

ITEM RATIONALE
2014 SCHOOL HEALTH PROFILES
LEAD HEALTH EDUCATION TEACHER QUESTIONNAIRE

REQUIRED HEALTH EDUCATION COURSES

QUESTIONS:

1. How many required health education courses do students take in grades 6 through 12 in your school?
2. Is a required health education course taught in each of the following grades in your school?

RATIONALE:

These questions measure the extent to which health education courses are required for students in grades 6 through 12. School health education could be one of the most effective means to reduce and prevent some of the most serious health problems in the United States, including cardiovascular disease, cancer, motor-vehicle crashes, homicide, and suicide.¹ The Institute of Medicine has recommended that schools require a one-semester health education course at the secondary school level;¹ however, the benefits of a health education curriculum increase when students receive at least three consecutive years of a quality health curriculum.²

REFERENCES:

1. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.
2. Lohrmann DK, Wooley SF. Comprehensive school health education. In: Marx E, Wooley SF, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York: Teachers College Press, 1998, pp. 43–66.

QUESTION:

3. If students fail a required health education course, are they required to repeat it?

RATIONALE:

This question measures the importance of a required health education course for students in grades 6 through 12.

QUESTION:

4. Are those who teach health education at your school provided with each of the following materials?

RATIONALE:

This question addresses the types of information and support materials health education teachers are given in order to implement health education classes. According to the Joint Committee on National Health Education Standards, quality health education is guided by access and equity principles that call for clear curriculum direction, including goals, objectives, and expected outcomes; a written curriculum; clear scope and sequence of instruction for health education content; and plans for age-appropriate student assessment.¹

REFERENCE:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition)*. Atlanta, GA: American Cancer Society, 2007.
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QUESTION:

5. Does your health education curriculum address each of the following?

RATIONALE:

This question addresses the extent to which schools have a health education curriculum that is based on, or is consistent with, current national health education standards.¹ *Healthy People 2020* objective Educational and Community Based Programs-3 (ECBP-3) calls for an increase in the proportion of elementary, middle, and senior high schools that address the knowledge and skills articulated in these standards.²

REFERENCES:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition)*. Atlanta, GA: American Cancer Society, 2007.
 2. U.S. Department of Health and Human Services. *Healthy People 2020*. Washington, DC: U.S. Department of Health and Human Services, 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed July 17, 2013.
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QUESTION:

6. Are those who teach sexual health education at your school provided with each of the following materials?

RATIONALE:

This question reflects the characteristics of exemplary sexual health education (ESHE), which is a systematic, evidence-informed approach to sexual health education that includes the use of grade-specific, evidence-based interventions, but also emphasizes sequential learning across elementary, middle, and high school grade levels.¹⁻³ ESHE provides adolescents the essential knowledge and critical skills needed to avoid HIV, other STD, and unintended pregnancy.² ESHE is delivered by well-qualified and trained teachers, uses strategies that are relevant and engaging, and consists of elements that are medically accurate, developmentally and culturally appropriate, and consistent with the scientific research on effective sexual health education.^{1,3,4} This item reflects the systematic characteristics needed for exemplary sexual health education that align with the Health Education Curriculum Analysis Tool³ and the National Health Education Standards.⁵

This item provides data for a school level impact measure (SLIM). Measurement of SLIMs is required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Lohrmann DK, Wooley SF. Comprehensive school health education. In: Marx E, Wooley S, Northrop D, editors. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York: Teachers College Press; 1998:43–45.
2. Kirby D, Coyle K, Alton F, Rolleri L, Robin L. *Reducing Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs*. Scotts Valley, CA: ETR Associates; 2011.
3. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool: Sexual Health Education. http://www.cdc.gov/healthyyouth/hecat/pdf/HECAT_Module_SH.pdf. Accessed June 21, 2013.
4. Centers for Disease Control and Prevention. Characteristics of an Effective Health Education Curriculum; www.cdc.gov/healthyyouth/sher/characteristics/index.htm. Accessed June 21, 2013.
5. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition)*. Atlanta, GA: American Cancer Society, 2007.

