REPORT OF THE
DEPARTMENT OF EDUCATION ON

Current Health Programs in the Public Schools of Virginia and the Efficacy and Appropriateness of Adopting a Comprehensive Approach to Health Education

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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PREFACE

This study of health education programs in the public schools was conducted by the Department of Education in response to House Joint Resolution No. 343 (1991 session). In addition to studying current health education programs, the resolution requested that the Department study the efficacy and appropriateness of adopting a comprehensive approach to health education in the public schools. This study was conducted in conjunction with a study by the Department of Education in response to House Joint Resolution No. 437 (1991 session)

The study was conducted during the spring and summer of 1991 by a team of Department of Education staff members under the leadership of Dr. Helen R. Stiff, Division Chief, Pre and Early Adolescent Student Services. The members of the team were:

Brenda F. Briggs
Associate, School Social Services

Patricia Catlett
Associate, Dropout Prevention

H. Douglas Cox
Principal, Pupil Personnel

Arlene Cundiff
Associate, Driver Education

Dr. Sandra Dofflemyer
Principal, Health and Physical Education

Dr. Jan Harris
Associate, Guidance

Marsha Hubbard
Associate, Youth Risk Prevention

Del L. Moser, co-leader
Associate, Health and Physical Education

Fran Anthony Meyer
Associate, Health Education

Dr. Jane R. Logan
Principal, School Food

Dr. Claude A. Sandy, co-leader
Associate, Norm-referenced Assessment

Vivian Sullivan
Associate, Health Occupations

Rayna Turner
Associate, Youth Risk Prevention

Chester C. Walrod, Jr.
Associate, Mentally Retarded

A Report on Current Health Programs in the Public Schools of Virginia and the Efficacy and Appropriateness of Adopting A Comprehensive Approach to Health Education

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EXECUTIVE SUMMARY

This study was conducted during the spring and summer of 1991 in response to House Joint Resolution (HJR) 343 (1991 session). The resolution requested that the Department of Education study current health education programs, as well as the efficacy and appropriateness of adopting a comprehensive approach to health education in the public schools. This study was conducted in conjunction with the study required by HJR 437 (1991 session) on HIV/AIDS education.

Objectives of the Study

- study current health education programs,
- determine the appropriateness of adopting a comprehensive approach to health education,
- evaluate school divisions' AIDS education programs, and
- develop a plan to encourage school divisions to revise their approaches to AIDS education if necessary.

Sources of Information

- review of relevant literature,
- review of health curriculum documents from Virginia school divisions;
- survey of school divisions and other state departments of education, and
- analysis of the need to coordinate efforts with other agencies and organizations.

Definition of Comprehensive School Health Program

A comprehensive school health program includes an organized set of policies, procedures, programs, activities, and services designed to protect and promote the health and well-being of students and staff. The development and implementation of a successful program requires the support and cooperation of individuals in the health services, health education, physical education, school food services, guidance and counseling, psychological services, social work, administration, and staff wellness.

Student outcomes, which are listed in the report and are the goals of the comprehensive school health program, relate to proper nutrition, emotional health, physical health, and health risk reduction.

Findings of the Study

- There is little consistency across Virginia school divisions in the provision of services related to comprehensive health programs.
- Current mandates in Virginia require school divisions to offer health and physical education programs, but don't require that students participate in them except for the need to earn two credits for graduation.
- Most elementary students in Virginia receive their health instruction from teachers who have little specialized training in the subject.
- School divisions' ratings of teacher preparation indicate a significant need for training in some of the specialized health topics (i.e., Family Life Education, HIV/AIDS, substance abuse, and mental health), as well as for elementary teachers in general.

- Pupil-teacher ratios for health and physical education courses in the middle and high schools exceed the maximum school-wide average permitted (i.e., across all subjects). In 1990-91, there were 1,742 health and physical education classes with more than 35 students.
- The amount of class time devoted to health and physical education varies greatly in Virginia. Fewer than half of Virginia's school divisions (57 of 118 responding) have a policy regarding the amount of time to be spent in health education and slightly more than half (63 of 115 responding) have a policy for physical education.
- Most school divisions favored the concept of a comprehensive approach to school health and 102 of 122 school divisions indicated that they either had a comprehensive program or considered it feasible to implement one within several years.
- To date, 130 of 135 school divisions have adopted local guidelines for school attendance for children with HIV.
- Instruction on HIV/AIDS, as well as other sexually transmitted diseases, is included in the FLE program, which all school divisions have implemented. Approximately 90 percent of students in grades 7-10 received instruction in HIV/AIDS prevention. Thirty-six school divisions judged their programs to be ineffective or in need of improvement and, statewide, 44 percent of the HIV/AIDS teachers (more than 1,000) needed additional training.

Recommendations

- All persons teaching health education in the elementary and middle school grades without a health education endorsement should be encouraged to complete training essential for quality instruction. This training should be a minimum of one undergraduate or graduate course in health education.
- Minimum standards for school health education curricula and health services should be developed jointly by the Departments of Education and Health, in conjunction with school divisions in Virginia.
- The Department of Education should design and implement a plan for evaluating the effectiveness of comprehensive school health programs.
- The Board of Education and the Department of Education should commit to the further development of Comprehensive School Health Programs, addressing all health education and health service needs in a coordinated and comprehensive manner, and to the promotion of the program in the public schools of Virginia. This would include consideration for expanding the Health Standards of Learning to include grades 11 - 12 and developing a K-12 health education curriculum guide using the Health Standards of Learning Objectives as a foundation. To be funded in the 1994-96 biennium.
- The Department of Education should continue to provide on-going training on timely health topics. This should be accomplished through the Blue Ridge School Health Conference and regional and local workshops.

I. INTRODUCTION

This study was conducted during the spring and summer of 1991 in response to Department of Education internal request for proposals (RFP) number 91-42. The objectives of the study, as stated in the RFP, were to:

- study current health education programs, including but not limited to the following: present curricula requirements, instructor qualifications and training; pupil-teacher ratio; and class time requirements;
- review the report of the Joint Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth;
- determine the appropriateness of adopting a comprehensive approach to health education in the Commonwealth;
- evaluate the AIDS education programs as implemented by local school divisions to assess (a) compliance with any relevant guidelines and standards of learning objectives, and (b) the effectiveness of such programs;
- develop a plan to encourage revision of local approaches for those divisions not aggressively complying with appropriate guidelines for AIDS education programs in elementary and secondary schools;
- prepare a report presenting the research resulting from this study, the recommendation of the team, and the implications of the recommendation, assuring consistency with the Board of Education directions on outcome assessment and the common core of learning.

This study was also designed to provide responses to specific questions and/or make recommendations regarding AIDS education, current school health programs, and the efficacy and appropriateness of adopting a comprehensive approach to health education in the public schools as requested in House Joint Resolutions 437 and 343 (1991 session).

The approach to this study was multi-faceted. Information was obtained from several sources using a variety of techniques, including:

- conducting a review of relevant literature;
- reviewing health curriculum documents from a sample of school divisions in Virginia and departments of education of other states;

- conducting a questionnaire survey of school divisions in Virginia and departments of education of other states; and

- analyzing the need to coordinate efforts with other agencies and organizations with related goals.

II. REVIEW OF LITERATURE

The expression "new morbidity" has recently been ascribed to a host of social and behavioral factors which are likely to increase the health risk of children and youth. Substance abuse, teen pregnancy, depression, and an increase in sexually transmitted disease are examples of the new morbidity. Allensworth and Kolbe (1987) reported that "in the early 1900's the major cause of morbidity and mortality largely were infectious agents; today the major causes largely are behaviors." Concurrently, there is increasing interest in the concept of wellness and in preventing high-risk behavior which may lead to disease, poor health, and premature death.

It is crucial that youth appreciate the importance of good health (or wellness) and develop healthful behaviors which will become entrenched in their value systems. Therefore, educators and others involved with health promotion must continually examine the way in which health education is delivered in schools and consider the concept of "comprehensiveness" as it relates to school health.

What is meant by comprehensive school health? Traditionally, school health programs have been viewed as incorporating three elements: health education, school health services, and a healthful school environment (Allensworth and Kolbe, 1987; Joint Committee on Health Education Terminology, 1990). While other programs such as school food services and pupil personnel services are not necessarily under the rubric of school health, clearly they support and augment traditional health programs and services; they contribute to students' physical and mental well-being. Wellness programs for employees are also becoming more and more a part of comprehensive school health programs. A review of research on three components of comprehensive school health follows.

Health Education

The term "comprehensive" is also used to define health instruction. The National Commission on the Role of the School and the Community in Improving Adolescent Health, in its report entitled *Code Blue: Uniting for Healthier Youth* (1990), recommended that "young people receive a new kind of health education -- a sophisticated, multi-faceted program that goes light years beyond present lectures about 'personal hygiene' or the four food groups. They need a new kind of health education that:

- Provides honest, relevant information about disease and accident prevention, family life and sex education, drug and alcohol abuse, violence, mental health, and nutrition;

- Teaches skills and strategies needed to make wise decisions, develop positive values, generate alternatives, deal with group pressure, work cooperatively, and avoid fights -- skills that are better learned through role playing and other small group participatory activities than through lectures.

- Includes participation in physical activity programs that foster lifelong exercise habits; and

- Begins before students are pressured to experiment with risky behaviors and continues throughout adolescence. It should begin in kindergarten and continue in a planned, sequential manner through grade 12."

