Health & Family Life Education:
Issues & Challenges for Our Schools

Report by the League of Women Voters CVA
Women's Issues Study Group

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Background

This study of the implementation of health and family life education (FLE) in the Charlottesville and Albemarle County schools was approved by the League of Women Voters of the Charlottesville Area at its 2011 annual meeting, based on the recommendation by the League's Women's Issues Committee. Health services and policy and local education have been ongoing focal points for League study and action. The committee focused on these local education issues in light of their relevance to current issues regarding youth health, safety and relationships (such as obesity, nutrition, sports performance, bullying, child abuse, intimate partner violence, teen pregnancy, STIs, etc.) In addition, it was aware that the city school administration was looking at revising the FLE curriculum and that the county had not revised its curriculum in over a decade.

The study entailed the committee's review of legal requirements regarding health and family life education; the role of the state and localities in developing standards and curricula; the history of these areas of study; local requirements and process; model and other available curricula; and other data regarding health and family life education (including surveys regarding parental interest and preferences regarding teaching health and sexuality. The committee also interviewed personnel at the Virginia Department of Education involved with the programs; local health professionals and health educators; city and county officials and school administrators, teachers and school nurses; and some parents. We attempted to talk with a cross-section of representatives, but did not receive responses from all of the school personnel we contacted. We appreciate the input we received and thank all of those who provided information.

As we began the study, we realized its large scope: two school systems and two areas of study. Our information gathering connected us with many people who gave us a great deal of input. Therefore, our report to the League necessarily summarizes the information and has some risks of generalization given the breadth of the study.

Statutory basis, requirements, structure and history

The roots of both Health Education and FLE are legislative. The Virginia Code specifies:

> Physical and health education shall be emphasized throughout the public school curriculum by lessons, drills and physical exercises, and all pupils in the public elementary, middle, and high schools shall receive as part of

> the educational program such health instruction and physical training as shall be prescribed by the Board of Education and approved by the State Board of Health. (§ 22.1-207)

It also establishes requirements for FLE (§ 22.1-207.1.) Legislation initially required the Board of Education to develop (by December 1, 1987), standards of learning and curriculum guidelines for a comprehensive, sequential family life education curriculum in grades K through 12. It specified that such curriculum guidelines include instruction "as appropriate for the age of the student in family living and community relationships" and, in the original legislation and subsequent amendments, has specified various areas that should be addressed. These include the benefits, challenges, responsibilities, and value of marriage; abstinence; the benefits of adoption; value of postponing sexual activity; human sexuality; human reproduction; dating violence, the characteristics of abusive relationships, and others.

It also specifies (in § 22.1-207.2) the right of parents to review the complete family life curricula, including all supplemental materials used in any family life education program and the right to excuse their child from all or part of family life education instruction, often referred to as the "opt-out."

This statutory framework draws important differences between health education and FLE. Health is like other academic areas of study. The Board of Education establishes standards of learning (SOLs) and provides technical assistance guidelines (www.doe.virginia.gov/testing/sol/standards_docs/health/index.shtml.) These provide a structure for all schools to develop their curriculum and activities. Students are required to be taught health starting in kindergarten and continuing through high school. Most schools have PE and health education through the 10th grade.

In contrast, for FLE, the Board has adopted SOLs and guidelines, with the most recent adopted in 2011 (www.doe.virginia.gov/testing/sol/standards_docs/family_life/index.shtml,) However, since 1997, school divisions can develop their own FLE programs, provided that they are consistent with state guidelines**.** (*Regulations Establishing Standards for Accrediting Public Schools in Virginia*, 8 VAC 20-131-170 *)* In addition, as mentioned above, parents can "opt" their children out of the classes.

