ITEM RATIONALE
2008 SCHOOL HEALTH PROFILES
QUESTIONNAIRE FOR SCHOOL PRINCIPALS

Question 1: Are any of the following grades taught in this school?

> **Rationale:** Based on the response to this question, the eligibility of the school is determined.

Question 2: Has your school ever used the School Health Index or other self-assessment tool to assess your school's policies, activities, and programs in the following areas?

> **Rationale:** This question assesses whether the school has conducted an assessment or diagnosis as a critical first step in improving implementation of policies, programs, or environmental strategies to effect change or improvement in school health (1). Studies confirm that the School Health Index helps bring health issues to the school's attention, builds school commitment, identifies changes that do not require resources, encourages development of policy and action, raises awareness of federal policies, and helps schools set policies and standards that meet national health objectives (2,3).

Question 3: The Child Nutrition and WIC Reauthorization Act of 2004 requires school districts participating in federally subsidized child nutrition programs (e.g., National School Lunch Program, School Breakfast Program) to establish a local school wellness policy. Do you have a copy of your district's wellness policy?

> **Rationale:** This question assesses school-level awareness of the district's wellness policy. According to the Child Nutrition and WIC Reauthorization Act of 2004, each school division that participates in the National School Lunch Program (NSLP) shall establish a local (school) wellness policy no later than the first day of the school year beginning after June 30, 2006, to cover all NSLP schools in the school division (4). It is important to measure school-level awareness of local wellness policies in order for state education and health agencies to provide technical assistance on the development, implementation, and evaluation of these policies, given the potential impact of school health policies on physical activity, diet, and the availability of foods and beverages (5,6).

Question 4: Currently, does someone at your school oversee or coordinate school health and safety programs and activities?

> **Rationale:** This question assesses whether the school has identified a person responsible for coordinating a school's health program. It is critical to have one person appointed to oversee the school health program (7). This individual coordinates school health activities, leads a school health committee or team, and integrates community-based programs with school-based programs (8,9) Administration and management of school health programs requires devoted time, attention, training, and expertise (10,11).

Question 5: Is there one or more than one group (e.g., a school health council, committee, or team) at this school that offers guidance on the development of policies or coordinates activities on health topics?

Question 6: Are each of the following groups represented on any school health council, committee, or team?

> **Rationale:** These questions assess whether the school has a health committee or team. The school health committee or team should represent a coalition of representatives from within and outside of the school community interested in improving the health of youth in schools (10,12). Participation on such committees or teams can empower others through increased awareness and knowledge of the school health program, increase the chance of ownership and commitment, activate channels of communication, and increase involvement in decision making (8,10,12-16). This includes parents and community members. Parent leaders help other parents understand and contribute ideas to issues and policies that affect the design and quality of school programs and opportunities for all children (15).

Question 7: Are any school staff required to receive professional development (such as workshops, conferences, continuing education, or any other kind of in-service) on HIV, STD, or pregnancy prevention issues and resources for the following groups?

> **Rationale:** This question assesses professional development requirements for school staff. Professional development enhances the health educator's ability to teach adolescents the knowledge and skills needed to prevent HIV, other STDs, and pregnancy. In the 2000 School Health Policies and Program Study, only 35% of health education teachers reported receiving staff development on HIV prevention during the two preceding years (17). Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching (18). Professional development increases educators' confidence in teaching subject matter and provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues (7,19).

Question 8: Does this school have a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth, regardless of sexual orientation or gender identity? These clubs sometimes are called gay/straight alliances.

> **Rationale:** This question assesses whether the school has a gay/straight alliance or similar student-led club. Such clubs are critical to the well-being of students. Students in schools with a gay/straight alliance are less likely to feel unsafe at school, less likely to miss school, and more likely to feel like they belonged at their school than students in schools with no such clubs (20).

Question 9: Has your school adopted a policy that addresses each of the following issues for students or staff with HIV infection or AIDS?

> **Rationale:** This question assesses important components of school policies in place to address students and staff infected with HIV or AIDS. Students and staff infected with HIV or AIDS need policies protecting their rights (21).

Question 10: Are all staff who teach health education topics at this school required to be certified, licensed, or endorsed by the state in health education?

