Investment*. "The committee began its study with the following basic assumptions:

1. The primary goal of schools is education.
2. Education and health are linked. Educational outcomes are related to health status, and health outcomes are related to education.
3. There are certain basic health needs of children and young people. These include nurturing and support;

timely and relevant health information, knowledge, and skills necessary to adopt healthful behavior; and access to health care.

4. The school has the potential to be a crucial part of the system to provide these basic health needs. Schools are where children and youth spend a significant amount of their time, and schools can reach entire families. However, the school is only part of the broader community system; the responsibility does not and should not fall only on the schools."<sup>3</sup>

More than 13 years later, these assumptions continue to hold true. And there is more data to support the fact that education and health are linked:

- Students with higher grades are less likely to engage in risk taking behaviors including early sexual activity, drinking, and smoking.<sup>4</sup>
- Students who report using tobacco or marijuana report less academic motivation.<sup>5</sup>
- School performance declines with early sexual activity.<sup>6</sup>
- Students with lower academic performance are more likely to drop-out. Subsequently, high-school drop outs tend to be unhealthy and poorer.<sup>7</sup>
- Across the life span, individuals with more education tend to be healthier.<sup>8</sup>

In sum, health education is critical to students' academic success, impacting graduation and dropout rates, grades, test scores, grade retention, absenteeism, tardiness, and behavior problems.<sup>9</sup>

## CURRENT STATUS OF HEALTH EDUCATION AND RELATIONSHIP TO SEXUALITY EDUCATION

Today, despite the overwhelming support for health education and its impact on student achievement, health education and its curricular content vary widely across states, districts, and grades. The good news: most schools are providing some level of health education and there are some fundamental structural supports in place to support health education. For example:

- Thirty-nine states and the District of Columbia require a course in health/physical education as a graduation re-

quirement. (Seven additional states leave decisions about graduation requirements to local school districts. Arizona, Oklahoma, Wyoming and South Dakota do not require health/physical education as a graduation requirement.)<sup>10</sup>

- Nearly 75 percent of states require districts to follow national or state health education standards
- Ninety-four percent of states had a person that coordinates school health
- Almost 20 percent of states require elementary students to be tested on health topics and almost 22 percent of states require middle and high school students to be tested
- Sixty percent of schools require health education in 5th grade – the highest percentage across K-12 grade levels. In 10th grade, only 25 percent of schools require health education and in 12th grade only 8.5 percent
- Seventy-three percent of districts have one or more school health councils which assist the district in developing school policies, coordinating health education, etc.<sup>11</sup>

The bad news: there are no national data about how well the existing policies and programs are being implemented or the extent to which health education is happening. For example, there is no information about how many instructional minutes are devoted to health education by grade, what topics are being covered, or how much time is spent on each topic.

**Coordinated School Health:** Ideally, health education is part of a coordinated school health program. A coordinated school health program (CSHP) as defined by the Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC-DASH), generally consists of eight elements:

1. Health Education
2. Physical Education
3. Health Services
4. Nutrition Services
5. Counseling, Psychological and Social Services
6. Healthy School Environment
7. Health Promotion for Staff
8. Family/Community Involvement

Health education encompasses a broad range of topics including sexuality education/family life education; alcohol and other drugs; community and environmental health; injury

prevention; mental and emotional health; nutrition; personal and consumer health; physical activity; and tobacco.

In 1995, the Joint Committee for National School Health Education Standards released its first set of national standards which were revised and updated in 2007. Comprised of representatives from the American Public Health Association, American School Health Association, Association for the Advancement of Health Education, and the Society of State Directors of Health, Physical Education and Recreation, the effort was led by the American Cancer Society.

The National Health Education Standards (NHES) are largely focused on skill development and drive the development of curriculum over the pre-K-12 life of a child by introducing and revisiting concepts with increasing depth and complexity as is age appropriate. “For each standard there are performance indicators to help educators determine the knowledge and skills that students should possess by the end of grades 2, 5, 8, and 12.

**Standard 1:** Students will comprehend concepts related to health promotion and disease prevention to enhance health.

**Standard 2:** Students will analyze the influence of family, peers, culture, media, technology and other factors on health behaviors.

**Standard 3:** Students will demonstrate the ability to access valid health information and health-promoting products and services.