Michael McGinnis, MD, U.S. Department of Health and Human Services, has been quoted as stating:

> What is very clear is that education and health for children are inextricably intertwined. A student who is not healthy, who suffers from an undetected vision or hearing defect, or who is hungry, or who is impaired by drugs or alcohol, is not a student who will profit from the educational process. Likewise, an individual who has not been provided assistance in the shaping of healthy attitudes, beliefs, and habits early in life, will be more likely to suffer the consequences of reduced productivity in later years.

The Joint Commission of Health Education Terminology (1990) defined "comprehensive school health instruction" as follows:

> Comprehensive school health instruction refers to the development, delivery and evaluation of a planned curriculum, pre-school through 12, with goals, objectives, content sequence, and specific classroom lessons which includes, but is not limited to, the following major content areas:

- Community health
- Consumer health
- Environmental health
- Family life
- Mental and emotional health

- Injury prevention and safety
- Nutrition
- Personal health
- Prevention and control of disease
- Prevention of substance abuse

Undoubtedly, the cornerstone of an adequate school health program is comprehensive health instruction. Lohrmann, Gold, and Jubb (1987) see three major goals of the health education program: "the championing of health as a value"; ". . . to provide students with the knowledge, skills and the empowerment requisite to choosing and sustaining personal health behaviors"; and ". . . to foster students' ability to garner, evaluate, and use new information as it becomes available to make appropriate future health-related decisions."

If comprehensive health education is vital to a healthier nation, the notion of who teaches it is vital to a viable instructional program. Health instruction is generally delivered at the elementary level by the classroom teacher, and in health classes by health educators in the middle and high schools. Often, elementary teachers have no training in health education content as part of their professional preparation. A review of elementary teacher education programs in Virginia revealed that only one college or university includes a course in health education as part of the requirements. Further, even certified health education specialists may be inadequately prepared to deal with the myriad of issues now seen as comprising a comprehensive health curriculum. An additional factor for consideration, as we examine the preparedness of those teaching health, is the cross-curricular aspect of comprehensive health education. Lohrmann, Gold, and Jubb (1987) state that health education must be "reinforced across the entire school curriculum in areas such as science, home economics, psychology, sociology, civics, social studies and physical education so that the learner can see the biological, social, cultural, economic, and political implication of his [sic] actions in regard to health matters."

Thus, many school faculty and staff members have a vital role in comprehensive health education. A strong professional development initiative will be required to prepare the teaching staff. Further, to ensure that there are no gaps in the program, schools must initiate an integrated health curriculum which features both horizontal and vertical continuity and which details the most logical staff members to be responsible for various elements of the overall curriculum.

Health Services

Another major component of comprehensive school health is health services. Zanga and Oda (1987) state "school health services today, it is generally agreed, function to support the process of education. They do so by working to maintain and improve the physical and mental health of students and staff." They

further state "the perfect expression of the school health program is a system of coordinated care that ensures a continuum of care from home to community physician to school and back." Traditionally, the major provider of such services has been the school nurse.

The National Association of School Nurses, Inc. has defined the role of the school nurse in three settings: the home, school, and community. Services in the home include acting as a liaison between the home and school, obtaining health histories, participating in parent conferences, providing information for community resources, and involvement in parent groups. In the school, the nurse conducts various screenings; provides emergency first aid; evaluates student health needs; provides health counseling on topics such as chronic illness, nutrition, disease prevention, and positive lifestyles; implements and monitors compliance with immunization requirements; participates in multi-disciplinary teams; conducts health-related classroom presentations; evaluates and monitors communicable and nuisance diseases; and acts as a resource to faculty and staff. In the community, the nurse serves as a liaison between home, school, and community resources; makes referrals to appropriate community agencies; serves as a liaison for recording and reporting child abuse to the appropriate department of social services; participates in professional conferences with community agencies; and provides expertise as a liaison to community service organizations.

In examining the role of the school nurse, it is also critical to consider a new element: that of nursing care in the school setting. The National Association of State School Nurse Consultants (1990) has noted that "students with special health care needs are placing new demands for services on school districts across the nation. Local school boards are being asked to provide health care staff to perform a level of nursing service not seen before in the school setting." The following four reasons are cited for this emerging role.

1. The trend toward outpatient and homebound treatment rather than treatment in an acute care setting;

2. Advances in medical technology which allow monitoring and health maintenance services outside the confines of acute care institutions;

3. The federal mandate for mainstreaming of special education students with complex health needs; and

4. Parents' expectations regarding their children's right to care in the school setting.

The importance of school nurses and of health services in Virginia's public schools was supported by findings and recommendations of a Task Force on the Health Needs of School Age Children appointed by the Secretary of Health and

Human Resources. The task force's report, Senate Document No. 22 (1987), included the following recommendations:

- The number of nurses providing school health services should be increased to allow for at least one nurse in every school, or a ratio of one nurse per 1,000 students.

- Minimum standards for school health services in Virginia should be developed jointly by the Departments of Education and Health.

The services of visiting teachers/school social workers, school psychologists, and school counselors must also be viewed as contributing to an overall comprehensive health program because they function to enhance the mental health and well-being of students. These professionals are uniquely qualified to provide intervention and support to students as they experience normal developmental concerns or problems specific to the individual. Services and programs such as group guidance, individual and group counseling, informational/educational programs for parents, crisis teams, educational interventions, resource location and referral, and home-school coordination advance the overall wellness of students as they seek to remove barriers to learning.

School Health Environment

The third element of comprehensive school health is the school health environment. Allensworth and Kolbe (1987) report that the health environment:

> . . . includes the psychological climate and physical surroundings in which students and faculty are expected to work. Factors that contribute to the physical environment include the school and location and the area that surrounds it, and the school building, including biological or chemical agents that may be detrimental to health, and physical conditions such as temperature, humidity, electromagnetic radiation, mechanical vibration, noise, lighting, and heat. The psychological environment comprises the interrelated physical, emotional, and social conditions that affect the well-being and productivity of students and personnel.

The American Association of School Administrators (1987) has noted that:

> An increasing number of school districts are seeking healthier school environments. For example: They have begun banning smoking for both students and teachers; or they ensure that school buildings and grounds do not contain exposed hazardous substances, including asbestos. In an effort to promote both mental and physical health, some schools have brought together 'teams' to help create an 'environment of support' for students who are suicidal, pregnant, or abused, or who

> have other special problems. Included in these support teams are other students and teachers and other school personnel who -- because of special interest or unique skills -- seek to maintain a productive working relationship with the student.

Schultz, Glass, and Kamholtz (1987) examined the dynamics of psychological health and well-being in school. They have reviewed the literature relative to those factors which promote a climate of psychological health and have concluded that "there are some emerging patterns in education that could make a difference for the better, including: 1) interpersonal relationship building and maintenance factors; 2) school improvement practices; and 3) systemic analysis and problem-solving procedures." Regarding interpersonal relationships, Schultz, Glass, and Kamholtz state:

> What is important is a commitment by each person to develop an open, nonrepressive form of communication where participants are regarded as human beings, are cared for and nurtured constructively by one another, and where trust, safety, and a spirit of cooperation and support abound.

School improvement practices which the authors feel relate to a positive psychological school climate include cooperative learning, social skills training, effective teaching practices, and positive student discipline. Regarding systemic analysis and problem-solving procedures, the authors state:

> School can be a place where individuals come together and as a result of the experience become something more than before. This is the essence of a healthy school climate. It is one where those present apply problem-solving procedures to: 1) define issues that separate them and that keep them from reaching their respective goals; 2) identify meaningful alternative strategies and procedures for potentially creating a healthy environment; 3) explore and apply the most useful alternatives for developing a more relevant environment; and 4) provide a feedback system for further problem identification, exploration, and resolution.

In summary, the future health of society depends upon the shaping of behaviors and attitudes which result in an appreciation of wellness and in healthful lifestyles. While parents and the community-at-large have a role in the pursuit of this goal, our schools, through a commitment to comprehensive school health programs, can make a difference.

III. STATUS OF SCHOOL HEALTH PROGRAMS

Virginia Programs

School health programs in Virginia were investigated through an analysis of state policies and guidelines, an analysis of health curriculum materials from a sample of school divisions in Virginia, and a survey of all school divisions in Virginia. (Note: The complete summary of the survey of school divisions is contained in Appendix B.) The overwhelming conclusion of this investigation is that there is great *variety* and little *consistency* in health education programs and other services associated with comprehensive school health. In some school divisions the health program appears to be excellent -- a comprehensive school health program (i.e., one addressing various elements of health education, health services, and the school health environment) is already in place, with adequate time allocated for health and physical education and staffs judged to be well prepared. In a majority of school divisions, however, the approach to school health is not comprehensive and has a limited conceptual framework. Following are summaries of the several areas of investigation.

Curricula requirements. Direct references to curricula requirements for health and physical education are contained in the Code of Virginia and Standards for Accrediting Public Schools in Virginia. The Standards of Quality make an indirect reference to health and physical education in Standard 1.B., regarding the establishment of educational objectives (Standards of Learning) by the Board of Education and the requirement that school divisions "implement these objectives or objectives specifically designed for their school divisions. . ." Since Standards of Learning have been adopted by the Board for health and physical education and Family Life Education, school divisions are required to use them or use locally developed alternatives.

The Standards for Accrediting Public Schools in Virginia include several curricula requirements regarding health and physical education, as follows:

- Standard C.1. requires that each elementary school provide instruction in health and physical education.