> **Rationale:** This question addresses the necessary qualifications of staff who teach health education. The National Commission for Health Education Certification, Inc. supports Certified Health Education Specialists (CHES). CHES teachers are more likely than non-CHES teachers to teach about HIV and sexually transmitted disease prevention (22). Studies in other disciplines reveal that nationally certified teachers, to a greater degree than non-certified teachers, possess pedagogical content knowledge that is more flexibly and innovatively employed in instruction; are more able to improvise and to alter instruction in response to contextual features of the classroom situation; understand at a deeper level the reasons for individual student success and failure on any given academic task; are more able to provide developmentally appropriate learning tasks that engage, challenge, and even intrigue students; are more able to anticipate and plan for difficulties students are likely to encounter with new concepts; are more easily able to improvise when things do not run smoothly; are more able to generate accurate hypotheses about the causes of student success and failure; and bring a distinct passion to their work (23). The leading national organizations supporting school health education, including the American School Health Association and the American Association for Health Education, recommend that those who teach health education have professional preparation and state certification in health education (24,25). The Joint Committee on National Health Education Standards recommends that local education agencies ensure that health education is taught by licensed/certified health education teachers with training in implementing the National Health Education Standards (26).

REQUIRED PHYSCIAL EDUCATION

Question 11: Is physical education required for students in any of grades 6 through 12 in this school?

Question 12: Is a required physical education course taught in each of the following grades in this school?

> **Rationale:** These questions measure the extent to which physical education is required for students in grades 6 through 12. Physical education provides students with the knowledge, attitudes, skills, behaviors, and confidence to adopt and maintain physically active lifestyles (27). The importance of physical education in promoting the health of young people is supported by *Healthy People 2010* Objectives 22-8, 22-9, and 22-10 (28).

Question 13: Can students be exempted from taking required physical education for one grading period or longer for any of the following reasons?

> **Rationale:** This question examines whether or not students are allowed to be exempt from physical education based upon participation in non-physical activities or interscholastic sports. Exemptions from required physical education do not allow students to participate in comprehensive, standards-based physical education; this practice diminishes the importance of physical education and its role in assisting students with establishing physically active lifestyles and developing various motor, movement, and behavioral skills unique to being physically educated (29).

PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

Question 14: Are all staff who teach physical education at this school certified, licensed, or endorsed by the state in physical education?

> **Rationale:** This question measures the necessary qualifications of staff who teach physical education (PE). The National Association for Sport and Physical Education (NASPE) recommends that those who teach PE have grade-specific preparation (30). CDC's *Guidelines for School and Community Programs to Promote Lifelong Physical Activity Among Young People* recommend that schools require the hiring of physical education specialists to teach physical education in kindergarten through grade 12 (31). Staff who have qualifications for teaching PE keep students active longer during PE classes and are more likely to teach to national, state, and/or local PE standards (32,33).

Question 15: During the past two years, did any physical education teachers or specialists at this school receive professional development (such as workshops, conferences, continuing education, or any other kind of in-service) on physical education?

> **Rationale:** This question examines professional development for PE teachers. PE teachers who participate in staff development programs are more likely to use recommended teaching methods such as holding group discussions, implementing physical activity stations, videotaping student performances, testing students' knowledge related to PE, giving fitness tests, and explaining to students the meaning of fitness scores (30,34,35). Professional development for PE teachers provides skills to increase the quality of PE classes through student engagement in physical activity and the content of lessons taught (32,36,37).

Question 16: Are those who teach physical education at this school provided with the following materials?

> **Rationale:** This question measures the type of information and support materials PE teachers are given in order to implement PE classes. According to NASPE, quality physical education is guided by and should include a written PE curriculum, goals, objectives, and expected outcomes, scope and sequence of instruction for PE, and plans for age-appropriate student assessment (34,38).

Question 17: Does this school offer opportunities for students to participate in intramural activities or physical activity clubs?

> **Rationale:** This question measures the extent to which students are provided the opportunity to participate in physical activities and clubs outside of the regular school day. According to NASPE, intramural activities, physical activity clubs, and recreation clubs contribute to young people's physical and social development. Additionally, intramural activities or physical activity clubs offer students the opportunity to be involved in planning and implementing such programs and offer safe and structured opportunities to be physically active (39-43).

TOBACCO-USE PREVENTION POLICIES

Question 18: Has this school adopted a policy prohibiting tobacco use?

Question 19: Does the tobacco-use prevention policy specifically prohibit use of each type of tobacco for each of the following groups during any school-related activity?

Question 20: Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups?

Question 21: Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups?

Question 22: Does your school have procedures to inform each of the following groups about the tobacco-use prevention policy that prohibits their use of tobacco?