**Standard 4:** Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

**Standard 5:** Students will demonstrate the ability to use decision-making skills to enhance health.

**Standard 6:** Students will demonstrate the ability to use goal-setting to enhance health.

**Standard 7:** Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

**Standard 8:** Students will demonstrate the ability to advocate for personal, family, and community health.”<sup>12</sup>

According to the American Cancer Society, “most states and many districts around the country have either adopted or adapted the NHES.” The National Health Education Standards deliberately avoid delving into specific content areas, including sexuality education. Given the number of health education topics – at least 10 – and grade levels (preK-12), it is unlikely that there is enough time allocated to health education to cover all relevant topics for each grade. Thus, the NHES focus on skills that are transferable across topic areas.

The emphasis on skills-based learning in health education – and other subject areas – has its share of critics. There are concerns that if we focus only on skills and do not adequately provide content that we are leaving out a critical ingredient which lays the foundation for behavior change. In contrast, others say that we have emphasized content for too long and have given priority to the memorization of facts (i.e., content) over the development of skills that can equip students to communicate and make better decisions about their health.

This tension between content and skill is particularly problematic in health education given that there are so many topic areas and little time allocated to health education in a given school year. For example, there is no consensus about which topics to include as essential aspect of sex education content and which skills are best reinforced by sex education content at each grade level. Given the fact that sexual development is a key milestone for school age children and teens, from a developmental perspective alone it makes sense to reinforce decision-making and interpersonal communication skills utilizing sex education content.

An added challenge to delivering health education is that too often decisions about which health topics are covered in a particular state or school district are driven by policy and funding “silos.” For example, New Jersey has mandated specific content including suicide prevention, domestic violence, and organ donation. California mandates parenting education. Decades of “Safe and Drug Free School” funding drove the amount of time spent on drug and alcohol education which, anecdotally, negatively impacted the amount of time given to other unfunded topic areas. It is no surprise that funding drives priorities. Regardless, current funding levels for school health education not only vary widely but also are insufficient given the list of health concerns and current health status of young people.<sup>14</sup>

Issues related to the balance between skills-based learning and content, policy and funding “silos” that have prioritized some topics over others, as well as a general lack of funding have resulted in fragmented health education for students. There is a great need to look at the health and well-being of students across multiple domains and begin to appropriately map content and skill by grade level such that skills are being reinforced each year in conjunction with appropriate amounts of content within health and other curricular areas. Clearly, students should have both the knowledge and skills they need to make responsible healthy decisions.

## FEDERAL INVOLVEMENT IN HEALTH EDUCATION

At the federal level, there are two government agencies that are tasked with some aspect of improving student health – the Department of Education and the Department of Health and Human Services. Overall, however, there is very little federal funding to support school health or direct classroom instruction about health. Instead, most of the federal funding goes to support state and local efforts to support health education through dissemination of best practices, guidelines, alignment and assessment tools, data and technical assistance.

Within the Department of Education, President Obama’s FY11 budget proposes “**\$410 million for a new Successful, Safe, and Healthy Students authority**, to consolidate six current authorities into a new program designed to give local communities the flexibility to focus on their greatest needs in the areas of improving school climate and safety; promoting student physical and mental health, preventing student drug and alcohol use; and expanding family and community engagement. The request is an increase of \$45 million, or 12 percent, over 2010 funding for the antecedent program authorities.”<sup>15</sup>

Within the Department of Health and Human Services, there are four agencies that address some aspect of school health including teen pregnancy, STD and HIV prevention. These include the Centers for Disease Control and Prevention, Office of Adolescent Health, Administration for Children and Families, and Office of Population Affairs.

Centers for Disease Control and Prevention (CDC) – By far, the CDC’s Division of Adolescent and School Health (DASH) tops the list of dedicated resources to improve school health. DASH’s mission is “to promote the health and well-being of

children and adolescents to enable them to become healthy and productive adults” by employing four key strategies:

1. **Identifying and Monitoring.** DASH does this by coordinating the following:
  - a. Youth Risk Behavior Surveillance System (YRBSS) which provides the only national, state and local level data on priority health risk-behaviors including those that contribute to unintended pregnancy and/or sexually transmitted diseases including HIV/AIDS. (However, not all states participate in YRBSS and some states have their own surveys.)
  - b. School Health Profiles, which assess school health education requirements and policies as well as community involvement in school health programs primarily at the state and large urban school district level.
  - c. School Health Policies and Programs Study (SHPPS), which provides similar data to the School Health Profile but goes much deeper in assessing health policy and practice at not only the state level but also district, school and classroom levels. It also collects detailed information about who is teaching health education.
2. **Synthesizing and Applying Research.** DASH provides research-based recommendations and guidelines on various health related topic areas as well as curriculum assessment tools such as the Health Education Curriculum Analysis Tool (HECAT).
3. **Enabling Constituents.** DASH provides funding to 49 state departments of education, the District of Columbia, six territories and 16 large urban districts to coordinate HIV/AIDS prevention activities. In addition, it funds 23 states to establish and run coordinated school health programs and 23 other non-governmental entities that provide a broad array of technical assistance and training to support high quality programming.
4. **Evaluating.** DASH provides technical assistance on evaluation to its grantees and also conducts its own evaluation processes to identify best practices.<sup>16</sup>

The CDC Divisions of HIV/AIDS Prevention (DHAP) and STD Prevention (DSTDP) also play a role in school health, but to a lesser extent. Mostly, they provide funding for smaller projects that may supplement DASH-funded efforts.

Finally, the CDC’s Division of Reproductive Health (DRH) works in the area of adolescent health through its Teenage Pregnancy Prevention: Integrating Services, Program and Strategies Through Communitywide Initiatives. To learn more visit <http://www.cdc.gov/TeenPregnancy/PreventTeenPreg.htm>.

Office of Adolescent Health (OAH) – In 1992, the federal government created the Office of Adolescent Health (OAH); the office was not funded, however, until 2010. The OAH is charged with coordinating all activities within the U.S. Department of Health and Human Services that relate to adolescent “disease prevention, health promotion, preventive health services, and health information and education,” including program design, support, and evaluation, trend monitoring, adolescent health research projects, and training for health providers who work with adolescents. OAH was also designed to carry out demonstration projects to improve adolescent health.<sup>17</sup> This office provides the opportunity to prioritize adolescent health, address the inter-related health needs of all adolescents, and provide true, comprehensive sex education that promotes healthy behaviors and relationships for all young people.

In 2010, OAH began administering a new teenage pregnancy prevention initiative to provide \$100 million in grant funding – \$75 million to replicate evidence-based programs and \$25 million for innovative or promising approaches to teen pregnancy prevention that do not yet have a quantitative evaluation. To learn more, visit: <http://www.hhs.gov/ash/oah/prevention/grantees/index.html>.

Two other offices within the DHHS that play a lesser role in school health are the Administration for Children and Families (ACF) and Office of Population Affairs (OPA). Because ACF oversaw the Community Based Abstinence Education grant making program, it became synonymous with abstinence-only-until-marriage funding. Today, ACF is charged with managing programs at the federal level that “promote the economic and social well-being of families, children, individuals and communities.”<sup>17</sup> As such, ACF administers a varied and far-reaching number of federal programs, including Title V, Section 510 Abstinence Education which was recently reauthorized (\$50 million) through health care reform.

ACF also administers the new Personal Responsibility Education Program (PREP) established as part of health care reform. This program allocated \$55 million to states for implementation of evidence-based programs to prevent pregnancy and

disease, including HIV. Also included was \$10 million for innovative strategies to reduce teen pregnancy and disease. An additional \$10 million was allocated for use by tribal communities and for program evaluation and support. Because each state submits its own plan to utilize Title V and PREP funding, it is unclear how much funding will support school-based efforts.

OPA is responsible for implementing the Title X family planning program, which provides public funding to support a national network of family planning providers that provide free or low-cost, confidential sexual and reproductive health services to low income, uninsured individuals, including adolescents. Many Title X family planning providers also have a community education program which may provide outreach and education within public schools.

## UNDERSTANDING SCHOOL HEALTH IN YOUR STATE

At the state level, there is a tremendous amount of variation in health education in the schools. To map the existing status of health and sexuality education in your state, you might begin by:

- Understanding who the decision makers are when it comes to health education and their respective roles. Key decision makers include members of the:
  - State Board of Education
  - State Department of Education
  - State Legislature
- Please see <http://www.futureofsexed.org/publiceducationprimer.html> to learn more about your state's public education and decision-making structure.
- Reviewing your state's school health policies via the National Association of State Boards of Education's State School Health Policy Database at [http://nasbe.org/healthy\\_schools/hs/index.php](http://nasbe.org/healthy_schools/hs/index.php).
- Reviewing your state's health education content standards. It is best to go directly to your state's department of education for this information.
- Learning more about your state's policy regarding coordinating or advisory councils at [http://nasbe.org/healthy\\_schools/hs/bytopics.php?topicid=6100&catExpand=acdnbtm\\_catF](http://nasbe.org/healthy_schools/hs/bytopics.php?topicid=6100&catExpand=acdnbtm_catF). Some states require School Health Advisory Committees. These committees typically are mandated to include certain school staff (e.g., health teacher, school nurse) and community members (e.g., faith-community representative, parent, student, etc.)