Our Local Schools: Overview

The city and county have adopted curricula and provide instruction in both health and family life education from kindergarten through 10th grade. Both school systems have revised the FLE curricula during the past two years, using similar processes. They brought together groups of individuals with diverse expertise and views (including teachers, administrators, community members, and School Health Advisory Board (SHAB) members) to look at the state guidelines, what needed to be taught, what assessment needed to be done. The superintendents reviewed and presented their recommendations to the school boards. The boards reviewed the proposed curricula and the materials to be used and made the proposals and materials available for comment. In both city and county almost no public comment was received.

The curricula cover a range of topics—in accordance with the state guidelines. For example, the Albemarle Health Curricula include instruction regarding disease prevention and hygiene; nutrition; body systems; violence and gang intervention; alcohol, tobacco, and other drugs; personal and mental health; injury prevention and first aid; consumer health; community health; and health and fitness. (www2.k12albemarle.org/dept/instruction/hpe/Family%20Life%20EducationHealth%20%20PE%20Curriculum/Health_Curriculum_approved_062408.pdf.) The county's FLE curriculum addresses family living and community relationships; sex/abstinence; human sexuality; reproduction and contraception; sexually transmitted diseases; stress management and resistance to peer pressure; development of positive self-concepts and respect for others, including people of other races, religions, or origins; parenting skills; the prevention of substance abuse; and, the prevention of child abuse. (www2.k12albemarle.org/ dept/instruction/hpe/ Family Life EducationHealth_PE Curriculum/FLE K-10_05102012_Final.pdf.)

The development of curricula and materials is one of the challenges on which the study focused. Since there is more local discretion regarding the establishment of the FLE curricula, we looked primarily at that area. The recent revision process aimed for and produced curricula that would have community acceptance. Some experts expressed their concern that the materials do not address important issues or do so later than desirable. (See pages 4-5.)

While the curricula and materials are established for all schools in each jurisdiction, in both the city and county, the implementation is at the school level. There are certain commonalities in both systems and in various schools. In elementary schools, health and FLE are integrated into classroom instruction, with classroom teachers and guidance counselors instructing. Often, health topics are covered in science.

In middle and high schools, time during the physical education (PE) block is used for health and FLE instruction (with health generally taught with boys and girls together, FLE generally sex-separated.) PE teachers have the primary role in both the city and county. As discussed below, non-teachers sometimes participate, but there are limitations.

In middle and high schools in both systems, there seems to be some flexibility regarding how health is taught and the materials that are used. In contrast, for FLE, administrators and teachers indicated that they use only the materials that have been approved by the school boards. Not only are schools reluctant to do anything more, some interviewees told us that they have been told there is no flexibility in choosing materials.

One administrator told us that when the school nurse participates in FLE classes, the teacher does a "pre-conversation" with the nurse to make sure she knows the areas she can and cannot discuss with students. Similarly, school nurses who were interviewed also felt constrained regarding participating in health and FLE. They indicated they would be told what topics they could and couldn't cover and materials they could use, even if they could give medically accurate information regarding the excluded topics.

The allocation of time in PE for teaching health and FLE and the qualifications and training of PE teachers regarding health and FLE were other issues the study group explored. Both issues present challenges for the successful implementation of these programs. Limited time is available for health and FLE and this instruction competes for class time because of institutional, parental and student priorities. PE teachers have

some background in health, but may have limited expertise regarding the topics in the health and FLE curricula. (See pages 5-7.)

Parental attitudes and understanding of the programs also affect the impact of health and family life education. The parental "opt out" seems to affect a fairly small number of students. Although parents receive notice in the school information packets at the beginning of each year with information about the FLE goals and scope and the availability of materials for their review (at the schools or at the central office), few come in to review the curriculum and materials and not many opt their children out in the schools where we conducted interviews. We must note, however, that the schools do not report to the central school administrations on the numbers excused from FLE, so we do not have a good picture of the total number.

However, several school personnel and community health educators expressed concern that parental lack of knowledge about health and FLE issues, or what FLE entails, and lack of engagement in the educational process may limit the effectiveness of the programs. One school principal expressed a need for parental and community education about health related issues, citing nutrition and tobacco use as examples.