Question 23: Does your school's tobacco-use prevention policy include guidelines on what actions the school should take when students are caught smoking cigarettes?

Question 24: At your school, who is responsible for enforcing your tobacco-use prevention policy?

Question 25: Which of the following help determine what actions the school takes when students are caught smoking cigarettes?

Question 26: When students are caught smoking cigarettes, how often is each of the following actions taken?

Question 27: Does your school post signs marking a tobacco-free school zone, that is, a specified distance from school grounds where tobacco use is not allowed?

> **Rationale:** These questions measure the extent to which schools develop, implement, and enforce a policy that creates a totally tobacco-free environment within the school experience for both young people and adults, as outlined in the CDC *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* (44) to achieve the *Healthy People 2010* Objective 27-11 of creating smoke-free and tobacco-free schools. (28). The Pro-Children Act of 1994, reauthorized under the No Child Left Behind Act of 2001, prohibits smoking in facilities where federally funded educational, health, library, daycare or child development services are provided to children under the age of 18 (45).
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> Because tobacco use is the most preventable contributor to mortality in the United States, it is important to restrict use or exposure to tobacco products at an early age (44). The existence and enforcement of a school policy creates a tobacco-free environment that models acceptable behavior and sends a clear message to students, teachers, staff, parents, and visitors that the use of tobacco is socially unacceptable (46). Environmental

interventions aimed at reducing use of tobacco in homes, public places, and worksites lead to reduction of tobacco use (47). Likewise, tobacco-free school policies are associated with lower rates of student smoking (46,48-50).

Prohibiting any use of any tobacco product at all times, whether or not school is in session, and regardless of whether students are present, protects students and staff from the harmful effects of secondhand smoke (a mixture of smoke from the burning end of tobacco products and the smoke exhaled by smokers). The 2006 U.S. Surgeon General's report, *The Harmful Effects of Involuntary Exposure to Tobacco Smoke*, outlines a large body of research findings which demonstrate that breathing secondhand smoke is harmful to health (51). Evidence shows that there is no safe level of secondhand smoke exposure, and even the most advanced ventilation systems cannot eliminate secondhand smoke or its harmful effects (51). A complete ban of indoor smoking *at all times* in a facility (such as a school building) is the only effective approach to controlling involuntary inhalation of secondhand smoke (51). Therefore, schools should eliminate smoking in school facilities by all persons at all times even when students or staff are not present. Additionally, preventing exposure to secondhand smoke at all school events and in school vehicles is also imperative to protect the health of all.

Question 28: During the past two years, has your school…Gathered and shared information with students and families about mass-media messages or community-based tobacco-use prevention efforts? Worked with local agencies or organizations to plan and implement events or programs intended to reduce tobacco use?

Rationale: These questions measure the extent to which the school coordinates their efforts with other tobacco-use prevention efforts in the community that target young people. School programs alone can be effective, but maintaining those effects present a challenge, especially with the many other influences encouraging tobacco use coming from outside of the child's school environment. The strongest evidence of success for school-based education programs has been shown with programs that are coordinated or delivered in conjunction with mass media and community tobacco control efforts, creating an environment of support for a tobacco-free lifestyle and delivering messages that are mutually reinforced. The Surgeon General has reported that 20-40% of tobacco use by youth can be prevented by educational strategies conducted in conjunction with community-and media-based activities (52). In 2004, the Task Force for the Community Guide to Preventive Services found "strong evidence for the use of school-based interventions when delivered in conjunction with mass media and community activities" (53). The Task Force recommendations were based on a subset of studies that showed evidence in reducing tobacco use among youth when multiple channels were used to support the in-school education program. Receiving consistent messages across community contexts and over time has been shown to enhance the maintenance of programs effects (54,55).

Question 29: Does your school provide tobacco cessation services for each of the following groups?

Question 30: Does your school have arrangements with any organizations or health care professionals not on school property to provide tobacco cessation services for each of the following groups?

> **Rationale:** These questions measure the extent to which schools provide access to tobacco-use cessation services, as outlined in the CDC *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction* (44) to achieve the *Healthy People 2010* Objectives 27-5 and 27-7 of increasing tobacco-use cessation attempts among adult and adolescent smokers (52). Nicotine addiction can occur at an early age for some adolescent tobacco users (56). People who begin using tobacco at an early age are more likely to develop higher levels of addiction in adulthood (56). Adolescent tobacco users suffer similar symptoms of withdrawal to those of adults when attempting to quit (57). Many young people want to quit but have tried and failed (58). Some are unaware of or do not have access to cessation services. Others underestimate the power of addiction and do not feel that quitting would require professional assistance; therefore recruitment into formal programs can be difficult (59). School health providers as a routine part of care should assess the tobacco-use status of students, and if they identify a student's use of tobacco, they should provide self-help materials and refer them to a tobacco-use cessation program provided on site or in the community (60-62). Also, providing a brief clinical intervention has been shown to encourage cessation among both adults and adolescents (62).