- Learning more about professional development requirements for teachers. For example, do teachers have to obtain a certain number of professional development hours each year? Does the required professional development have to be in their content area? Your state's department of education is a good starting point for gathering this information.
- Understanding what type of undergraduate and/or graduate training, as well as certification, teachers must have in your state in order to teach sexuality education. Are health teachers required to be certified in health education and/or have any background in human sexuality in order to teach that subject area?
- Contacting your state's school health education staff to learn more. For a directory, visit <http://directory.thesociety.org/>. School health education staff could include your state's DASH funded HIV/AIDS prevention coordinator (in every state except Utah) and/or coordinated school health program staff (in 23 states). Some questions to ask:
  - What are the state laws and/or policies pertaining to health and sexuality education?
  - What are some model school-based sex education programs that exist throughout the state?
  - Who is responsible for monitoring and advancing this issue in your state?
  - What kind of support exists within the state department of education for sexuality education and/or State Department of Health? Who are the champions?
  - What funding opportunities exist at the local level to support sexuality education implementation?
  - What are some of your priorities for advancing sex education?

## UNDERSTANDING SCHOOL HEALTH IN YOUR SCHOOL DISTRICT

At the district level, the variation continues. As you drill down to an individual school district after having mapped the state policies and content standards, it becomes an issue of school climate, capacity and available resources. To begin, you will want to learn:

- About the local decision-making structure including local school board, superintendent, building principals, curriculum coordinators or directors and individual classroom teachers.
- How much support exists for sex education in the curriculum at the district (i.e., superintendent), community

(i.e., parents), individual school building (i.e., principal) and classroom (i.e., teacher) levels?

- If sex education is being taught. If so, at what grade levels? How many instructional minutes per grade level?
- Who is teaching sex education and what training do they have? If health education is being taught at the elementary level, it is typically a school nurse or classroom teacher. In middle and high school, typically a health or physical education teacher is charged with teaching sex education. Since health educators are not required to have any background in sexuality education per se in order to teach, what kind of training do these educators have?
- What curriculum is being used if any, and is it accurate and developmentally and age-appropriate?
- What is the capacity of the district, school, and assigned teacher to implement sexuality education? Do they have the requisite comfort, knowledge, and skills to do so?

## CONCLUSION: MAKING CONNECTIONS

Overwhelmingly, we want our children to be healthy and educated. To do so, we must “integrate school health into the fundamental mission of schools, support the widespread development and implementation of high quality, strategically planned, and effectively coordinated approaches that address a variety of health-related barriers to teaching and learning.”<sup>18</sup>

This level of integration will require a deeper level of outreach, understanding and coordination between the school health and sex education communities. Together we need to (1): advocate for further investment in the Centers for Disease Control and Prevention to improve the number of and extent to which school districts participate in the Youth Risk

Behavior Survey bi-annually and increase the number and role of comprehensive school health coordinators and HIV/AIDS coordinators at the state level; (2) build capacity of local school districts to support health education, ensuring that appropriate professional development is provided to support implementation of “high-quality, strategically planned and effectively coordinated approaches;” (3) continue to educate policy makers, school administrators and other key stakeholders regarding the link between academic achievement and school health.

While there are some important structural supports in place at the state level for health education (e.g., mandates for health education, content standards, health as a graduation requirement), there remains much more work to be done. Generally, mandates for health education are quite broad, the strength of health content standards varies considerably from state to state, and graduation requirements for health education can be quite minimal. We need to provide models of effective coordinated school health programs, examples of strong state policies for health education, and clear content standards for sexuality education that link to the National Health Education Standards. This way, we’ll provide a road-map for states and individual school districts to develop more robust sexuality education curriculum.

Finally, we need to seize this moment in time during which health care and education reform are garnering a greater share of public attention and discourse. There is a well-documented historical role that public schools have successfully played in advancing our nation’s public health and overwhelming data that points to the relationship between academic achievement and school health.

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