- Standard C.2. requires that each middle level school provide instruction in health and physical education, and that health and physical education be included among offerings in the eighth grade.

- Standard C.3.e. requires that each secondary school offer a minimum of two courses in health and physical education in grades 9-12 and, when health and physical education are taught as a combination class, at least 40 percent of the instructional time shall be devoted to health education.

- Standards F.2. and F.3. require that students earn two credits in health and physical education to meet the minimum requirements for the 21-credit diploma and 23-credit diploma (Advanced Studies Program), respectively.

Several sections of the Code of Virginia address curricula requirements for health and physical education, as follows:

- 22.1-200 requires that health and physical education be taught in the elementary grades of every public school.

- 22.1-204 requires that accident prevention be taught in one or more of the elementary grades and one or more of the secondary grades of every school division.

- 22.1-205 requires the Board of Education to establish a standardized program of driver education for the public school system.

- 22.1-206 requires that instruction concerning drugs and drug abuse shall be provided by the public schools as prescribed by the Board of Education.

- 22.1-207 requires that health and physical education be emphasized throughout the public school curriculum, and that all pupils in the public elementary and secondary schools shall receive health instruction and physical training prescribed by the Board of Education and approved by the Board of Health.

- 22.1-207.1 requires the Board of Education to develop Standards of Learning and curriculum guidelines for a comprehensive, sequential family life education curriculum in grades K-12. (Note: The Board's regulations for the program required school divisions to implement the program in the 1989-90 school year.)

- 22.1-208 requires emphasis on moral education throughout the entire scheme of instruction in the public schools.

An analysis of these various requirements leads to the conclusion that school divisions have considerable flexibility in their offerings for health and physical education. There are several sections of the Code "encouraging" school divisions to emphasize certain health and physical education topics or making some general requirements for instruction on health and physical education topics. These have little impact on health and physical education curricula unless the Board of Education specifies requirements through regulations. For example, section 22.1-208 requiring emphasis on moral education has had limited impact on the curriculum. Likewise, section 22.1-207 has not produced an increase in the emphasis on health and physical education since its adoption in 1980. The accreditation standards no longer require a daily period of physical education for elementary students and they

continue to allow teacher loads for physical education at the middle and secondary levels that are one-third larger than for other subjects.

Under the current accreditation standards, it is possible for students to have limited health and physical education instruction in grades K-8. Schools are required by the standards to provide instruction in health and physical education, but are not specifically required to provide instruction to every student. The only requirement that students take health and physical education is in the secondary grades (9-12), where students are required to take two years of health and physical education in order to earn the credits required for a diploma.

The review of curriculum materials from Virginia school divisions indicates that school divisions are most often implementing programs for which there is a specific mandate, such as the Family Life Education program. When there is a lack of a specific mandate, inclusion in school divisions' curricula is inconsistent.

Instructor qualifications and training. Teachers of health and physical education subjects which require endorsements are certified and properly endorsed in a very high percentage of cases across Virginia. In Virginia during 1990-91, only about 70 health and physical education teachers (less than 2% of the total of approximately 3,700) taught one or more subjects for which they were not endorsed. Almost all of these teachers were in the middle and high schools. Health education is taught in elementary schools primarily by regular classroom teachers with general elementary endorsements. In the survey of Virginia school divisions conducted for this study, 111 of 122 school divisions reported that some or all of their elementary classroom teachers teach health. Typically, there is no requirement for a course in health or physical education in teacher preparation programs for the elementary endorsement. A survey of 37 Virginia colleges and universities revealed that *only one college required a course in health education for the elementary and middle school endorsements*. A majority of elementary students in Virginia receive most or all of their health instruction from teachers who have *no formal training* in the subject. Unless requirements are changed, this is likely to be the case for the foreseeable future.

Especially since the implementation of the Family Life Education (FLE) program and the recent attention to substance abuse and HIV/AIDS education, there have been a large number of "teachers" teaching these specialized topics within health education. In the elementary schools, these topics are taught primarily by regular classroom teachers. *There are no endorsement requirements for teaching any of these specialized topics.* On the survey, school divisions judged the general preparation of their teachers to be poorest in these areas. For HIV/AIDS education in the elementary schools, 62 divisions rated their staff preparation to be fair or poor compared to only 53 divisions rating their staff preparation to be good or excellent. Comparable ratings for mental health were 46 fair or poor and 70 good or excellent, and for FLE sexuality topics 38 fair or poor and 81 good or excellent. These compare to the best ratings on physical education with 97 good or excellent and 23 fair or

poor, and *general* health (i.e., excluding the specialized health topics) with 101 good or excellent and 18 poor or fair. As expected, the ratings of teacher preparation were higher in the middle and high schools; however, the lowest ratings were on the same specialized health topics as in the elementary schools. It was not a surprise that school divisions reported that their most important health education training needs were in the areas of FLE, HIV/AIDS, substance abuse, and mental health, as well as for elementary teachers in general.

Pupil-teacher ratios. The Standards of Quality (SOQ), July 1990, state that school-wide pupil-teacher ratios (across all subjects) in the middle and high schools shall average no more than 25-1. Information supplied by school divisions on the 1990-91 Teacher Daily Assignment (TDA) forms indicates that the average class size in *health and physical education classes in grades 6-10* exceeds the SOQ ratio required across all subjects. Statewide, the typical health and physical education class size (i.e., the mode) fell into the group size 26-30. Across health and/or physical education subjects statewide, the average class size ranged from about 29-1 in grade six to about 27-1 in grade ten. In 1990-91, school divisions reported 1,742 classes with more than 35 students.

Class time requirements. The only staff time requirements pertaining to health and physical education is contained in Standard C.4. of the Standards for Accrediting Public Schools in Virginia. The two health and physical education courses required for graduation, as well as any other health and physical education courses for which credit is given, must be a minimum of 150 clock hours. In the survey conducted for this study, there was marked variance in the number of minutes per week for health and physical education reported by school divisions in Virginia. As shown in the table below, school divisions reported that their elementary school students received instruction in health and physical education an average of about 203 minutes per week. For middle and high school students, comparable figures were 264 and 277 minutes per week, respectively.

Average Minutes Per Week Students Receive Health and Physical Education by School Level -- Virginia, 1990-91

School Level	Min./Week Health Ed.	Min./Week Phys. Ed.	Min./Week Total
Elementary	79.5	123.4	202.9
Middle	110.9	153.5	264.4
High	125.5	151.1	276.6
Alternative	115.2	152.4	267.6

Presumably, the figures for middle and high school students include only students who are receiving instruction in health and physical education. The averages per

day, 53 and 55 minutes, approximate a class period. For elementary school students, however, the average is just slightly more than 40 minutes per day, and it is believed that these figures are probably inflated due to the inclusion of recess time. What is more remarkable,though, are the ranges of time for school divisions in Virginia. In the elementary schools, reported time for health education varied from 16 minutes per week to 180 minutes per week. School divisions also reported a wide range of time for physical education, from 30 to 300 minutes per week. Ranges for the middle and high schools were similar, although not as extreme.

As noted earlier, the state has few requirements related to class time for health and physical education. Whether or not school divisions had established local standards for their schools was another topic addressed in the survey. Only 57 of 118 school divisions reported that they had a *division-wide policy* regarding the amount of time to be devoted to physical education. For health education, 63 of 115 reported that they had such a policy.

Status and feasibility of comprehensive school health programs. The status of school divisions in Virginia regarding comprehensive school health programs was investigated through the survey of school divisions and the review of health curriculum materials. Only 24 of 121 school divisions documented that they met minimal criteria for a comprehensive school health program. Of the small number with a comprehensive program, 63 percent had a K-12 program and 30 percent had a K-10 program. Most of the 24 divisions with comprehensive programs had written plans/curricula for the program, and many other school divisions reported that they had written plans/curricula for programs or activities which might be parts of a comprehensive program.

The school division respondents felt positive toward the concept of a comprehensive school health program. Of 119 divisions responding, only one reported they did not favor the concept. Eighty-three divisions were in favor of the concept and 35 were uncertain at this time. With regard to the feasibility of implementing a comprehensive school health program, 102 of 122 either already had a comprehensive school health program or considered it feasible within the next several years. The most frequently mentioned barriers to implementing a comprehensive school health program were time, funds, and staffing. Comparing the responses of only those 64 divisions reporting that they did not have a comprehensive program but considered the development of one feasible, 61 percent felt several years would be needed compared to 39 percent considering it feasible within a two-year period.

HIV/AIDS Education. The Department of Education receives funding from the Centers for Disease Control (CDC), through annual cooperative agreements, to provide educational services to prevent the spread of HIV and address other important health problems. The Department is receiving funds for the fourth year of a five-year CDC commitment to state education agencies.

The program has four primary objectives, each having several activities. The objectives are:

- to increase the number and percentage of schools providing effective HIV/AIDS education;
- increase the number of students receiving HIV/AIDS education;
- increase the number of schools that offer HIV/AIDS education within a comprehensive health education program; and
- increase the HIV prevention education programs for high-risk, minority, and out-of-school youth, and youth who have special education needs.

To achieve these objectives, the Department of Education is working with school divisions and teacher training institutions to provide the consultative and training services needed for delivering high quality programs for students.

On October 25, 1989, the Board of Education adopted the Model Guidelines for School Attendance for Children With Human Immunodeficiency Virus. Copies of these guidelines were mailed to superintendents in November 1989. To date, 130 of 135 school divisions have submitted to the Department of Education their locally-developed guidelines for review, as requested.

