Enhancing the Understanding of Healthful Living Essential Standards in North Carolina Middle and High Schools: Who are the Educators, How Standards Are Taught and What Resources Are Needed?

by

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A Master's Paper submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Masters of Public Health in the Public Health Leadership Program

Fall 2017

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Abstract

The purpose of this qualitative research was to gather feedback to understand the current state of how the Healthful Living Essential Standards are implemented in North Carolina middle and high schools. The Essential Standards educate students about the risks associated with use of (1) alcohol, tobacco, and other drugs, (2) interpersonal communication and relationships (3) mental and emotional health, (4) personal and consumer health and (5) nutrition and physical activity. The focus was on how the Essential Standards are taught, who teaches it, what resources are used, and what support is needed. While the questions address healthful living overall, there were also questions specifically regarding reproductive health and safety.

This research was a collaboration with North Carolina Department of Public Instruction’s (NCDPI) Healthy Schools Team from June 2016 until March 2017. Over two-hundred administrators and educators were contacted utilizing purposive sampling. Thirty-five interviews were completed in person or via telephone lasting approximately forty-five minutes each. The interviews were audio recorded and coded for themes. Those interviewed included at least two members of the central education office, such as a principal or curriculum lead and at least two health education teachers in each of the eight N.C. State Board of Education Districts.

Key findings include 1) Eighty-eight percent of the health/PE teachers did not receive sexuality education courses for their health education degree at their university or college. 2) Thirty-seven percent of health education teachers have not received professional development for reproductive health and safety in five or more years. 3) Fifty-two percent of participants reported that condom demonstrations were not occurring in the classroom. 4) Thirty-four percent of schools surveyed offer health for approximately seven weeks a semester. Thirty-four percent of those surveyed also stated that class time was shared evenly. Administrators were more likely
to report that health and PE share instruction time evenly but teachers reported that health
received less time.

Recommendation Summary includes: 1) Separate health and physical education into two
semester-long courses offered each year. 2) Enhance and disseminate a portal for resources and
materials related to Reproductive Health and Safety 3) Provide additional professional
development and support to attend trainings 4) Include health education in the Every Student
Succeeds Act (ESSA) and add health education to the Common Core.

Keywords: Public Schools, North Carolina, Sexual Health, Reproductive Health and Safety,
Public Education, Healthy Youth Act
Acknowledgements

I am a grateful to the teachers and administrators who shared their stories with me. Thank you for trusting me with your experiences. Deepest gratitude to Dr. Leah Devlin for her generous gift and the Robert Wood Johnson Foundation for matching funding, which made this research possible and to Susanne Schmal, Lori Evarts, Dr. Alexandra Lightfoot, Dr. Ellen Essick, Burt Jenkins, Les Spell, Nakisha Floyd, Dwayne Madison and Kelily Langston, whose expert guidance and support facilitated the success of this project and resulting thesis. And thank you Tony for reminding me to breathe and Noah, Ethan and my entire family for your love and encouragement.
# TABLE OF CONTENTS

Abstract ......................................................................................................................... 1

Acknowledgements ........................................................................................................... 3

List of Figures .................................................................................................................. 6

List of Abbreviations ....................................................................................................... 7

Introduction ..................................................................................................................... 8

Literature Review ............................................................................................................ 9
  Search strategy ............................................................................................................... 9
  Synthesis of results ...................................................................................................... 10
    Hygiene and the History of Health Education in American Public Schools ................ 10

Sexual Health Education ................................................................................................. 11

Sexual Health Education in North Carolina .................................................................. 12

Cultural Narrative Lacks Comfort with Discussion of Sexual Health ......................... 16

Health Education is Not a Priority ................................................................................ 20

Teachers Are Not Receiving Adequate Pre-Service Training or Professional Development ......................................................... 21

Qualitative Research ..................................................................................................... 23

Study design and methods ............................................................................................. 23

Participants ..................................................................................................................... 24