Challenges Regarding Curricula and Teaching Materials

The development of curricula and selection of materials for any course of instruction is the first step in assessing how the subject is taught. Regarding health education, the State Department of Education has published *Technical Assistance Guides,* which include instructional resources, instructional lessons, available curricula, and activities that can be used to educate students at each grade level in the specified concepts as well as assessment ideas. In contrast, as mentioned above, the state does not specify similar materials for FLE instruction, leaving it up to localities to develop instructional materials and content. In light of this broad local discretion, our group focused on the local curriculum for FLE.

We were aware when we began the study that there had been controversy about the content of FLE when it had been reviewed previously. As noted above, during the time of the study, the city and county reviewed and revised their FLE curricula (in 2011 and 2012, respectively.) As part of the study, we tracked these developments. We also compared the local curricula to the state guidelines and other available curricula.

FLE addresses a range of issues regarding family living and community relationships; including many issues relating to sexuality. When health educators talk about "sexuality," it isn't just "sex" but also concepts like self-awareness and respectful relationships.

One middle school health teacher called the FLE curriculum "conservative but accurate." This description seems appropriate regarding both the city and county approaches, in light of model curricula and more expansive programs that have been developed and implemented in other jurisdictions.

One model for comparison is the *National Sexuality Education Standards Core Content and Skills, K-12*, published in 2011 by the Future of Sex Education Initiative (www.futureofsexeducation.org/ documents/josh-fose-standards-web.pdf.) This national

initiative is a partnership of several organizations—Advocates for Youth (www.advocatesforyouth.org), Answer (http://answer.rutgers.edu), and the Sexuality Information and Education Council of the United States (SIECUS, www.siecus.org). Those groups, as well as the American Association of Health Education (www.aahperd.org/aahe), the American School Health Association (www.ashaweb.org), the National Education Association–Health Information Network (www.neahin.org), and the Society of State Leaders of Health and Physical Education (www.neahin.org) and an advisory committee of national experts develop the FoSE standards. The standards provide guidance to schools and teachers on "the essential minimum core content" that is developmentally and age appropriate for students in grades K-12 (FoSE Standards, p. 6.) The approach is what is frequently referred to as *comprehensive sexuality education*.

Other curricula that provide comprehensive sexuality education are the Unitarian Universalist non-denominational, values based *Our Whole Lives Lifespan* Sexuality *Education Curricula* (www.uua.org/re/owl/index.shtml) for grades K-12 and the FLASH curriculum used in Seattle and King County, WA (www.kingcounty.gov/healthservices/health/personal/famplan /educators/FLASH.aspx). These curricula meet or exceed the National Sexuality Education Standards and are used in some local private schools and in private and public schools in other states.

Examples of the more conservative approach in our schools is when the use of anatomically correct language for body parts occurs and how sexual involvement is discussed. Both the National Sexuality Education Standards and the VA guidelines for FLE, use of correct terminology for body parts is recommended or permitted to begin in the first grade. Yet, in our schools, such terminology is not part of the instruction until 4th of 5th grade when puberty is taught. Local teachers in grades K-3 talk about appropriate and inappropriate touches, but do not name or identify the private parts by their proper anatomic names.

Some health professionals and sexuality educators we interviewed expressed concern about this omission; it can imply to children that these body parts are inconsequential, bad, shameful, or something that should be kept secret. They felt that this can have potentially negative effects on their safety or self-esteem.

Regarding sexual involvement, local programs take an *abstinence-plus* approach. While other methods of preventing pregnancy (birth control) are discussed in high school, the emphasis is on abstinence.

Other limitations regarding the scope of what is taught seem to stem from the state guidelines not just local decisions. Two topics that are not mentioned in the state guidelines are gender identity (other than heterosexuality) and abortion. However, the national FoSE standards recommend that gender identity be part of the curriculum as early as grade 3, and abortion be discussed in high school in a compare-and-contrast of laws relating to pregnancy, adoption, abortion, and parenting.