On the survey of school divisions, it was reported for 1990-91 that more than 90 percent of schools in Virginia provided HIV/AIDS prevention education to students in grades 7-10. For grades 11-12, only about 50 percent of the schools were providing HIV/AIDS prevention education. Presumably, the smaller percentage for grades 11-12 is due to the fact that most students are not taking health in those grades and, therefore, it is more difficult to fit HIV/AIDS prevention education into the curriculum. The data in the table below indicates that approximately 93 percent of the students in grades 7-10 were reported to have received HIV/AIDS prevention education during 1990-91, whereas, only about 50 percent of the students in grades 11-12 received such instruction. Of 117 divisions reporting, 101 indicated that they had provided HIV/AIDS prevention education to all students at appropriate age/grade levels.

Students Receiving HIV Prevention Education, Grades 7-12
Virginia, 1990-91 (122 of 134 divisions reporting)

Grade	Students Enrolled	No. Students Rec. HIV Ed.	% Students Rec. HIV Ed.
7	70,175	61,330	87.4
8	69,182	67,038	96.9
9	71,614	64,352	89.9
10	63,914	62,474	97.7
11	53,007	29,096	54.9
12	52,039	23,944	46.0

Ninety of 118 divisions reported that they had a local curriculum for HIV/AIDS instruction. Approximately 70 percent of the divisions reported that their HIV/AIDS instruction was contained entirely within the Family Life Education program.

School divisions were asked to rate the effectiveness of their HIV/AIDS prevention education programs. Their responses indicated that a high percentage (86 divisions or about 70%) considered their programs to be effective or very effective; however, that still leaves 36 divisions (about 30%) with programs that they judged to be ineffective or in need of improvement. Also, school divisions reported that 1,055 (about 44%) of their HIV/AIDS instructors needed additional training.

Programs in Other States

As a way of obtaining information about the status of health programs in other states, a questionnaire was mailed to the education agency in each of the 50 states and the District of Columbia. (Note: References to states in this context will include the District of Columbia.) Of the 51 possible respondents, 49 returned the survey form. In addition to being asked to respond to specific questions in the survey, they were asked to enclose relevant curriculum materials. The major finding was that a high percentage of respondents reported having a comprehensive school health program which is either required or suggested. Twenty-two respondents reported that their comprehensive school health program was required statewide, 21 reported that their program was suggested, and six said they did not have a comprehensive school health program. This information is provided by state in Appendix A.

Other findings of interest include data on pupil-teacher ratios, certification requirements, state mandates, and class time requirements. Findings related to each of these topics are discussed below.

- Average pupil-teacher ratios for the reporting states in health education classes averaged 25-1 to elementary schools, 28-1 in middle schools, and 29-1 in high schools. These ratios are generally consistent with those in Virginia, except that in Virginia the ratios are higher at 29-1 in the sixth grade and decline to 27-1 by the tenth grade.

- Regarding requirements for teachers to be endorsed to teach health and physical education, 27 of 46 states responding reported that elementary health teachers were not required to be certified or endorsed in health or physical education. The picture was different at the middle and high school levels, where only nine and six states, respectively, reported that certification/endorsement was not required. By comparison, in Virginia, health teachers do not have to be endorsed in health and physical education in grades K-8.

- A high percentage of states reported that they have a state mandate that health and physical education be provided. Of those responding, only five reported that they had no elementary mandate, six reported no middle school mandate, and four reported no high school mandate.

- Two questions in the survey addressed the amount of time *allotted* (at the state level) to health education and physical education. Approximately half of the states reported a specific time allotment. For those reporting an allotment, the average number of minutes allotted per week was 148 for elementary schools, 208 for middle schools, and 247 for high schools. By comparison, there are no Virginia state requirements except for students earning high school credit, typically grades 9-10, for which the requirement is 250 minutes per week. However, the average instructional time per week as reported by Virginia school divisions (i.e., 203, 264, and 277 minutes at the elementary, middle, and high school levels, respectively) is slightly higher than the time allotted by other states.

IV. COORDINATION WITH OTHER INITIATIVES

Department of Education Initiatives

There are several initiatives underway in the Department of Education which could have a significant impact on the course of education, including the course of health education, in Virginia. Those most related to the study of comprehensive health education are the Common Core of Learning (CCL) and Outcome-based Assessment. Other initiatives -- World Class Education and Restructuring -- have a more tangential relevance for this study. It is believed that the recommendations resulting from this study are highly consistent with and supportive of the current thinking of the team working on the CCL. Although the team's ideas are still fluid,

it appears that the recommendations from this study will fit easily into most of the domains being developed in CCL. As an example, the elements in the domain Personal Management and Well-being are (1) self awareness, (2) attitudes, values, and dispositions, (3) healthy choices, and (4) personal planning and goals. Each of these elements has a direct relationship to major goals of comprehensive health. There is also a strong relationship between health and some of the elements in the Natural and Constructed Systems and Skillful Thought domains. The ability to make healthy choices requires understanding of the interdependence of humans and the physical environment, as well as the ability to think critically. Additionally, it appears that the objectives of health education would adapt readily to the interdisciplinary approach to instruction that is anticipated in the CCL. Comprehensive school health programs require a coordinated school-wide effort involving not just the faculty, but others on the staff as well. The custodial staff has a responsibility to maintain a healthful physical environment, the cafeteria staff must be supportive of nutrition education, and all staff members must contribute to a positive psychological environment.

Outcome-based Assessment (OBA) is under development, also, but it is not difficult to speculate on the relationship of this program to comprehensive health. Included in this report are several student outcomes which could be used to identify "indicators" for the OBA and performance measures, which are to be used in the OBA, are ideal for assessing the accomplishment of most health and physical education objectives.

Non-Department of Education Initiatives

Subcommittee Studying Means of Reducing Preventable Death and Disability in the Commonwealth. This study is consistent with several national studies, including findings of a linkage between smoking and fatal and disabling diseases, and the *Healthy People, Promoting Health,* and *The Year 2000* document. The study documents Virginia's efforts as follows:

- Emphasis on nutrition
- Emphasis on disease and injury prevention
- HIV/AIDS-related disease control measures
- Increased funding for prevention programs
- 1987 Governor's Task Force on Coordinating Preventive Health, Education, and Social Programs
- Virginia Council on Coordinating Prevention and the Comprehensive Prevention Plan
- Health promotion and disease prevention measures
  - -- School health education

-- Worksite wellness
-- Community health education
-- Injury prevention
-- Training for health care professionals
-- Minority health
-- Independent living
-- Health insurance
-- Support for health promotion and disease prevention
-- Data collection

The study contained twenty-two conclusions and recommendations. An analysis of these conclusions and recommendations reveals at least fourteen references to issues that have an identifiable impact on a comprehensive school health program and support the design of a comprehensive health curriculum.

The various recommendations in the report make reference to the need for healthy lifestyles, the Department of Health's Behavioral Risk Factor Surveillance System, worksite wellness programs, worksite health promotion programs, the Minority Health Advisory Committee to address health promotion, injury prevention, seat belt use, increased public education efforts regarding injury and accident prevention, and building code safety issues.

Virginia Council on Coordinating Prevention. The Council on Coordinating Prevention was established by the General Assembly of Virginia in 1987 to "provide leadership and articulate a broad prevention agenda for the Commonwealth." The 1990-92 Comprehensive Prevention Plan for Virginia, produced by the Council, sets forth a number of goals and objectives with direct implications for a comprehensive school health program. The plan includes goals related to healthy life styles, healthy mothers and babies, positive child and youth development, and safe environment, as well as several other areas indirectly related to comprehensive health.

Other Initiatives. There are at least several other non-Department of Education health promotion initiatives with which the Department of Education should be involved in order to fully coordinate its efforts with related efforts of other agencies and organizations. Some of these initiatives are:

- Health Promotion and Education Council -- includes public and private organizations in an effort to improve health and the quality of life for people in Virginia.

- Virginia Council on Teen Pregnancy Prevention -- was established by the Virginia Secretary of Health and Human Services to develop specific recommendations for the 1992-94 biennium and set priorities for statewide and community-based activities.

- HIV/AIDS Task Force -- was created by the Virginia Secretary of Health and Human Services to develop a plan for prevention and care for the period 1991-2000.

- Domestic Violence Task Force -- was created by the Virginia Attorney General to provide education related to various forms of domestic violence.

- Governor's Council on Alcohol and Drug Abuse Problems and the Governor's Youth Council on Alcohol and Drug Abuse Problems -- advise on policies and goals and develops plans for strengthening substance abuse prevention activities.

V. DEVELOPING A COMPREHENSIVE APPROACH TO SCHOOL HEALTH

Definition

A comprehensive school health program includes an organized set of policies, procedures, programs, activities, and services designed to protect and promote the health and well-being of students and staff. The development and implementation of a successful program requires the support and cooperation of individuals in the health services, health education, physical education, school food services, guidance and counseling, psychological services, social work, administration, and staff wellness.

Rationale

The citizens of the United States, and especially its youth population, are in the midst of an unprecedented health crisis. Most of the health problems which have contributed to this crisis are the result of discretionary participation in high-risk behaviors; e.g., AIDS and other sexually transmitted diseases, alcohol and other substance abuse, accidental injury, teen pregnancy, and progressive diseases resulting from poor nutritional habits and/or lack of exercise. Because these health problems result primarily from discretionary behaviors, we have the potential to reduce or virtually eliminate them by effecting changes in the attitudes, values, and behaviors of students.