Analysis and results ....................................................................................................... 26
  Dissemination of Results ............................................................................................ 27

Findings ........................................................................................................................... 27

Themes ............................................................................................................................ 40
  Theme #1 Not Enough Time to Teach ........................................................................ 40
LIST OF FIGURES

Figure 1: Summary of Interviews Conducted by N.C. State Board of Education Districts ......................................................................................................................... 26

Figure 2: Results of Interview Question, “Who is Responsible for Teaching Health Education?” ................................................................. 28

Figure 3: Results of Interview Question, “Do All Students Receive Health Education?” .................................................................................. 29

Figure 4: Results of Interview Question, “Who is Responsible for Teaching Reproductive Health and Safety Education in Your School/District?” ..... 30

Figure 5: Results of Interview Question, “Did You Receive a Sexuality Education Course as Part of Your Health Education Degree at your University or College?” ................................................................................. 31

Figure 6: Results of Interview Question, “How Often Do You Receive Professional Development for Health?” .......................................................... 32

Figure 7: Results of the Interview Question, “How Often Do You Receive Professional Development for Reproductive Health and Safety?” .......... 32

Figure 8: Results of the Interview Question, “What Resources Are Used to Teach Reproductive Health and Safety?” .......................................................... 33

Figure 9: Results of Interview Question, “Is Instruction Time Shared Evenly?” ...... 35

Figure 10: Results of Interview Question, “How Much Time is Designated for Reproductive Health and Safety?” ................................................................. 36

Figure 11: Results of Interview Question, “Do You Offer an Opt-Out Letter Concerning Reproductive Health and Safety?” ......................................................... 37

Figure 12: Results of the Interview Question, “Are Contraceptive Methods Discussed?” ........................................................................................................ 38

Figure 13: Results of the Interview Question, “Are Condom Demonstrations Allowed?” ................................................................................................. 39

Figure 14: Results of the Interview Question, “Are HIV/AIDS and STI’s Discussed?” ................................................................................................. 39

Figure 15: Results of the Interview Question, “Is What Constitutes Sexual Assault, Sexual Abuse and Consent Discussed?” ................................................. 40
LIST OF ABBREVIATIONS

ASHA  American Social Hygiene Association
AAPHER  American Association for Health, Physical Education, and Recreation
CDC  Centers for Disease Control & Prevention
FDA  Food and Drug Administration
HIV  Human Immunodeficiency Virus
HLES  Healthful Living Essential Standards
HACP  Healthy Active Children Policy
HYA  Healthy Youth Act
IRB  Institutional Review Board
K-12  Kindergarten through grade 12
LEA  Local Education Agency
NC  North Carolina
NCAE  North Carolina Association of Educators
NCDPI  North Carolina Department of Public Instruction
PE  Physical Education
PHS  Public Health Service
PTA  Parent Teacher Association
RHS  Reproductive Health and Safety
SCT  Social Cognitive Theory
STIs  Sexually Transmitted Infections
UNC  University of North Carolina
US  United States
WSWC  Whole School, Whole Community, Whole Child Model
YRBS  Youth Risk Behavior Survey
Introduction

Health education is a critical aspect of adolescent development, and in some cases, as with sexuality education, school may provide the only opportunity students have to learn about how to make healthy decisions (Kendall, 2013). Prior to my work, there was no existing research in North Carolina addressing how the Healthful Living Essential Standards are taught in middle and high schools, who teaches it, what resources are used, identification of the most prevalent barriers, and what support is needed. One and a half million students in North Carolina (NC) public schools will receive instruction on the Essential Standards during kindergarten through grade 12 (K-12) instruction.