REQUIRED HEALTH EDUCATION

QUESTION:

7. Is health education instruction required for students in any of grades 6 through 12 in your school?

RATIONALE:

Not all health education instruction takes place in health education courses.¹ This question addresses whether schools require any classroom instruction on health topics, including instruction that occurs outside of health education courses.

REFERENCE:

1. Kann L, Telljohann SK, and Wooley SF. Health education: results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77(8): 408-434.
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QUESTION:

8. During this school year, have teachers in your school tried to increase student knowledge on each of the following topics in a required course in any of grades 6 through 12?

RATIONALE:

This question addresses the extent to which traditional health content areas and the prevention of health risk behaviors are taught in required courses in grades 6 through 12. *Healthy People 2020* objective ECBP-2 calls for an increase in the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent morbidity and mortality resulting from unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity.¹

Additionally, chronic health conditions such as epilepsy or seizure disorder, diabetes, asthma, and food allergies may affect students' physical and emotional well-being, school attendance, academic performance, and social participation. Given the clustering of chronic conditions, many students face the added burden of living with two conditions. The opportunity for academic success is increased when communities, schools, families, and students work together to meet the needs of students with chronic health conditions and provide safe and supportive learning environments.^{2,3} Providing health education in these areas contribute to raising awareness of these chronic health conditions within the broader school community.

REFERENCES:

1. U.S. Department of Health and Human Services. *Healthy People 2020*. Washington, DC: U.S. Department of Health and Human Services, 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed July 17, 2013.
 2. National Asthma Education and Prevention Program, National School Boards Association, American School Health Association, American Diabetes Association, American Academy of Pediatrics, Food Allergy and Anaphylaxis Network, Epilepsy Foundation. Students with chronic illnesses: Guidance for families, schools, and students. *Journal of School Health* 2003; 73(4):131-132.
 3. Taras H, Brennan JJ. Students with chronic diseases: Nature of school physician support. *Journal of School Health* 2008; 78(7):389-396.
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QUESTION:

9. During this school year, did teachers in your school teach each of the following tobacco-use prevention topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the tobacco-use prevention curricula content, and relates to the *Healthy People 2020* ECBP-2: Increasing the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems including tobacco use and addiction.¹ Since most smoking is initiated by persons less than 18 years old, programs that prevent onset of smoking during the school years are crucial. When implemented in conjunction with broader community-based mass media campaigns that show strong evidence of their effectiveness in reducing tobacco use among adolescents, school-based tobacco prevention programs that address multiple psychosocial factors related to tobacco use among youth and that teach the skills necessary to resist those influences have demonstrated consistent and significant reductions or delays in adolescent smoking.²⁻¹⁰ Social influence programming has reduced smoking onset by as much as 50%, with effects lasting up to 6 years, and with effects including reduction of the use of other tobacco products as well.⁴

In addition, this question measures the extent to which schools are complying with the components of the National Health Education Standards, which provide a framework for decisions about the lessons, strategies, activities, and types of assessment to include in a health education curriculum.¹¹ It also measures the extent to which the content aligns with the Health Education Curriculum Analysis Tool.¹²

REFERENCES:

1. U.S. Department of Health and Human Services. *Healthy People 2020*. Office of Disease Prevention and Health Promotion. November 2010. Available at: www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=11. Accessed July 17, 2013.
2. U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Youth and Young Adults: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2012.
3. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.
4. Sussman S. School-based tobacco use prevention and cessation: where are we going? *American Journal of Health Behavior* 2001; 25(3):191-9.
5. Dent CW, Sussman S, Stacy AW, Craig S, Burton D, Flay BR. Two-year behavior outcomes of project towards no tobacco use. *Journal of Consulting and Clinical Psychology* 1995; 63(4):676-677.
6. Botvin GJ, Baker E, Dusenbury L, Botvin EM, Diaz T. Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association* 1995; 273(14):1106-1112.
7. Lantz PM, Jacobson PD, Warner KE, Wasserman J, Pollack HA, Berson J, Ahlstrom A. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control* 2000; 9:47-63.
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9. Bruvold WH. A meta-analysis of adolescent smoking prevention programs. *American Journal of Public Health* 1993; 83(6):872-80.
10. Guide to Community Preventive Services. Reducing tobacco use initiation: mass media campaigns when combined with other interventions (1999 archived review). www.thecommunityguide.org/tobacco/massmediaeducation_archive.html. Accessed July 9, 2013.

11. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition)*. Atlanta, GA: American Cancer Society, 2007.
 12. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. <http://www.cdc.gov/healthyyouth/hecat/index.htm>. Accessed June 21, 2013.
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QUESTION:

10. During this school year, did teachers in your school teach each of the following HIV, STD, or pregnancy prevention topics in a required course for students in each of the grade spans below?

RATIONALE:

This question measures HIV, other STD, and pregnancy prevention health education curricula content. The National Health Education Standards outline knowledge and skills that should be attained by students following the completion of a high-quality health education program.¹

HIV and sex education programs can increase knowledge and skills to prevent unintended pregnancy and decrease risk of HIV and STD infection.^{2,3} Given variability among adolescents in cognition, social maturity, and sexual experience, curricula should be tailored to meet the unique needs of younger, as well as older adolescents.^{4,5} To coincide with the maturity level and cognitive abilities of the learner, the progression of sexual health education concepts and skills increase in complexity as the sequence advances up grade levels. The Centers for Disease Control and Prevention's Health Education Curriculum Analysis Tool is aligned with the National Health Education Standards and provides a guide to developmentally-appropriate topics for sexual education within schools for pre-K-12th grade.⁶

This item provides data for a school level impact measure (SLIM). Measurement of SLIMs is required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition)*. Atlanta, GA: American Cancer Society, 2007.
2. Kirby D. *Emerging Answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington, DC: The National Campaign to Prevent Teen Pregnancy, 2007. Available at: www.thenationalcampaign.org/EA2007/EA2007_full.pdf. Accessed June 1, 2011.

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 4. Kirby D, Coyle K, Alton F, Roller L, Robin L. *Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs*. Scotts Valley: ETR Associates, 2011. Available at: <http://pub.etr.org/ProductDetails.aspx?id=100000042&itemno=A063>. Accessed July 17, 2013.
 5. Pedlow CT, Carey MP. Developmentally appropriate sexual risk reduction interventions for adolescents: rationale, review of interventions, and recommendations for research and practice. *Annals of Behavioral Medicine* 2004; 27(3):172-184.
 6. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. Atlanta, GA, 2013 Available at: www.cdc.gov/Healthyyouth/HECAT/index.htm. Accessed June 21, 2013.
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QUESTION:

11. During this school year, did teachers in your school teach about the following contraceptives in a required course for students in any of grades 9 through 12?

RATIONALE:

This question measures the extent to which various contraceptive methods have been taught to high school students. Births among US adolescents have decreased¹ but disparities in teen births exist relative to race, geographic region, and socio-economic status,² and can impact the ability of teens to succeed academically and to graduate high school. Further, the US has the highest teen birth rate among Western industrialized nations.⁴ Knowledge of contraceptive options is an important step in decreasing unintended pregnancy rates. While many sexually active teens are familiar with and use the condom and the birth control pill, only a small percentage use newer methods that are equally or more effective in pregnancy prevention.⁴

Long-acting reversible contraceptive methods, sometimes referred to as LARC, are highly effective forms of contraception which have been judged appropriate for adolescent use.⁵ LARC methods include the Copper T IUD (“Paraguard”) and the hormonal IUD (“Mirena”) as well as the implant (“Implanon”). Once started, LARC methods prevent 99% of pregnancies for 3-10 years without further action on the part of the user.⁶ While these methods are highly effective, they require insertion and removal by a healthcare professional and, like all contraception, may have side effects that are off-putting to some teens.⁷ Adolescents may also find Depo-Provera (effective for 3 months), the Nuvaring (effective for 1 month), and the contraceptive patch (effective for 1 week) to be viable alternatives.^{8,9}

REFERENCES:

1. Martin JA, Hamilton BE, Ventura SJ, et al. Births: Final data for 2010. *National vital statistics reports*; vol 61 no 1. Hyattsville, MD: National Center for Health Statistics. 2012. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf#table02 Accessed June 21, 2013.
 2. Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2011. *National Vital Statistics Reports* 2012; 61(5). Table 2.
 3. Singh S, Darroch JE. Adolescent pregnancy and childbearing: levels and trends in developed countries. *Family Planning Perspectives* 2000; 32(1):14-23.
 4. Abma JC, Martinez GM, Copen CE. Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, National Survey of Family Growth 2006–2008. National Center for Health Statistics. *Vital Health Statistics* 2010; 23(30). Available at: www.cdc.gov/nchs/data/series/sr_23/sr23_024.pdf. Accessed July 17, 2013.
 5. Centers for Disease Control and Prevention. U S. Medical Eligibility Criteria for Contraceptive Use, 2010. *MMWR* 2010; 59(No. RR-04):1-6. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/rr5904a1.htm?s_cid=rr5904a1_e. Accessed July 17, 2013.
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 7. French, RS, Cowan FM. Contraception for adolescents. *Best Practice and Research Clinical Obstetrics and Gynecology* 2009; 23:233-247.
 8. Stewart FH, Brown BA Raine TR, Weitz TA, Harper CC. Adolescent and young women’s experience with the vaginal ring and oral contraceptive pills. *Journal of Pediatric and Adolescent Gynecology* 2007; 20:345-51.
 9. American Academy of Pediatrics, Committee on Adolescents. Contraception and adolescents. *Pediatrics* 2007; 120(5):1135-1148.
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QUESTION:

12. During this school year, did teachers in your school assess the ability of students to do each of the following in a required course for students in each of the grade spans below?

RATIONALE:

This question measures the extent to which students were expected to increase and were assessed on their skills to perform behaviors associated with reduced sexual risk behaviors. When adolescents are confident in their ability to perform behaviors (called self-efficacy) and when

they have practice in implementing behaviors, they are more likely to engage in protective behaviors and to refrain from sexual risk behaviors.^{1,2} The skills listed are part of exemplary sexual health education and are based on the characteristics of sexual health education curricula as listed in the Health Education Curriculum Analysis Tool (HECAT)³ and the National Health Education Standards.⁴

This item provides data for a school level impact measure (SLIM). Measurement of SLIMs is required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Kirby D., Coyle, K., Forrest A., et al. *Reducing Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs*. 2011; ETR Associates: Scotts Valley, CA.
2. Gavin LE, Catalano RF, Corinne David-Ferdon C, et al. A review of positive youth development programs that promote adolescent sexual and reproductive health. *Journal of Adolescent Health* 2010; 46(3):S75–S91.
3. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. 2013. http://www.cdc.gov/healthyyouth/hecat/pdf/HECAT_Module_SH.pdf. Accessed June 24, 2013.
4. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition)*. Atlanta, GA: American Cancer Society, 2007.

QUESTION:

13. During this school year, did teachers in your school teach each of the following nutrition and dietary behavior topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the curricula content related to nutrition and dietary behavior. Comprehensive, sequential nutrition education using the classroom and the lunchroom can reinforce healthful eating behaviors.^{1,2} Nutrition education should be part of a comprehensive school health education curriculum that is aligned with the National Health Education Standards^{3,4} and includes⁵ concepts to promote healthy eating.^{5,6} This list of 20 nutrition topics is based on the Dietary Guidelines for Americans, 2010,⁷ CDC guidelines,⁸ the School Health Index,⁹ and the HECAT.¹⁰ *Healthy People 2020* objective ECBP-2.8 calls for an increase in the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in unhealthy dietary patterns.¹¹ In addition to understanding healthy eating, students should also understand how to assess their weight status

using body mass index. An individual's weight status is linked to nutrition and their overall health.¹² *Healthy People 2020* objective ECBP-4.3 calls for an increase in the proportion of elementary, middle, and senior high schools that provide health education in growth and development to promote personal health and wellness.¹¹