While it is not reasonable to expect immediate and significant changes in the behaviors of the masses, it is believed that significant changes can be effected over an extended period of time. For example, the varied efforts -- mostly educational -- to dissuade young people from using tobacco has begun to pay off during the past 10 to 15 years. Today, a much smaller percentage of young people are beginning tobacco use. It is believed that such changes can be effected with regard to other high-risk behaviors, also.

Effecting significant behavioral changes requires the type of coordinated school-wide and community-wide effort described in this document. Schools must give frequent and consistent messages to students about what is appropriate behavior and what is not, through direct instruction, other educational activities, and modeling. Every staff member in a school *can* contribute significantly to either the educational activities or the modeling, *and should*. Additionally, the school must coordinate its efforts with community agencies and organizations with related goals. As difficult as the task may be, school divisions in Virginia indicated support for a comprehensive approach and more than 80 percent either have a comprehensive program already or believe it is feasible to implement one within "several years."

This kind of coordinated effort can influence attitudes, values and, ultimately, behaviors. Obviously, it will require a significant amount of effort; however, it will address a problem that must be addressed. If we do not influence our youth to make healthier choices, we cannot expect them to reach their academic potential or, ultimately, function well as adults in the society. In this sense, it is more important and more fundamental than academic learning.

Student Outcomes

In order to develop a healthful lifestyle that reinforces positive behavior formation, a comprehensive school health program must focus primarily on changing behaviors in four areas: nutrition, emotional health, physical health, and risk behaviors.

A review of the Standards of Learning for health education and other publications support the need for continued reinforcement of risk reduction behaviors to promote healthful lifestyles. While the objectives of the Standards of Learning are not an all-inclusive prescription for a comprehensive school health program, they represent a dynamic framework to encourage and promote an understanding of the impact on lifestyle choices. Student outcomes for a comprehensive school health program must include a commitment to continuing positive health practices. Although it is recognized that this expectation is affective and difficult to measure, it is the basis for the development of attitudes and values that influence health. To truly provide data pertaining to the effectiveness of a comprehensive school health program, it would be necessary to conduct a long-term study of attitudes and health habits of individuals.

The suggested student outcomes for a comprehensive school health program are:

- Nutrition
    1. Students will exhibit sound nutritional practices.
    2. Students will demonstrate an understanding of the interrelationship of proper nutrition and health maintenance.

- Emotional Health
    1. Students will demonstrate coping skills based on informed decision-making.
    2. Students will develop feelings of positive self-worth and self-esteem.

- Physical Health
    1. Students will engage in physical fitness activities that foster lifelong participation.
    2. Students will value wellness and engage in healthy practices.

- Health Risk Behaviors
    1. Students will demonstrate the ability to make effective decisions regarding health risk behaviors

Model Program

The Model Comprehensive School Health Program described herein is based on the best information available, including research studies and expert opinion; however, there is no empirical evidence that indicates this is the best model for Virginia or the only model that will work. Indeed, we believe that a number of models -- as long as they are comprehensive and coordinated -- could work. Examples of essential program characteristics are interactions between school staff and students that evidence goodwill and enhance self-respect, support of nutrition instruction by the cafeteria staff, and modeling of good health practices by school staff. Other ways of coordinating efforts and providing school-wide support for the goals of the program will be obvious as one becomes familiar with the model program's elements and criteria.

Elements of the program. This design of a comprehensive school health program has eight elements touching all aspects of the school experience and having the potential to significantly impact students' health knowledge, attitudes, and values. The eight elements are described below.

1. Health Education -- is a sequential instructional program covering all grades (pre-K through 12) and addressing the physical, mental, emotional, and social dimensions of health. This aspect of the program must assure that students acquire relevant knowledge about health issues, develop the skills needed to support the maintenance of health and fitness, and develop values and attitudes which lead to making healthy choices. Appropriate learner objectives for grades K-10 have already been developed in the Standards of Learning.

2. Health Services -- promotes the health of students and school personnel through prevention, early intervention, and remediation of specific health problems. These services must ensure access to and the appropriate use of primary health care, prevent and control

communicable disease, provide emergency care for injury or sudden illness, promote a safe and sanitary school environment, and provide concurrent learning opportunities which support the instructional program.

3. School Environment -- focuses on creating and maintaining physical and psychological well being of students. The physical environment must promote accident and disease prevention, and include facilities necessary for health and physical education. The psychological environment -- which is created by the physical facilities, the school staff, as well as all aspects of the school program -- must promote positive psychological development.

4. School and Community Agencies -- involves an integrated approach among health and education professionals in the school and community to provide and/or support improved school health programs.

5. Physical Education -- serves as a means for students to develop strength, coordination, and cardiovascular and respiratory efficiency, as well as for social development, stress reduction, and movement appreciation. The focus of the program must be on developing the skills needed for lifetime sports and fitness activities, developing and maintaining fitness while in school, and developing motivation for lifetime fitness. It is crucial that physical education be supportive of the goals of health education. Appropriate learner objectives for grades K-12 have already been developed in the Standards of Learning.

6. School Nutrition -- promotes good nutritional practices both within and outside the school setting. It must provide a model for good nutritional practices, complement health instruction which addresses nutrition, and assist in efforts to teach students to select nutritionally appropriate foods.

7. Counseling -- provides broad-based prevention and intervention programs to promote the physical and psychological health of students and faculty.

8. Staff Wellness -- provides school personnel with the opportunity to take an active role in maintaining and improving their own physical and psychological health. This aspect of the program also supports school personnel in becoming better models for students.

Other comprehensive school health programs may have more or fewer elements. What is essential, however, is that efforts to provide services related to these eight elements are integrated and coordinated to provide the best possible health environment and experiences for students.

In this study of current health programs, both inside and outside Virginia, a number of characteristics (herein referred to as criteria) of effective comprehensive school health programs were identified. The criteria associated with each of the eight elements described above are listed in Appendix C. Although we may tend to associate these criteria with particular elements of the program and with particular staff members in the school, *coordination of efforts* is essential if the comprehensive program that youth require is to be successfully planned and implemented. The *entire staff of a school* must be concerned with the health of students and support the program's objectives. Additionally, this section includes descriptions of school strategies for implementation of such a program in Virginia.

School strategies. The probability of developing a successful comprehensive school health program will be increased if schools follow certain implementation and operational strategies. The following are suggested as reasonable strategies for initiating a comprehensive school health program.

- Written policies are established to identify objectives and provide direction for the program.

- A comprehensive school health program is established and a program coordinator is named (may be assigned to a curriculum/program supervisor on staff).

- Representatives from each program area meet periodically to assure coordination of efforts.

- There is a two-way communication plan which aims to increase parents' support for the comprehensive school health program, informs them of current health issues, and provides them with an opportunity to influence the program objectives and activities.

- Interdisciplinary school teams attend a comprehensive school health education conference, such as the Blue Ridge Conference, for training and identification of resources to assist with program implementation and improvement.

- The curriculum and other educational plans incorporate concepts and activities identified in, but not limited to: *The Health Objectives for Nation: 2000; Comprehensive Prevention Plan For Virginia; Code Blue: Uniting For Healthier Youth;* and *Beyond The Health Room.*

- Periodic evaluations are conducted and plans for the program modified, as indicated.

- A review committee is established to assess the health-related counseling needs of the students.

- Parents are involved in the work of a school committee to provide guidance and support for the program.

- School and community agencies collaborate to address the various health needs or students.

- Resource directories to provide information regarding outside counseling for health related problems and wellness activities are available.

- Written communications regarding health related issues for students are sent to the community periodically.

- School personnel are provided regular in-service education and provided with the means to stay informed on current health issues.

VI. RECOMMENDATIONS AND IMPLICATIONS

Recommendations

Following are recommendations related to the development and implementation of a Comprehensive School Health Program in the public schools of Virginia. The recommendations are based on program findings from Virginia and the national perspective and have been rank ordered from the highest priority to the lowest priority on the basis of the assessment of importance.

1. All persons teaching health education in the elementary and middle school grades without a health education endorsement should be encouraged to complete training essential for quality instruction. This training should be a minimum of one undergraduate or graduate course in health education.

2. Minimum standards for school health education curricula and health services should be developed jointly by the Departments of Education and Health, in conjunction with school divisions in Virginia.

3. The Department of Education should design and implement a plan for evaluating the effectiveness of comprehensive school health programs.

4. The Board of Education and the Department of Education should commit to the further development of Comprehensive School Health Programs, addressing all health education and health service needs in a coordinated and comprehensive manner, and to the promotion of the program in the public schools of Virginia. This would include consideration for expanding the Health Standards of Learning to include grades 11 - 12 and developing a K-12 health education curriculum guide using the Health

Standards of Learning Objectives as a foundation. To be funded in the 1994-96 biennium.

5. The Department of Education should continue to provide on-going training on timely health topics. This should be accomplished through the Blue Ridge School Health Conference and regional and local workshops.