NUTRITION-RELATED POLICIES AND PRACTICES

Question 31: When foods or beverages are offered at school celebrations, how often are fruits or non-fried vegetables offered?

Question 32: Can students purchase snack foods or beverages from one or more vending machines at the school or at a school store, canteen, or snack bar?

Question 33: Can students purchase each of the following snack foods or beverages from vending machines or at a school store, canteen, or snack bar?

Question 34: Does this school limit the package or serving size of any individual food and beverage items sold in vending machines or at the school store, canteen, or snack bar?

> **Rationale:** These questions address the extent to which schools are making more nutritious foods available to students, limiting portion sizes, and not offering less nutritious foods and beverages. Many schools offer foods and beverages in after-school programs, school stores, snack bars, or canteens (63) and these foods sold in competition to school meals are often relatively low in nutrient density and relatively high in fat, added sugars and calories (64). Competitive foods are widely available in many elementary schools, in most middle schools, and in almost all secondary schools (63,65,66). Given that schools offer numerous and diverse opportunities for young people to learn and make consumption choices about healthful eating, schools should provide a consistent environment that is conducive to healthful eating behaviors (67). To help improve dietary behavior and reduce overweight among youths, schools should offer appealing and nutritious foods in school snack bars and vending machines and discourage sale of foods high in fat, sodium, and added sugars, and beverages and foods containing caffeine on school grounds (68-70). Because students' food choices are influenced by the total food environment, the simple availability of healthful foods such as fruits and vegetables may not be sufficient to prompt the choice of fruits and vegetables when other high fat or high sugar foods are easily accessible (71,72). However, offering a wider range of healthful foods can be an effective way to promote better food choices among high school students (73). Taken together, such findings suggest that restricting the availability of high-calorie, energy dense foods in schools while increasing the availability of healthful foods might be an effective strategy for promoting more healthful choices among students at school (67).

Question 35: During this school year, has your school done any of the following?

> **Rationale:** This question addresses the variety of methods schools can use to promote healthy eating. Students' food choices are influenced by the total food environment. The simple availability of fruits and vegetables may not be sufficient to prompt the choice of these items when items high in fat and/or added sugar are also available (72). Even when fruit and vegetable items are available, they compete in the context of a vast array of other food items, mostly high in fat and sugar, that are competitively priced (71). Schools should employ effective or promising strategies in the school setting to promote healthy eating, such as pricing strategies (74,75), input from stakeholders (76), provision of nutrition information (67), taste tests, and using the cafeteria as a learning laboratory (77).

Question 36: At this school, are candy, meals from fast food restaurants, or soft drinks promoted through the distribution of products, such as t-shirts, hats, and book covers to students?

Question 37: Does this school prohibit advertisements for candy, fast food restaurants, or soft drinks in the following locations?

> **Rationale:** These questions addresses prohibiting marketing of less nutritious foods to students while at school or at school-sponsored events. Nationwide, 23.3% of schools allow the promotion of candy, meals from fast food restaurants, or soft drinks through the distribution of coupons for free or reduced price, 14.3% allow the promotion of these products through sponsorship of school events, and 7.7% do so through publications such as a school newsletter or newspaper (63). Many contracts for soft drink or other vending products have provisions to increase the percentage of profits schools receive when sales volume increases, and this is a substantial incentive for schools to promote soft drink consumption by adding vending machines, increasing the times they are available, and marketing the products to students (64,78). In some districts, these incentives have led schools to aggressively promote student purchases of soft drinks (79). Research suggests that exposure to advertisements may have adverse impacts on children's eating habits (80). Food advertisements have been found to trigger food purchase by parents, have effects on children's product and brand preferences, and have an effect on consumption behavior (81). Further, younger children do not generally understand the difference between information and advertising, (82) such that children may interpret school-based advertising to mean that teachers or other adults endorse the use of the advertised product. Given that schools provide a captive audience of students, the IOM Report on Food Marketing to Children and Youth recommends that schools should promote healthful diets for children and youth in all aspects of the school environment (e.g., commercial sponsorships, meals and snacks, curriculum), and outlines the importance of prohibiting advertising of less nutritious foods (83).