In our interviews with teachers, we learned that if a student asks about these topics in class, the teachers are instructed to tell the student that this is a question that will not be addressed in class; they should ask their parents. This approach is also taken if a student asks about a topic that is supposed to be covered in a later grade.

This response troubled our study group. If a student wants information, answering his or her questions seems important, especially since many students would not pose the questions to their parents. Many parents are likely not to have accurate information or be comfortable answering their children's questions about sensitive matters. Teachers could provide the information outside of the classroom discussion (in private). This outcome may not be likely. As one former local public school administrator told us: teachers are on the defensive so much these days that they do not wish to initiate any programs that may invite parental controversy.

Challenges Regarding Time for Teaching Health and FLE

As everyone knows, there is pressure on schools and students to fit in everything that must be taught and all that school personnel, parents, and students want to have taught. Our discussions also revealed the competing priorities that affect how much time is spent on health and FLE.

As discussed above, health and FLE are taught during PE, which means that these subjects have relatively few hours of class time and are only taught through the 10th grade. For example, in the middle schools where we interviewed administrators or teachers, PE is taught every other day, with health instruction for part of the time on some of the days and FLE often only a few hours during the course of a semester.

We discussed the limited time for health education during our interviews. Some people thought that the lack of standardized state tests in health (despite the state SOLs), means that the subject is given a lower priority. Others indicated that there is pressure from parents and students to allow students to take extra classes and engage in extracurricular activities, which would be considered more valuable when students apply for college. Interviewees noted that many parents did not seem to think that PE and health education are important. School administrators indicated that some children take PE during the summer rather than the school year to free up their school hours. This means that they are not getting class time regarding health/FLE but also they are not getting regular physical education instruction. (Students who do this are required to keep a log of their activity during the school year.)

Another pressure is created by driver's education. This instruction also occurs during PE time and, in 10th grade, students take driver's education rather than health education during their PE hours for half of the semester.

Challenges Regarding Resources and Personnel

Having personnel with expertise in the subjects being taught are essential for successful implementation of any educational program. The study looked at the personnel involved in teaching health and family life education, their qualifications and training, the inclusion of other educators, and the availability of other resources.

As discussed above, classroom teachers in the elementary schools and PE teachers in middle and high schools have primary responsibility for teaching health and family life education. We were unable to learn what instruction in these areas is part of pre-licensure education of teachers. Given the special role of the PE teacher in

implementing health and family life education, we focused our inquiry on PE teacher qualifications.

PE teachers in Virginia are now certified in Physical Education and Health, not solely in physical education. Therefore, newer teachers have this dual certification. We were told, however, that the emphasis is still on Physical Education and there is no special requirement or training to qualify PE/Health teachers to teach FLE.

We were unable to get data regarding how many teachers in our local schools have PE/Health certification. It is our understanding, from our interviews, that most teachers in the city and county have the dual certification in PE and Health.

After initial licensure, teachers are required to have other "professional development" (180 points in a five-year period) to renew their licenses. Various activities can qualify, ranging from college courses, professional conferences, participation in curriculum planning, publication of books or articles, mentorship or supervision and other educational projects or professional development activities. It is up to the teacher to choose what he/she pursues and a PE/health teacher may choose options other than ones with health or FLE-related content.

One way to ensure that local teachers have relevant training is for the city and county to provide it. During the course of our study, both the jurisdictions did so after the adoption of the new FLE curricula. In our interviews prior to the training, teachers seemed to be looking forward to it, so that they would understand and have some tools with which to teach the new materials.

Ongoing training is vital to enhance teacher skills in these areas. Programs offered by the Virginia Department of Education, professional and non-profit organizations, and sessions conducted by local health professionals can help address this challenge.

Non-teachers with relevant expertise can and do supplement the information that teachers provide. This has occurred primarily in health classes. In some city and county schools, people outside of the school system, such as policemen, nutritionists and physicians have participated in health education and in some city schools an outside health educator has taught FLE. Because we were unable to interview representatives of all schools, it is unclear how many schools bring in outside speakers, who they are and what topics are addressed.