Comprehensive Health Issues for Further Study and Interagency Collaboration

At the discretion of the Board, the Department of Education will study the following in preparation for presentation to the Board:

- complete annual health appraisals for all students
- school nurse services for all students
- wellness programs for school staff in all public schools
- after-school intramural program opportunities for middle and high school students
- physical fitness testing requirements
- smoke-free schools
- student teacher ratios for health and physical education classes, and
- minimum requirements for participation in health and physical education (elementary,middle and high school)

The Department of Education recommends that the Board consider the development of pilot comprehensive health programs in LEA's to include:

- health education
- health services
- healthful environments
- school and community
- physical education
- counseling services
- school nutrition, and
- faculty wellness

At the discretion of the Board, the Department of Education will proceed to coordinate health program goals and strategies with other state agencies and private organizations concerned with health promotion and health education.

Implications

General Assembly. It is important that the General Assembly give recognition to and support for a comprehensive approach to health in the public schools of Virginia. A comprehensive approach, focused in schools and with the support of community organizations and agencies, is needed to effectively address this society's most serious health problems.

Board of Education. Implications for the Board of Education are similar to those for the General Assembly. The Board's recognition of the need for a comprehensive approach to health in the public schools and inclusion of funding for the program in its budget proposals are essential. Additionally, the Board's continuing support and guidance in the development of the program are extremely important. Essentially, there is a need for a long-term commitment to pursue one of the present Goals of Public Education in Virginia, i.e., "To aid each pupil to the full extent of his or her abilities to practice good habits of personal health and physical fitness."

Department of Education. The implementation of comprehensive school health programs in the public schools will be a high priority for the Department of Education. The Department will recommend to the Board that it support the comprehensive school health program, both philosophically and financially. Finally, the Department will increase its support of several interagency initiatives, especially the Council on Coordinating Prevention, and aggressively pursue cooperative efforts with other agencies and private organizations working toward common goals.

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APPENDICES

SUMMARY OF RESPONSES

49 OF 51 STATES RESPONDING

Appendix A

VIRGINIA DEPARTMENT OF EDUCATION

STATE COMPREHENSIVE SCHOOL HEALTH EDUCATION

QUESTIONNAIRE

Please read each item and provide a brief response. Please return this form by **June 28, 1991** to the individual and address below. Thank you for your assistance.

Ms. Patricia M. Catlett
Pre and Early Adolescent Education, 21st Floor
Virginia Department of Education
P. O. Box 6Q, Richmond, Virginia 23216-2060
(804) 225-2055

Department of Education Identification Information:

Department of Education: _____
Name of Superintendent/Commissioner: _____
Name of Person Completing Questionnaire: _____
Title: _____ Telephone: ( ) _____

1. Does your state have either a required or suggested comprehensive school health education program?
   22 yes, required 21 yes, suggested 6 no,program

   * Indicate grade level(s): Varied from state to state _____

2. Check all health topics included in your comprehensive school health education program. (Mark all that apply)

44	Alcohol Abuse Prevention	46	Nutrition
	Driver Education	31	Parenting
16	(classroom only)	30	Physical Education
47	Drug Abuse Prevention	46	Safety
43	Family Life/Living	44	STDs
45	First Aid	39	Suicide Prevention
42	Fitness/Wellness	39	Teen Pregnancy Prevention
21	Guidance/Counseling		
46	HIV/AIDS Prevention		
48	Mental Health		

Other: See Appendix B

* **Note: If you have information supporting the above topics, please forward these materials with the completed questionnaire. (eg. pamphlets, brochures, curriculum guides)**

3. What is the average teacher-pupil ratio in your Health Education classes? (eg. 1 teacher/25 students)

1 / 25	Elementary (23-569.7)	1 / 27	Middle/Jr. High (24-656.9
1 / 29	High School (24-695)	1 / 18	Alternative Ed. (10-177)

4. Are health educators in your state required to be certified/ endorsed in health and/or physical education? (Mark all that apply)

	No	Health Only	PE Only	Both H&PE
Elementary	26	5	3	11
Middle/Jr. High	9	19	6	22
High School	6	22	8	25
Alternative Ed.	13	7	2	12

* Specific requirements: See Appendix B
Please provide a copy any certification standards.

5. Does your state have mandates which require that health education and physical education be provided? (Mark all that apply)

	Health Mandate	Phys. Ed. Mandate	No Mandate
Elementary	37	35	5
Middle/Jr. High	34	34	6
High School	36	37	4
Alternative Ed.	15	24	4

* Specific requirements: See Appendix B

6. How much time is allotted for students to participate in your health program?

DATA PROVIDED ARE AVERAGES

Elementary	81.0	minutes per week
Middle/Jr. High	110.6	minutes per week
High School	121.7	minutes per week
Alternative Ed.	148.1	minutes per week

7. How much time is allotted for students to participate in your physical education program?

DATA PROVIDED ARE AVERAGES

Elementary	66.76	minutes per week
Middle/Jr. High	97.84	minutes per week
High School	125.1	minutes per week
Alternative Ed.	121.1	minutes per week

COMMENTS: _____

APPENDIX B

COMPREHENSIVE SCHOOL HEALTH PROGRAM SURVEY
Virginia Department of Education
Due June 28, 1991

School Division SUMMARY OF RESPONSES **Telephone** _____
122 OF 134 DIVISIONS RESPONDING

Person Completing Survey _____

PART I
INFORMATION ON PROGRAMS AND ACTIVITIES RELATED TO COMPREHENSIVE SCHOOL HEALTH

DIRECTIONS: Part I of this survey requests information on the various components of the school health program in your division during the current academic year (1990-91). Please provide the best information available without conducting a formal survey of your schools. The information you provide will enable us to complete the study required by House Joint Resolution (HJR) 343. Questions regarding the survey should be addressed to either Fran Anthony Meyer at (804) 225-3210, Del Moser at (804) 225-2840, or Claude Sandy at (804) 225-2917. Thank you for your assistance.

A. HEALTH AND PHYSICAL EDUCATION PROGRAMS

1. Circle the grades at which your *division requires* all students (with limited exceptions) to take health education.
   105 OF 122 REPORTED K-10.

2. Circle the grades at which your *division requires* all students (with limited exceptions) to take physical education.
   107 OF 119 REPORTED K-10.

3. Do you have a *division-wide policy* regarding the amount of time to be devoted to *health education*?

   Yes 57 No 61. If "yes," please describe the requirement. _____

   _____

   _____

4. On the average, how many minutes per week do your students receive *health education* at each school level?
   DATA SHOWN ARE AVERAGES AND RANGES.

79.5 (16-180)	Elementary school	125.5 (20-275)	High school
110.9 (15-360)	Middle/junior high school	115.2 (45-275)	Alternative education

5. Do you have a *division-wide policy* regarding the amount of time to be devoted to *physical education*?

   Yes 63 No 52. If "yes," please describe the requirement. _____

   _____

6. On the average, how many minutes per week do your students receive *physical education* at each school level?

123.4 (30-300)	Elementary school	151.1 (45-250)	High school
153.5 (22-275)	Middle/junior high school	152.4 (55-275)	Alternative education

7. Which of the following topics are typically included in your *health (including physcial) education* program? Mark those that apply.

GRADES --	K	1	2	3	4	5	6	7	8	9	10	11	12
Tobacco use prevention	75	87	88	99	103	112	109	112	114	105	95	9	8
Alcohol use prevention	73	83	87	96	104	111	112	115	115	106	107	11	10
Illegal drug use prevention	75	84	88	97	103	109	113	114	115	102	102	12	13
Nutrition & healthy food choices	108	109	108	112	108	105	108	105	101	91	81	8	7
Injury prevention and safety	106	106	109	110	107	106	106	102	106	102	86	7	7
Conflict resolution	59	66	70	79	83	88	91	91	90	81	80	8	7
Fitness & physical activity	104	104	105	106	106	106	109	109	111	108	103	11	7
Sexuality and sexual behavior	44	47	48	59	81	91	100	105	109	107	104	16	16
Suicide prevention	20	24	23	26	38	47	62	83	87	86	95	8	8
Growth and development	92	94	95	103	105	107	106	108	109	99	97	6	5
Personal health	107	107	108	108	110	110	112	110	111	100	93	4	3
Communicable disease prevention	73	78	80	87	99	103	104	102	98	106	85	8	6
Community health	62	62	67	74	76	84	86	95	92	95	80	6	4
Consumer health	41	42	50	62	69	77	81	88	85	97	72	4	2
Environmental health	58	59	64	78	82	83	84	90	82	92	70	5	4
Classroom driver education	0	0	0	0	0	0	0	0	0	22	106	9	7

8. a. Does your Family Life Education (FLE) program cover grades K-10 or K-12? K-10 86 K-12 34.
   b. Did you adopt the state's FLE SOLs or develop local Standards of Learning (SOLs)? State 55 Local 65.
   c. How is your FLE program integrated into your curriculum? Taught as an independent program 40; Taught as part of the health program 98; Taught as part of other disciplines (specify) _____

SCIENCE - 26, SOCIAL STUDIES - 21, AND OTHER - 23.