HEALTH SERVICES

Question 38: Is there a full-time registered nurse who provides health services to students at your school?

> **Rationale:** This question examines the degree to which schools are being adequately staffed by school nurses. Because a school nurse is an essential component of a healthy school, *Healthy People 2010* Objective 7-4 calls to increase the proportion of elementary, middle, and senior high schools with a nurse-to-student ratio of 1:750 (28). School nurses can link students and schools to physician and community resources.

Question 39: Which of the following sources of school health information does your school use to identify students diagnosed with chronic health conditions such as asthma?

> **Rationale:** This question examines the appropriate use or adaptation of existing school health records to identify students with asthma. Asthma is a common chronic condition and one of the leading causes of school absenteeism. In 2003, students who had asthma episodes missed an estimated 12.8 million days of school (84). Asthma can be controlled with proper diagnosis, appropriate asthma care, and management activities. Schools play an important role in these asthma management activities, but individuals must first be identified in order to receive school-based support (85). Successful school-based asthma management programs identify students with asthma utilizing low-cost and/or no-cost adaptations of existing school health records and by avoiding mass screening and mass case detection as methods for routine identification of students with asthma (86-91).

Question 40: At your school, how many students with known asthma have an asthma action plan on file?

> **Rationale:** This question addresses the need for clear, written guidance about the needs of individual students with asthma. Assessment of successful school-based asthma management programs suggest these plans play an important role in providing school staff, students, and families with an understanding of an individual student's asthma management needs at school, including how to respond in an emergency. Additionally, the use of an asthma action plan at school results in affected students experiencing significant improvement in several health-related outcomes, including a decrease in the frequency of asthma-related nighttime awakenings, number of days of restricted activity, and frequency of acute medical treatment (92,93). Schools should have asthma action plans on file for all students with known asthma. These plans help schools meet the needs of students with asthma during the school day and at school-related activities. Based upon current research, federal agencies and other national organizations have provided additional guidance and recommendations related to the collection and implementation of individualized plans. Plans should be developed by a primary care provider and be provided by parents; and include individualized emergency protocol, medications, environmental triggers and emergency contact information. School staff should actively solicit copies of asthma action plans from families and/or asthma care providers. When necessary, school nurses can construct asthma action plans based on information from the

family and medication orders. A constructed plan should be sent to the asthma care provider for confirmation that it is appropriate (85,94-96).

Question 41: At your school, which of the following information is used to identify students with poorly controlled asthma?

Rationale: This question examines the type of information schools use to monitor and then assess the need for additional case management of students with known asthma. Assessment of successful school-based asthma management programs reveal that this type of tracking and case management can contribute to the medical management of students with asthma (87,92,97,98). This information can subsequently be used by schools to focus their asthma programs on students with poorly managed asthma as demonstrated by frequent school absences, school health office visits, emergency department visits, or hospitalizations (85,99).

Question 42: Does your school provide the following services for students with poorly controlled asthma?

Rationale: This question examines whether schools provide intensive case management for students with poorly controlled asthma. Schools should ensure that case management is provided by a trained professional for students with frequent school absences, school health office visits, emergency department visits, or hospitalizations due to asthma (85,92,98,100-103). Assessment of successful school-based asthma management programs reveal that monitoring and then providing case management can contribute to the medical management of students with asthma (87,98) Case management activities help students better manage their asthma, and have been shown to decrease hospitalizations, emergency department visits, and school absences among students with severe, persistent, or poorly controlled asthma (97,104).

Question 43: Does this school have a designated and secure storage location for medications, including quick-relief asthma medications?

Question 44: Is this location accessible at all times by the school nurse or her designee?

Question 46: Has your school adopted a policy stating that students are permitted to carry and self-administer asthma medications?

Question 47: Does your school have procedures to inform each of the following groups about your school's policy permitting students to carry and self-administer asthma medications?

Question 48: At your school, who is responsible for implementing your school's policy permitting students to carry and self-administer asthma medication?

Rationale: These questions address the need for schools to have policies and procedures to support students in receiving the asthma medications they may need at school. Many students with asthma require preventive or quick-relief medicine at school. Students with

asthma have had serious episodes and have died at school when they did not have access to quick-relief medicine (105). Access to medications is critical and it must meet usual safety guidelines for medication storage (94,106). To ensure compliance with federal, state, and many local laws and guidelines, schools should ensure that students have immediate access to asthma medications, as prescribed by a physician and approved by parents (85). Several national guidance documents, along with evaluations of successful school based asthma programs, have provided additional information that addresses the process and methods for self-carry policies. Policies should include medication storage in a safe, controlled, and accessible location, and appropriate attention should be given to expiration dates and safe disposal (95,107-109).