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1. Food and Nutrition Board, Institute of Medicine, Committee on Prevention of Obesity of Children and Youth, Schools. In: JP Koplan, CT Liverman and VI Kraak, eds. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: National Academy Press, 2005, pp. 237–284.
2. Briggs M, Mueller CG, Fleischhacker S. Position of the American Dietetic Association, School Nutrition Association, and Society for Nutrition Education: Comprehensive school nutrition services. *Journal of the American Dietetic Association* 2010; 110:1738-1749.
3. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition)*. Atlanta, GA: American Cancer Society, 2007.
4. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. Atlanta, GA: CDC; 2007. Available at: www.cdc.gov/healthyyouth/hecat/index.htm. Accessed July 17, 2013.
5. Ralston K, Buzby J, Guthrie J. *A Healthy School Meal Environment*. United States Department of Agriculture, Economic Research Service, Food Assistance and Nutrition Research Report Number 34-5, 2003. Available at: www.ers.usda.gov/publications/fanrr34/fanrr34-5/fanrr34-5.pdf. Accessed July 17, 2013.
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 12. Barlow SE and the Expert Committee. Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. 2007; 120:S164-S192.
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QUESTION:

14. During this school year, did teachers in your school teach each of the following physical activity topics in a required course for students in any of grades 6 through 12?

RATIONALE:

This question measures the extent to which physical activity concepts are taught in a required course. Health education that includes physical activity concepts increases the likelihood of students increasing their participation in physical activity,¹⁻³ reinforces what has been taught in physical education,⁴ and assists students in achieving the National Health Education Standards.⁵ The content also aligns with the HECAT.⁶

REFERENCES:

1. Hoelscher D, Feldman H, Johnson C, et al. School-based health education programs can be maintained over time: results from the CATCH institutionalization study. *Preventive Medicine* 2004; 38(5):594-606.
2. Nader P, Stone E, Lytle L, Perry C, Osganian S, Kelder S et al. Three-year maintenance of improved diet and physical activity: the CATCH cohort. *Child and Adolescent Trial for Cardiovascular Health. Archives of Pediatrics & Adolescent Medicine* 1999; 153:695-704.
3. Marcoux MF, Sallis JF, McKenzie TL, Marshall S, Armstrong CA, Goggin K. Process evaluation of a physical activity self-management program for children: SPARK. *Psychology and Health* 1999; 14:659-77.
4. Pate RR, Davis MG, Robinson TN, Stone EJ, McKenzie TL, Young JC. Promoting physical activity in children and youth: a leadership role for schools. *Circulation* 2006; 114:1-11.

5. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2nd Edition)*. Atlanta, GA: American Cancer Society, 2007.
6. Centers for Disease Control and Prevention. Health Education Curriculum Analysis Tool. <http://www.cdc.gov/healthyyouth/hecat/index.htm>. Accessed June 21, 2013.

HIV PREVENTION

QUESTION:

15. Does your school provide curricula or supplementary materials that include HIV, STD, or pregnancy prevention information that is relevant to lesbian, gay, bisexual, transgender, and questioning youth (e.g., curricula or materials that use inclusive language or terminology)?

RATIONALE:

This question assesses whether the school uses inclusive curricula or supplementary materials for lesbian, gay, bisexual, transgender, and questioning youth (i.e., sexual minority youth). In a recent report that presented data from 14 states and large urban school districts on sexual minority youth, the percentage of students self-identifying as gay or lesbian, bisexual, or not sure ranged from 1.0-2.6, 2.9-5.2, and 1.3-4.7, respectively.¹ The percentage of students reporting sexual contact with same sex only or both sexes was 0.7-3.9 and 1.9-4.9, respectively.¹ Results from this report and other studies have found that sexual minority students more often participate in behaviors that put them at greater risk for HIV, STD, and unintended pregnancy, including not using a condom during last sexual intercourse.¹⁻⁴ Furthermore, the percentage of sexual minority students reporting they were taught in school about AIDS or HIV was lower than that of heterosexual students.¹ Research indicates reduced risk behaviors for some lesbian, gay, and bisexual youth when using inclusive HIV instruction in schools.⁵

This item provides data for a school level impact measure (SLIM). Measurement of SLIMs is required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

REFERENCES:

1. Kann L, Olsen E, McManus T, et al. Centers for Disease Control and Prevention. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9–12 — Youth Risk Behavior Surveillance, Selected Sites, United States, 2001–2009. *MMWR* Early Release 2011; 60 [June 6]:1-133.