9. In your *elementary schools*, who teaches the following topics? Check the boxes that apply.

	Classroom Teachers	Health Specialists	Phys. Ed. Specialists	Drug Ed. Specialists	HIV/AIDS Specialists	School/PH Nurses	Other (specify)
Health Education	111	17	27	5	3	20	3
Physical Education	64	11	103	0	0	0	1
Mental Health	119	13	22	7	1	15	29
HIV/AIDS Prevention	76	16	22	3	8	41	18
Substance Abuse	107	15	26	31	1	19	36
Family Life -Sexuality	97	15	29	0	2	54	31
Family Life -Other	106	11	24	7	4	35	0

10. In your *middle/junior high schools*, who teaches the following topics? Check the boxes that apply.

	Health Specialists	Phys. Ed. Specialists	Drug Ed. Specialists	HIV/AIDS Specialists	School/PH Nurses	Other (specify below)
Health Education	68	70	6	2	19	17
Physical Education	22	104	1	0	1	2
Mental Health	67	63	10	2	11	26
HIV/AIDS Prevention	55	57	9	9	38	24
Substance Abuse	61	67	33	2	19	32
Family Life -Sexuality	54	54	3	7	41	36
Family Life -Other	58	61	4	5	20	38

11. In your *senior high schools*, who teaches the following topics? Check the boxes that apply.

	Health Specialists	Phys. Ed. Specialists	Drug Ed. Specialists	HIV/AIDS Specialists	School/PH Nurses	Other (specify below)
Health Education	73	79	7	2	16	11
Physical Education	27	112	2	0	1	3
Mental Health	72	67	9	1	11	16
HIV/AIDS Prevention	63	65	7	14	35	25
Substance Abuse	70	75	31	2	14	24
Family Life -Sexuality	60	77	6	3	39	40
Family Life -Other	65	67	5	4	24	39

12. Do you have a written curriculum (i.e., more than learner objectives):
for your *health education program?* Yes 96 No 24
for your *physical education program?* Yes 95 No 24
If you have written curricula, check the blank beside each of the following that are characteristic of your programs.

Health	Phys. Ed.	
96	95	Has an established scope (what is taught) and sequence (when taught).
96	95	Has written goals and objectives.
96	78	Includes objectives that address a wide range of health problems and issues (e.g., drug abuse, nutrition, injury prevention).
93	73	Includes teaching activities aimed at establishing health-related behaviors.
73	65	Includes a periodic evaluation which is used to revise and improve the program.

B. COMPREHENSIVE SCHOOL HEALTH PROGRAMS

Definition: A comprehensive school health program includes an organized set of policies, procedures, programs, activities, and services designed to protect and promote the health and well-being of students and staff. The development and implementation of a successful program requires the support and cooperation of individuals in the health services, health education, physical education, school food services, guidance and counseling, psychological services, social work, administration, and staff wellness.

1. Do you have a *comprehensive school health program* (as defined above)? Yes 24 No 97 If "yes," Which grade levels does it cover? 63% K-12, 30% K-10. Please describe your program, indicating the programs/activities included.

2. a. Do you have a written plan/curriculum for a *comprehensive school health program*? Yes 20 No 95.
   b. Do you have written plans/curricula for programs or activities which might be parts of a comprehensive school health program? Yes 62 No 24. If "yes," please indicate the programs/activities included (if different from those listed in item B.1).

3. In your opinion, would it be feasible to implement a comprehensive school health program in your school division?
   - 38 We already have a comprehensive school health program.
   - 39 Yes, it seems feasible if we are allowed several years to develop and implement the program.
   - 25 Yes, it is probably feasible within the next two years.
   - 20 No, it does not appear to be feasible at this time.

   Please comment on your reasons for your response to this item.

4. Does your division favor the concept of a comprehensive school health program?
   - 83 Yes, we favor the concept.
   - 1 No, we do not favor the concept.
   - 35 Our position is uncertain at this time.

5. What might be significant barriers to the implementation of a comprehensive school health program?

   REASONS MENTIONED WERE PRIMARILY STAFFING, TIME, AND MONEY.

C. TEACHER QUALIFICATIONS AND TRAINING

1. Rate the general preparation of teachers of the following topics in your *elementary schools*.

	Excellent	Good	Fair	Poor
General health topics	22	79	17	1
Physical education	39	58	17	6
Specific health topics:				
Mental health	10	60	40	6
HIV/AIDS prevention	12	41	55	7
Substance abuse prevention	20	68	25	2
FLE -- sexuality topics	21	60	33	5
FLE -- other topics	26	66	19	4
Other VARIED				

2. Rate the general preparation of teachers of the following topics in your *middle/junior high schools*.

	Excellent	Good	Fair	Poor
General health topics	40	60	8	2
Physical education	44	58	8	1
Specific health topics:				
Mental health	15	74	20	2
HIV/AIDS prevention	23	59	28	2
Substance abuse prevention	34	66	12	2
FLE -- sexuality topics	31	53	23	3
FLE -- other topics	31	63	13	4
Other VARIED				

3. Rate the general preparation of teachers of the following topics in your *high schools*.

	Excellent	Good	Fair	Poor
General health topics	52	59	6	2
Physical education	54	56	6	1
Specific health topics:				
Mental health	28	67	22	2
HIV/AIDS prevention	32	61	21	3
Substance abuse prevention	41	65	15	3
FLE -- sexuality topics	38	63	15	4
FLE -- other topics	37	60	14	2
Other VARIED				

4. What do you consider to be your division's most important training needs in the area of comprehensive health education? Give special consideration to those areas rated as "fair" or "poor" in the item above.

PRIMARILY SEXUALITY AND OTHER F.L.E. TOPICS, HIV/AIDS, SUBSTANCE ABUSE, AND MENTAL HEALTH. ALSO FREQUENTLY MENTIONED WAS TRAINING FOR ELEMENTARY TEACHERS.

Note: Please add other comments about health and physical education, comprehensive school health programs, and teacher qualifications and training which you believe are important and were not addressed in your responses to the survey items.

NOTABLE COMMENTS: College courses do not prepare elementary teachers to teach our comprehensive curriculum. Health and physical education (must) be interrelated and taught as a core subject rather than as separate subjects. Teachers need inservice training to help them understand the "wellness/fitness for life" concept.

PART II
INFORMATION ON HIV/AIDS EDUCATION
FOR THE CENTERS FOR DISEASE CONTROL (CDC) AND HJR 437

DIRECTIONS: Part II of the survey requests information about HIV/AIDS prevention education in your school division for the current academic year (1990-91). For the first six items, include schools teaching students in grades 7-12 in the data for each of those grades. The information you provide will enable us to meet our reporting obligation to CDC and complete the study required by HJR 437.

DEFINITION: HIV or human immunodeficiency virus is the virus that causes AIDS.

	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
1. How many of your schools have the following grades?	374	310	280	267	256	277
2. How many schools provided HIV prevention education in the following grades?	338	294	264	261	135	130
3. How many schools provided comprehensive health education in the following grades?	292	250	230	217	48	48
4. How many schools integrated HIV prevention into comprehensive health education in the following grades?	286	232	215	207	42	42
5. How many students were enrolled in each of the following grades this year?	70,175	69,182	71,614	63,914	53,007	52,039
6. How many students in each grade received HIV prevention education this year?	61,330	67,038	64,352	62,474	29,096	23,944

7. During 1990-91, was HIV/AIDS prevention instruction provided to all students at appropriate age/grade levels? Yes 101 No 16. If "no,"of those students for whom it was appropriate, approximately what percent received instruction? 12 DIVISIONS - MEAN 80%, MEDIAN 96%

8. Do you have a local curriculum for your HIV/AIDS prevention education program? Yes 90 No 28
Is it *entirely* within your Family Life Education program? Yes 77 No 32.

9. How many staff members teach HIV/AIDS prevention? 2,392
How many of these staff members need additional training in HIV/AIDS instruction? 1,055 (44%)

10. Rate the overall effectiveness of your HIV/AIDS prevention education program.
14 Very effective
72 Effective
34 Needs improvement
2 Ineffective

Please return this survey by June 28, 1991, to
Mrs. Fran Anthony Meyer
Virginia Department of Education
P. O. Box 6-Q
Richmond, Virginia 23216

AGAIN, THANK YOU FOR YOUR ASSISTANCE!

Appendix C

Comprehensive School Health Program Elements and Criteria

Element 1: Health Education

- A current health education curriculum guide is available that includes inclusive health topics for grades K-12.
- The health curriculum is updated regularly.
- Students are scheduled for a daily period of health instruction.
- A sequential and comprehensive program of both health and physical education, each are scheduled separately.
- Health education concepts are integrated into other curriculum areas as appropriate.
- Current health textbooks are provided for each student.
- Health educators, who are skilled in providing health education instruction, are assigned to teach at the grade levels for which they are endorsed.
- Teachers of health education participate in workshops and in-service training dealing with specific content and programmatic issues on a timely basis. Training is initiated at the school, division, state, and/or national levels.
- The student/teacher ratio for health education classes is equivalent to other curricular areas.
- Adequate classroom space and appropriate materials are provided for health education instruction.
- Elementary classroom teachers responsible for health instruction have the necessary undergraduate course work to qualify them to teach health education topics.
- The focus of the curriculum is on prevention and intervention of health problems and the maintenance of good health and health practices.
- The curriculum provides health related knowledge and an opportunity to develop positive attitudes and skills for good health practices.

- A parent education component is included in the health education curriculum to involve and inform parents about good health practices and critical health issues.

Element 2: Health Services

A full-time school nurse is available to work with students, parents, school staff, and community agencies to:

- Obtain health histories.
- Participate in parent conferences.
- Provide information on community resources.
- Coordinate the school health services program.
- Conduct health screening.
- Evaluate student health needs and provide early intervention.
- Implement and monitor compliance with immunization requirements.
- Provide emergency first aid.
- Provide counseling on various health topics.
- Provide health instruction for faculty and students.
- Provide direct service to disabled students.
- Provide specialized health care needs as required.
- Act as a resource to faculty and students.
- Develop a school health advisory council.
- Act as liaison to community service organizations.
- Make referrals to community agencies.
- Record and report information to appropriate regulatory agencies.
- Elicit the services of appropriate health professionals as needed.