According to the Youth Risk Behavior Survey (YRBS) collected from NC middle school students in 2015: 42% were not physically active for a total of at least 60 minutes per day on five or more of the past seven days, 35% had ever carried a weapon, 10.5% had ever attempted suicide, and 11.4% had ever had sexual intercourse (Centers for Disease Control & Prevention [CDC] Youth Risk Behavior Survey [YRBS] 2015). Among high school students surveyed in 2015, 43.4% were not physically active for a total of at least 60 minutes per day on five or more of the past seven days, 9% of twelfth graders had ever carried a weapon, 16.4% were obese, 20.5% of female students had seriously considered attempting suicide, 34% of males and 24% of females currently used electronic vapor products, 54% of students ever had sexual intercourse and of those who are sexually active, 60.5% used a condom the last time they had sex (CDC YRBS 2015).

The statistics are similar nationally with 58.1% of adolescents having engaged in sexual intercourse by twelfth grade (Kann & Harris, 2015). Among those who are sexually active, 56.9% did not use a condom at last intercourse and 81.8% did not use hormonal birth control
(Kann & Harris, 2015). When compared to the world’s developed nations, the United States (US) ranks highest in adolescent teen pregnancy rate with 24 pregnancies per 1,000 females leading to nearly 750,000 teen pregnancies of which 82% were unintentional (The World Bank, 2014).

Adolescents aged 13-24 account for 25% of all new Human Immunodeficiency Virus (HIV) infections in the United States (CDC Sexually Transmitted Disease Surveillance 2011). Those aged 14-25 account for nearly half of all new sexually transmitted infection (STIs) (CDC Sexually Transmitted Disease Surveillance 2012). The need to improve access to vetted, up-to-date health education curriculum, and materials offered by trained instructors to support the health education of the one and a half million NC public school students is a compelling issue that is not unique to NC.

**Literature Review**

A review of literature pertaining to the history of health education and sexual health education highlights the struggles encountered over the past hundred years as teachers and administrators have worked to establish health as an integral piece of the US educational system. Understanding past processes can facilitate future successes as it helps the public health professional navigate the journey of prioritizing health education in NC public schools.

**Search strategy**

Mary White, Health Sciences Librarian at the University of North Carolina at Chapel Hill (UNC Chapel Hill), facilitated the identification of key search words and themes. Health education and sexual health education terms searched for in literature include: “Sex Education” OR “Reproductive Health Education” OR “Sexuality Education” OR “Sexual Health Education” OR “North Carolina Public Schools” OR “Public Education” OR “K-12” OR “Middle School”
OR "High School" OR "Healthy Youth Act". In addition to this search, I performed an extended search through the UNC Chapel Hill Health Sciences Database. As I found pertinent research, I would locate additional work of the authors and then explore their references and further research those additional authors and associated works.

**Synthesis of results**

**Hygiene and the History of Health Education in American Public Schools**

Findings from the literature examining the history of health education demonstrate that the barriers to effective instruction, as expressed by current health educators, are echoed by the writings of the teachers and administrators throughout the timeline of health education in the United States. This paper aims to explore the original barriers to health education that have thrived over one hundred years to impede American public school students’ understanding and embodiment of health within the context of education. The voices in the historic review of the literature mirror those I heard during my 2016 research. Identifying core barriers will provide a path to strengthening the implementation of the North Carolina Healthful Living Essential Standards (HLES). These barriers include: a socio-cultural narrative that lacks comfort with discussion of sexual health, the perception that health education is not a priority as a course of study within schools, and the lack of adequate pre-service training or professional development for classroom teachers charged with teaching health education.

The first schools in the United States did not offer a healthy environment for students to learn and prosper. A lack of resources and knowledge concerning health resulted in schools that were not structurally sound and had insufficient lighting, unsafe venting for heating with a wood stove, and no bathrooms (Means, 1962). Health or health education was not in the awareness of teachers and administrators. Literacy was the sole educational objective. Benjamin Franklin was the first to suggest that schools should offer students a “healthful situation” and the first to
include exercise into the curriculum (Wyche, Nicholson, Lawson, & Allensworth, 1997. p 33). Franklin planted the seeds of school health education.