2. Garofalo R, Katz E. Health care issues of gay and lesbian youth. *Current Opinion in Pediatrics* 2001; 13(4):298-302
 3. Pathela P, Schillinger J. Sexual behaviors and sexual violence: adolescents with opposite-, same-, or both-sex partners. *Pediatrics* 2010; 126(5):879-886.
 4. Goodenow C, Szalacha L, Robin L, Westheimer K. Dimensions of sexual orientation and HIV-related risk among adolescent females: evidence from a statewide survey. *American Journal of Public Health* 2008; 98(6):1051-1058.
 5. Blake SM, Ledsky R, Lehman T, Goodenow C, Sawyer R, Hact T. Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: the benefits of gay-sensitive HIV instruction in schools. *American Journal of Public Health* 2001; 91(6):940-946.
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COLLABORATION

QUESTION:

16. During this school year, have any health education staff worked with each of the following groups on health education activities?

RATIONALE:

This question measures the extent to which health education staff work cooperatively with other components of the school health program (school health services, school mental health or social services, food service, and physical education staff). An integrated school and community approach is an effective strategy to promote adolescent health and well-being.¹⁻³

REFERENCES:

1. Allensworth D, Kolbe L. The comprehensive school health program: state of the art. *Journal of School Health* 1987; 63:14–20.
 2. Kann L, Telljohann SK, Wooley SF. Health education: results from the School Health Policies and Programs Study 2006. *Journal of School Health* 2007; 77:408–434.
 3. Lohrmann DK. A complementary ecological model of the coordinated school health program. *Journal of School Health* 2010; 80:1-9.
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QUESTION:

17. During this school year, did your school provide parents and families with health information designed to increase parent and family knowledge of each of the following topics?

RATIONALE:

This question measures whether schools are providing health information to students' families. School programs that engage parents and link with the community yield stronger positive results. Studies aimed at preventing childhood overweight, treating childhood overweight, and promoting physical activity and healthy eating have demonstrated more success when targeting the parent and child versus targeting the child alone.^{1,2} School-based tobacco prevention programs and community interventions involving parents and community organizations have a stronger impact over time when working in tandem rather than as separate, stand-alone interventions.³ Assessments of successful school-based asthma management programs indicate that with increased knowledge, parents can assist their children in better managing their asthma.⁴ Parents also are teenagers' primary sex educators, able to capitalize on teachable moments when youth may be more open to learning new information.⁷ Parents can continue prevention messages delivered in school, thereby enhancing the likelihood of sustained behavioral changes.⁸ Increased communication affects both parenting and health practices of parents. Communicating information on healthy lifestyles aims to reinforce the child's coursework at school, facilitate communication with parents about school activities, and increase parent knowledge of healthy living.^{9,10} An estimated 4% to 6% of U.S. children under age 18 have food allergies.¹¹ Ensuring that parents have the knowledge to help keep their children safe from potential exposure to all foods that might trigger an allergic reaction is an important role schools can play in addressing the needs of students with food allergies. In 2010, 0.26% of youth under the age of 20 had been diagnosed with type 1 or type 2 diabetes.¹⁴ In 2005-2006 NHANES, 16% (overall) of youth 12-19 years and 30% of obese youth 12-19 years had prediabetes, a condition in which blood glucose levels indicate a high risk for development of diabetes.¹⁵ In addition, between 1995 and 2010, the prevalence of diagnosed diabetes in adults increased 50% or more in 42 states, and by 100% or more, in 18 states.¹⁶ Therefore, creating awareness among parents about diabetes may increase knowledge about the extent of the disease and appropriate activities for prevention.

This item provides data for a school level impact measure (SLIM). Measurement of SLIMs is required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

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1. Golan M, Crow S. Targeting parents exclusively in the treatment of childhood obesity: long-term results. *Obesity Research* 2004; 12:357-361.
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QUESTION:

18. During this school year, have teachers in this school given students homework assignments or health education activities to do at home with their parents?