Element 3: Healthful Environment

Physical and Psychological Climate

- Develop lead and radon testing programs and establish a monitoring schedule.

- Develop environmental sanitation plans in conjunction with the local health department.

- Develop tobacco-free directives and prohibit smoking or consumption of tobacco products on the school site. Provide tobacco cessation programs.

- Develop an administrative policy to address:

Safety Needs -- reduction of potential hazards including physical or psychological abuse

Social Needs -- facilitation of the promotion of positive relationships

Recognition Needs -- recognition of the worth and success of individuals and facilitation of the promotion of self-esteem for students and school personnel

Biological and Chemical Agents

- Develop standards for safe use and storage, and inspection schedules for dealing with hazardous materials (e.g., PCB spills, cleaning fluids, pesticides, and disposal of unused/old laboratory chemicals).

Location and Surroundings

- Give attention to stimulating colors and lighting, as appropriate.

- Develop standards to ensure the safety of the school site and the conditions that may be detrimental to health (e.g., temperature, humidity, electromagnetic radiation, mechanical vibration, noise, lighting, heat and air conditioning).

- Establish cooperative efforts with the Department of Transportation and local police/sheriff's department to ensure traffic safety around and within the school site.

- Establish a regular schedule for school site fire safety inspection.

Fire Drill Procedures

- Develop regular fire drill procedures and follow with established reporting procedures. A special emphasis is placed on roll call after building evacuation.

- Develop a close working relationship with local fire departments.

Element 4: School and Community

- Schools and community agencies work collaboratively to ensure that all children and youth receive appropriate health services.

- Establish local coordinating councils for children, youth, and families to develop strategies for designing plans and policies to meet the health and education needs of the communities.

- School and community agencies work collaboratively to establish division-wide school wellness programs that address the health needs of the community.

- Schools, communities, and businesses curtail the access of teens to tobacco products and alcoholic beverages.

- Civic leaders receive training on health and education issues and serve as healthful role models and support for the schools.

- Encourage businesses to develop partnerships with schools and to assist schools with activities that enhance healthful lifestyles.

- Encourage businesses to make financial contributions to the health and education of the children, the youth, and the community to improve the quality of the future work force.

- Churches, schools, and public and private centers provide recreational services and programs to children, youth, and families.

- Community serving agencies and businesses work with schools to establish and support peer facilitation programs.

Element 5: Physical Education

- Develop and implement an age appropriate sequential curriculum (K-12) that emphasizes personal meaning in movement:

Fitness -- circulatory-respiratory efficiency, neuromuscular efficiency, catharsis

Performance -- mechanical efficiency, spatial orientation, object manipulation, participation, group interaction

Transcendence -- joy of movement, self-knowledge, challenge, communication, movement appreciation, cultural understanding

- Provide daily physical education instruction for all students by an endorsed physical education specialist.
- Ensure that the student/teacher ratio is equivalent to all other academic courses.
- Ensure that the physical education teacher's class load is equivalent to the classroom teacher's class load (particularly the early childhood physical education specialist).
- Provide an intramural program for all students.
- Provide adequate facilities and equipment to implement the adopted curriculum.
- Integrate physical education content across the curriculum. At the elementary level, the physical education teacher should provide in-service for classroom teachers who have responsibility for physical education instruction thus facilitating the implementation of the curriculum.
- Develop partnerships when applicable, with local recreational facilities/programs to enhance the program.
- Develop and distribute a resource directory that identifies local recreational and fitness opportunities.
- Sponsor promote, and advertise appropriate fitness recognition activities for Physical Fitness and Sports Month.
- Administer the physical fitness tests annually in grades 4-10.
- Develop public relation policies to keep parents informed of the child's movement performance.
- Encourage staff development of all school personnel which relates to a comprehensive health program. The Blue Ridge School Health Education Conference is suggested as an excellent opportunity for staff development.

- Encourage all staff members to model appropriate fitness and movement principles.

- Ensure a sequential and comprehensive program of physical education by scheduling each grade level separately.

- Evaluate and update curriculum guides, facilities, and equipment are periodically.

- Have teachers who have been endorsed specifically for the age levels they teach (i.e., early childhood, pre-adolescent, adolescent).

- Ensure that teaching takes precedence over athletic coaching.

Element 6: School Nutrition

- The school division has an established nutrition policy which governs the foods available for sale throughout the entire school day and considers nutrient density, dental health, fat and sodium content.

- The school nutrition program provides menus that enable students to choose meals that are consistent with the Dietary Guidelines for Americans.

- The school nutrition program is used as a laboratory so that students may practice and model the nutrition, health and food safety information learned in the classroom.

- Nutrition concepts are infused throughout the curricula. An integrated approach is used to teach nutrition and dietary lifestyles.

- The school nutrition program provides students with nutrition information about the foods available and students' nutritional needs.

- The school provides adequate time and space so that all students have access to eating a nutritious school meal.

- Teachers and school nutrition personnel are kept current in nutrition concepts and receive pre-service and in-service education regarding school nutrition programs and strategies to use the programs as educational experiences.

- The school staff encourages all children to choose and eat meals that are consistent with the Dietary Guidelines for Americans.

- The cafeteria design and school personnel provide a pleasing atmosphere conducive to meal enjoyment and positive social interaction.

- Resources of the health department, extension service, and voluntary health agencies are used, as appropriate, to provide nutrition education.

- Students serve on advisory committees to the school nutrition programs.

- A parent education component is included in the school nutrition program and curricula to involve and inform parents about child nutrition and health education.

Element 7: Counseling Services

- All students, grades K-12, are provided developmental guidance services with planned sequential activities.

- Programs are structured for developmental health needs such as weight control and good hygiene.

- Programs are structured for health-related social needs such as stress management and behavior management.

- Individual counseling is available by appropriate professionals who may include guidance counselors, school social workers, mental health workers, school nurse, substance abuse counselors, and other intervention specialists.

- Individual counseling sessions are focused on personal developmental needs and concerns including physique and figure, exercise, personal hygiene, and acne.

- Provisions are made for crises and intervention for problem behaviors.

- Counseling includes the identification of health problems that may interfere with student development.

- Counseling services include the identification by and referrals to other professionals including school psychologists, school social workers, school nurses, and mental health workers.

- Counseling services are focused on programs for individuals, groups, and classrooms on topics such as divorce, death and dying, child abuse and neglect, single parenting, suicide prevention, pregnancy prevention, safety, violence prevention, crisis intervention, dealing with grief, and coping skills.

- Group and personal counseling, group guidance, and teacher advisory programs are provided to address the issues of problem-solving and decision-making.

- Counseling services may include the involvement of the community in the identification and appropriate utilization of community resources.

Element 8: Faculty Wellness

- A faculty wellness coordinator and committee are appointed to plan and provide leadership for the school worksite wellness program.
- Faculty representatives responsible for the comprehensive school health program are afforded the opportunity to attend the annual Blue Ridge School Health Education Conference to obtain information, awareness, and to develop the knowledge to implement a wellness program.
- The faculty is surveyed to determine the needs the worksite wellness program should address.
- An annual physical assessment is provided to faculty members.
- Community resources and personnel are utilized to provide various wellness programs.
- The faculty serve as wellness role models for students.
- A summary report regarding activities and successes is developed at the end of each year by the wellness coordinator.

LD6927466

Appendix C

HOUSE JOINT RESOLUTION NO. 437

Offered January 22, 1991

Requesting the Board of Education to strive aggressively to increase the adequacy of AIDS education in the Commonwealth's elementary and secondary schools.

Patrons—Glasscock, Harris, E.R., Munford, Van Landingham and Wilkins; Senators: Chichester, Miller, Y.B., DuVal and Nolen

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Referred to the Committee on Education

WHEREAS, the characteristics of the AIDS patient population is changing as the epidemic moves into the heterosexual population; and

WHEREAS, the proportion of this population comprised by minorities, women, adolescents and children continues to increase; and

WHEREAS, the Commonwealth has a duty to inform its young people about the methods of transmission and prevention of transmission of infection with human immunodeficiency viruses; and

WHEREAS, it is essential to begin to educate children at young ages about the dangers of this disease and other sexually transmitted diseases; and

WHEREAS, if education is initiated during adolescence, the message may be too late; and

WHEREAS, although the Department of Education has initiated efforts to train teachers, administrators, and students concerning infection with human immunodeficiency viruses, there are still many areas of the Commonwealth in which little, if any, instruction is available; and

WHEREAS, the law and guidelines require instruction concerning the etiology, effects, and prevention of sexually transmitted diseases including human immunodeficiency viruses; and

WHEREAS, the health education program and other curricula, such as home economics, biology and science classes, are already in place and can be continued within present funding parameters; and

WHEREAS, the attitudes and understanding of this epidemic must be adjusted in order to safeguard Virginia's youth; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Board of Education is hereby requested to strive aggressively to increase the adequacy of AIDS education in the Commonwealth's elementary and secondary schools. The Board is also requested to evaluate the AIDS education programs as implemented by the local school divisions to assess (i) the compliance with any relevant guidelines and standards of learning objectives and (ii) the effectiveness of such programs. Those school divisions which are not aggressively complying with any such guidelines shall be encouraged to revise their approaches to more realistically reflect current issues related to HIV infection and other sexually transmitted diseases.