Question 45: How often are school staff members required to receive training on recognizing and responding to severe asthma symptoms?

Rationale: This question examines professional development for school staff. Because asthma can be life-threatening, it is essential to assist those involved in monitoring and managing children with asthma at school to provide timely, appropriate care. Therefore, all school staff members should be provided with basic information about asthma so that they can support students' asthma management and appropriately respond to asthma emergencies (85,87,92,95,101,103,107).

FAMILY AND COMMUNITY INVOLVEMENT

Question 49: During the past 2 years, have students' families helped develop or implement policies and programs related to the following topics?

Question 50: During the past 2 years, have community members helped develop or implement policies and programs related to the following topics?

> **Rationale:** These questions emphasize the importance of engaging family and community members in school health programs. Parent leaders help other parents understand and contribute ideas to issues and policies that affect the design and quality of school programs and opportunities for all children (16). School programs that engage parents and link with the community yield stronger positive results. Studies aimed at preventing childhood overweight, treating childhood overweight, or promoting physical activity and healthy eating have demonstrated more success when targeting the parent and child versus targeting the child alone (110,111). School-based tobacco prevention programs and community interventions involving parents and community organizations have a stronger impact over time when working in tandem rather than as separate, stand alone interventions (55). Collaboration with parent groups, community organizations, and other agencies can help to build broad-based support for school health programs, especially when they address topics that can be emotionally charged, such as HIV, other STD, and pregnancy prevention (112). Without parental support of HIV, other STD, and pregnancy prevention education programs and policies, they cannot be sustained (112-114). Collaborative asthma interventions require a team effort and involve the whole school community: school administrators, faculty, and staff, as well as students, parents, and local community organizations (95,103).

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ITEM RATIONALE
2008 SCHOOL HEALTH PROFILES
QUESTIONNAIRE FOR LEAD HEALTH EDUCATION TEACHERS

REQUIRED HEALTH EDUCATION

Question 1: Is health education required for students in any of grades 6 through 12 in this school?

Question 2: How many required health education courses do students take in grades 6 through 12 in this school?

Question 3: Is a required health education course taught in each of the following grades in this school?

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

Question 4: **If students fail a required health education course, are they required to repeat it?**

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

Question 5: Are those who teach health education at this school provided with the following materials?

> **Rationale:** This question addresses the types of information and support materials health education teachers are given in order to implement health education classes. According to the Joint Committee on National Health Education Standards, quality health education is guided by access and equity principles that call for clear curriculum direction, including goals, objectives, and expected outcomes; a written curriculum; clear scope and sequence of instruction for health education content; and plans for age-appropriate student assessment (3).

Question 6: Does your health education curriculum address each of the following?

Rationale: This question addresses the extent to which schools have a health education curriculum that is based on, or is consistent with, current national health education standards (3).

Question 7: During this school year, have teachers in this school tried to increase student knowledge on each of the following topics in a required course in any of grades 6 through 12?

Rationale: This question addresses the extent to which traditional health content areas and the prevention of health risk behaviors are taught in required courses in grades 6 through 12.

Question 8: During this school year, did teachers in this school teach each of the following tobacco-use prevention topics in a required course for students in any of grades 6 through 12?

Rationale: This question measures the tobacco-use prevention curricula content, and relates to the *Healthy People 2010* Objective 7-2 of providing school health education to prevent health problems among middle, junior high, and high school students including those from tobacco use (4). Since most smoking is initiated by persons less than 18 years old, programs that prevent onset of smoking during the school years are crucial (5). School-based tobacco prevention programs that address multiple psychosocial factors related to tobacco use among youth and that teach the skills necessary to resist those influences have demonstrated consistent and significant reductions or delays in adolescent smoking (5-12). Social influence programming has reduced smoking onset by as much as 50%, with effects lasting up to 6 years, and with effects including reduction of the use of other tobacco products as well (7).

In addition, this question measures the extent to which schools are complying with the components of the National Health Education Standards, which provide a framework for decisions about the lessons, strategies, activities, and types of assessment to include in a health education curriculum (3).