RATIONALE:

This question assesses whether teachers develop family-based education strategies that involve parents in discussions about health topics with their children. Supporting learning at home is a type of involvement promoted in CDC's *Parent Engagement: Strategies for Involving Parents in School Health*.¹ Engaging parents in homework assignments or other health activities at home can increase the likelihood that students receive consistent messages at home and in school as well as decrease the likelihood that they engage in health-risk behaviors.²⁻⁴

This item provides data for a school level impact measure (SLIM). Measurement of SLIMs is required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

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PROFESSIONAL DEVELOPMENT

QUESTIONS:

19. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics?
21. Would you like to receive professional development on each of the following topics?

RATIONALE:

These questions address the importance of professional development for teachers. It is vitally important that teachers be well prepared when they begin teaching and that they continue to improve their knowledge and skills throughout their careers.¹ Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching.² Professional development increases educators' confidence in teaching subject matter and provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues.^{3,4} Districts that have made improvements in their professional development activities have seen a rise in student achievement.^{5,6} Staff development is associated with increased teaching of important health education topics.⁷ The Institute of Medicine's Committee on Comprehensive School Health Programs in Grades K-12 recommended that health education teachers should be expected to participate in ongoing, discipline-specific in-service programs in order to stay abreast of new developments in their field.³

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QUESTION:

20. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics?

RATIONALE:

This question measures the extent to which professional development about HIV, other STD, or pregnancy prevention has been received by the lead health teacher. As new information and research on prevention is available, those responsible for teaching about adverse sexual health outcomes should periodically receive continuing education about HIV, other STD, and pregnancy to assure they have the most current information on effective prevention and health education intervention strategies and priority populations identified as most at-risk for pregnancy and HIV/STD infection.¹⁻³

Effective implementation of school health education is linked directly to adequate teacher training programs.⁴ School health education designed to decrease students' participation in risk behaviors requires that teachers have appropriate training to develop and implement school health education curricula.⁴ Staff development activities for health education teachers need to focus on teaching strategies that both actively engage students and facilitate their mastery of critical health information and skills and should include information about district and state policies affecting sexual health education.⁵

This item provides data for a school level impact measure (SLIM). Measurement of SLIMs is required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

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QUESTIONS:

22. During the past two years, did you receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics?
23. Would you like to receive professional development on each of these topics?
 - (a) Teaching students with physical, medical, or cognitive disabilities...
 - (b) Teaching students of various cultural backgrounds...
 - (c) Teaching students with limited English proficiency...
 - (d) Teaching students of different sexual orientations or gender identities...
 - (e) Using interactive teaching methods (e.g., role plays or cooperative group activities)...
 - (f) Encouraging family or community involvement...
 - (g) Teaching skills for behavior change...
 - (h) Classroom management techniques (e.g., social skills training, environmental modification, conflict resolution and mediation, and behavior management)...
 - (i) Assessing or evaluating students in health education.

RATIONALE:

These questions address the importance of professional development for teachers. It is vitally important that teachers be well prepared when they begin teaching and that they continue to

improve their knowledge and skills throughout their careers.¹ Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching.² Professional development increases educators' confidence in teaching subject matter and provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues.^{3,4} Districts that have made improvements in their professional development activities have seen a rise in student achievement.^{5,6} Staff development is associated with increased teaching of important health education topics.⁷ The Institute of Medicine's Committee on Comprehensive School Health Programs in Grades K-12 recommended that health education teachers should be expected to participate in ongoing, discipline-specific in-service programs in order to stay abreast of new developments in their field.³

Items 22d and 22h provide data for a school level impact measure (SLIM). Measurement of SLIMs is required for grantees receiving funding under CDC-RFA-PS13-1308: Promoting Adolescent Health Through School-Based HIV/STD Prevention and School-Based Surveillance.

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PROFESSIONAL PREPARATION

QUESTIONS:

24. What was the major emphasis of your professional preparation?
25. Currently, are you certified, licensed, or endorsed by the state to teach health education in middle school or high school?
26. Including this school year, how many years of experience do you have teaching health education courses or topics?

RATIONALE:

These questions measure the extent to which lead health education teachers are formally trained in the topic of health education as well as the teaching experience and credentials of the lead health education teacher. Health education teachers need to be academically prepared and specifically qualified on the subject of health.¹ In addition, pre-service training in health education is associated with increased teaching of important health education topics.²

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