We were told by administrators and teachers at several schools that having outsiders would require approval. The city has a list of approved outside speakers, which includes personnel from the Departments of Health, Social Services and Parks and Recreation.

In our interviews, there seemed to be a willingness to consider outside speakers but many teachers do not feel they have the time to identify whom to contact. In addition, there seems to be cautiousness about who might be brought in. One administrator noted that they would want to make sure that any outsiders were in agreement with what is taught in FLE. Another indicated that the concern was not a reluctance to exposing students to controversial opinions, but that they want to guarantee that any opposite view is presented as well to ensure balance.

One teacher also noted the difficulty in scheduling outside speakers, telling us that they would have to be available for more than one day and multiple class sessions. Such multiple presentations would be needed to ensure that all students in a grade heard the same thing. This limitation might be addressed by more use of technology, such as video.

As noted earlier, we found in our interviews that school nurses have played a limited teaching role. Several nurses to whom we spoke would like to be more involved with the health and family life instruction. They noted, however, that they wanted to be able to present medically-accurate information and respond to student questions, without the limitations that currently exist.

Challenges of community and parental engagement

The engagement of people outside of the school system is linked to all of the other challenges we have discussed. It can be a powerful component for continuing the improvement in curriculum, instruction and increasing the impact of health and FLE for the health of students, their families and this community.

As we discussed earlier, the local curricula have been developed to have community acceptance and that there is a gap between our programs and the national standards and other jurisdictions' curricula. Several health educators suggested to us that, until parents have a greater understanding of what is included in the FLE program, it will be hard to expand and improve what is taught.

Other improvements in both health and FLE can occur with greater use of community resources, both for teacher training and to supplement what teachers do. We are unaware of any current mechanisms for identifying people and organizations who might become involved and other resources that might be used. Barriers that seem to inhibit having qualified medical and other professionals need to be addressed.

There is another reason to increase community and parental engagement, which was reflected in comments by teachers and school administrators. The schools cannot do all that needs to be done to educate children about health and family life issues. Even if we have the best curriculum and instruction, what students are taught needs reinforcement in everyday life. If children are taught about healthy behaviors and they hear inconsistent messages at home or in the media, the impact of what is taught in school is likely to be decreased.

The value of parental engagement is clear from the stated goal of the county's FLE program (to "develop skills, to promote parent/child discussion and to impart accurate information".) This interaction depends on parental understanding, knowledge and involvement. Our discussions with school personnel and community educators highlighted the need to create tools to encourage such parental and community engagement and increase parents' knowledge about the substance of health and family life education, as well as their knowledge about health more generally. For example, one school administrator emphasized the need for parents to learn about nutrition and the impacts of tobacco use.

Possible approaches to this challenge were suggested in our interviews, including inviting parents to programs at the schools and sending more information to parents on a regular basis to help them discuss the topics with their children. However, those steps may be impractical given the time overload that many parents feel and the likelihood that only highly motivated parents are likely to come to PTO or school programs. These measures would also be more work for teachers, who told us how little time they have to do what they currently need to do.

Conclusion

The city and county schools have implemented health and family life education that address the criteria established by the state standards and have engaged the community in the process. While there has been considerable recent improvement in the FLE curricula in both jurisdictions, regular periodic review seems warranted to update and improve curricula and materials in both health and family life areas, with an eye to incorporating the model curricula of the national standards.

Addressing other challenges cited in this report are also critical to improving the programs. Efforts can begin with engaging more health professionals, including school nurses and health care providers and educators in the community for teaching students, training teachers and identifying materials that can be used for student and parent education. Outside of the schools, community organizations including non-profit, business and faith groups should be encouraged to work with the schools and parents to help youth develop the skills and behaviors needed for healthier lives and relationships.

[You may access any of the references cited in the study, by clicking on the blue links above in the report.]