Question 9: During this school year, did teachers in this school teach each of the following HIV, STD, or pregnancy prevention topics in a required course for students in any of grades 6, 7, or 8?

Question 10: During this school year, did teachers in this school teach each of the following HIV, STD, or pregnancy prevention topics in a required course for students in any of grades 9, 10, 11, or 12?

Rationale: These questions measure the HIV prevention curricula content. HIV and sex education programs can increase knowledge about how to avoid HIV and STD infection and unintended pregnancy. Efforts to increase knowledge alone about modes of transmission and strategies for prevention do not directly lead to behavior change (13). In order to reduce HIV, other STDs, and unintended pregnancy, programs must address perceptions of risk, intentions, communication, and skills, in addition to HIV and STD knowledge (14).

Adolescents have different HIV prevention needs than do adults. However, because of the variability among youth with respect to cognitive and social maturity and sexual experience, interventions must be tailored to meet the unique needs of younger versus older youth or sexually naive versus experienced teens. HIV prevention interventions also have to be matched to the cognitive level of adolescents and should be designed to improve behavioral skills for risk reduction, decision making, planning, and problem solving (15).

Part of a program's effectiveness involves its organization and presentation of activities and materials in an age appropriate and logical sequence. A typical logical sequence includes basic information about HIV, other STDs, and pregnancy, including susceptibility and severity of HIV, other STDs, and pregnancy; discussion of behaviors to reduce vulnerability; knowledge, values, attitudes and barriers related to these behaviors; and skills needed to perform these behaviors (16). Messages in these effective programs are appropriate to the age, sexual experience, gender and culture of the youth (14).

In addition, the appropriateness for age and HIV prevention curricula content were aligned with the National Health Education Standards (NHES), which provide a framework for decisions about the lessons, strategies, activities, and types of assessment to include in a health education curriculum (3). The NHES, other state-level standards, and research findings from the literature on effective programs in HIV, other STD, or pregnancy prevention were used to determine the activities and materials for age appropriateness for grades 6-8 and 9-12 related to HIV prevention curricula content (3, 14-16).

Question 11: During this school year, did teachers in this school teach each of the following nutrition and dietary behavior topics in a required course for students in any of grades 6 through 12?

Rationale: This question measures the curricula content related to nutrition and dietary behavior. Comprehensive, sequential nutrition education using the classroom and the lunchroom can reinforce healthful eating behaviors (17,18). Nutrition education should be part of a comprehensive school health education curriculum and include concepts to promote healthy eating (19,20). This list of 15 nutrition topics is based on CDC guidelines (21) and the *School Health Index* (22).

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

Rationale: This question measures the extent to which physical activity concepts are taught in a required health education course. Health education that includes physical activity concepts increases the likelihood of students increasing their participation in physical activity (23), reinforces what has been taught in physical education (24,25), and assists students in achieving the national health education standards (3).

HIV PREVENTION

Question 13: During this school year, did your school provide any HIV, STD, or pregnancy prevention programs for ethnic/racial minority youth at high risk (e.g. black, Hispanic, or American Indian youth), including after-school or supplemental programs, that did each of the following?

Rationale: This question measures whether a school addresses HIV, other STD, and pregnancy prevention through targeted efforts reaching those identified as most at-risk. Risk for HIV infection is especially notable for youth of minority races and ethnicities. African-Americans are the largest group of young people affected by HIV, accounting for 56% of all HIV infections ever reported among those aged 13–24 by 2001 (26). And, although only 15% of teenagers (ages 13-19) in the United States are African-Americans, they accounted for 73% of new AIDS cases reported among teens in 2004 (27). In 2002, HIV/AIDS was the number one cause of death for African- American women aged 25-34 years and the number two cause of death for all African- Americans aged 35-44 (28). Of the more than half a million people with AIDS who have died in the U.S., 38% were African American (29). In addition, the incidence of AIDS for adult and adolescent Latinos in 2001 was more than 3 times higher than that among their non-Hispanic white counterparts (29,30).

Data from CDC's 2005 National Youth Risk Behavior Survey (YRBS) show that, compared with white students and Hispanic/Latino students, black students have the highest rates of several sexual risk behaviors: 67.6% of black students had ever had sexual intercourse, compared with 43.0% percent of white students and 51.0% of Hispanic/Latino students; 47.4% of black students were currently sexually active (i.e., had sexual intercourse with 1 or more persons during the 3 months preceding the survey), compared with 32.0% of white students and 35.0% of Hispanic/Latino students; 16.5% of black students had had sexual intercourse before age 13 years, compared with 4.0% of white students and 7.3% of Hispanic/Latino students; and 28.2% of black students had had sexual intercourse with 4 or more persons during their life, compared with 11.4% of white students and 15.9% of Hispanic/Latino students (31).

In addition to effective curricula, access to valid information and products, as well as access or referral to health, social, and psychological services to prevent HIV, other STDs, and pregnancy are especially important in ethnic/racial minority communities where the higher prevalence of HIV, other STDs, and pregnancy reflects both risky adolescent sexual behaviors and system barriers to quality prevention services (32). Factors which may influence adolescents' access to care include health insurance, cost, convenience, confidentiality, and demographic factors such as age, gender, and ethnicity (33-35).

COLLABORATION

Question 14: During this school year, have any health education staff worked with each of the following groups on health education activities?

> **Rationale:** This question measure the extent to which health education staff work cooperatively with other components of the school health program (school health services, school mental health or social services, food service, and physical education staff) and families. An integrated school and community approach is an effective strategy to promote adolescent health and well being (36).

Question 15: During this school year, did your school provide parents and families with health information designed to increase parent and family knowledge of the following topics?

> **Rationale:** This question measures whether schools are providing health information to students' families. School programs that engage parents and link with the community yield stronger positive results. Studies aimed at preventing childhood overweight, treating childhood overweight, and promoting physical activity and healthy eating have demonstrated more success when targeting the parent and child versus targeting the child alone (37,38). School-based tobacco prevention programs and community interventions involving parents and community organizations have a stronger impact over time when working in tandem rather than as separate, stand-alone interventions (10). Assessments of successful school-based asthma management programs indicate that with increased knowledge, parents can assist their children in better managing their asthma (39-41). Parents also are teenagers' primary sex educators, able to capitalize on teachable moments when youth may be more open to learning new information (42). Parents can continue prevention messages delivered in school, thereby enhancing the likelihood of sustained behavioral changes (43). Increased communication affects both parenting and health practices of parents. Communicating information on healthy lifestyles aims to reinforce the child's coursework at school, facilitate communication with parents about school activities, and increase parent knowledge of healthy living (44,45).

PROFESSIONAL DEVELOPMENT

Question 16: During the past two years, did you receive professional development (such as workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics? (HIV)

> **Rationale:** This question measures the extent to which professional development has been received by the lead health teacher responsible for teaching about HIV/AIDS. As new information and research on prevention is available, those responsible for teaching about HIV/AIDS should periodically receive continuing education about HIV and other STD infections to assure they have the most current information about how widespread HIV and other STDs are, effective prevention and health education intervention strategies, and priority populations identified as most at-risk for HIV and other STD infection (14,47,48)
>
> Effective implementation of school health education is linked directly to adequate teacher training programs (49). School health education designed to decrease students' participation in risk behaviors requires that teachers have appropriate training to develop and implement school health education curricula (49). Staff development activities for health education teachers need to focus on teaching strategies that both actively engage students and facilitate their mastery of critical health information and skills (50).

Question 17: During the past two years, did you receive professional development (such as workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics?

Question 18: Would you like to receive professional development on each of these health education topics?

Question 19: During the past two years, did you receive professional development (such as workshops, conferences, continuing education, or any other kind of in-service) on each of the following topics?

Question 20: Would you like to receive professional development on each of these topics?

> **Rationale:** These questions address the importance of professional development for teachers. It is vitally important that teachers be well prepared when they begin teaching and that they continue to improve their knowledge and skills throughout their careers. (51). Districts that have made improvements in their professional development activities have seen a rise in student achievement (52,53). Staff development is associated with increased teaching of important health education topics (54). The Institute of Medicine's Committee on Comprehensive School Health Programs in Grades K-12 recommended that health education teachers should be expected to participate in ongoing, discipline-specific in-service programs in order to stay abreast of new developments in their field (1).

PROFESSIONAL PREPARATION

Question 21: What was the major emphasis of your professional preparation?

Question 22: Currently, are you certified, licensed, or endorsed by the state to teach health education in middle school or high school?

Question 23: Including this school year, how many years of experience do you have teaching health education classes or topics?

> **Rationale:** These questions measure the extent to which lead health education teachers are formally trained in the topic of health education as well as the teaching experience and credentials of the lead health education teacher. Health education teachers need to be academically prepared and specifically qualified on the subject of health (50). In addition, pre-service training in health education is associated with increased teaching of important health education topics (54).

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