The first mention of a need for health curriculum to be added the standard course of study was in the early 1840s. Horace Mann (1796-1859) was the first secretary on the Massachusetts State Board of Education, the first state board of education in the country (Means, 1962.). In 1843 he wrote a report on public education specifically including a request to include health curriculum in schools due to the fact that there was a lack of understanding as how to cultivate and maintain health and it was, “so little regarded or understood by the community” (Sliepecevich, 1963, p. 145).

**Sexual Health Education**

Sexual health education is the most controversial strand of health education. Sexual health is also possibly the most crucial to deliver in middle and high school because of the scarcity of educational opportunities at any other time or location throughout the lifespan (Kendall, 2012). The impetus for sexual health education in public schools was women working to enact social change.

In 1913 Dr. Ella Flagg Young, Chicago City Schools Superintendent made history when she spearheaded a program for the city’s 20,000 high school students to receive the country’s first sex education in public schools (Jensen, 2010). In the 1920’s, Marie Oehl von Hattersheim Bauernschmidt, a health and education activist in Baltimore was alarmed by the deformities caused by congenital syphilis and took it upon herself to improve sex education in the public schools including teaching that condoms can protect against venereal disease. She was silenced repeatedly and her speaking events were cancelled (Lord, 2010). Bauernschmidt prevailed by collaborating with the Parent Teacher Association (PTA). She also testified before Congress.
about the barriers she was experiencing as she promoted sexual health education. This courageous testimony facilitated the creation of a sexual health education program that was then replicated around the country (Lord, 2010). Unfortunately, the barriers that Bauernschmidt faced have also been replicated around the country and continue almost a century later.

**Sexual Health Education in North Carolina Schools**

The first mention of sex education in North Carolina Schools in available literature was in 1996. The North Carolina General Assembly passed House Bill 834 which stated that abstinence-only sex education curriculum should be taught in public schools (Teach Abstinence Until Marriage, 1995). This piece of legislation was passed after Robin Hayes, a Republican State Representative, introduced this abstinence-only sex education bill (Bach, 2006). This passing of House Bill 834 resulted in the majority (100 of the 117) of school systems adopting abstinence-only until marriage curriculum. Abstinence-only education, as described in Section 510 of the Social Security Act, originally enacted in 1996, states that an abstinence-only education program:

1) *has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;*

2) *teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;*

3) *teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;*

4) *teaches that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;*

5) *teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;*

6) *teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child’s parents, and society;*
7) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

8) teaches the importance of attaining self-sufficiency before engaging in sexual activity

(Santelli, Kantor, Grilo, Speizer, Lindberg, Heitel & Heck, 2017, p.3).

Despite this adoption of abstinence-only policy in NC, research has shown that abstinence-only education is not effective at reducing rates of teen pregnancy and does not reduce rates of teens engaging in vaginal intercourse (Kohler, Manhart & Lafferty, 2008). In fact, contrary to belief, adopting abstinence-only education as a state policy may be instrumental in the rise of teenage pregnancy rates (Stanger-Hall & Hall, 2011). In their position paper for the Society for Adolescent Medicine, Santelli et al. reported that:

Current federal abstinence-only legislation is ethically problematic, as it excludes accurate information about contraception, misinforms by overemphasizing or misstating the risks of contraception, and fails to require the use of scientifically accurate information while promoting approaches of questionable value.

(Santelli, Ott, Lyon, Rogers & Summers 2006, p. 86)

With research indicating that abstinence-only education is not effective at preventing teen pregnancy (Perrin & DeJoy, 2003), parents in a study conducted in NC supported using evidence-informed, medically accurate sexual health curricula (Ito, Gizlice, Owen-O’Dowd, Foust, Leone & Miller, 2006). A 2009 independent survey of both conservative and liberal parents conducted by the UNC Gillings School of Global Public Health found that 91.8% of parents wanted sex education to be taught in schools. In addition, of the 91.8% of parents who wanted sex education to be taught in schools:

- 99.6% of parents wanted their child to be taught about the transmission and prevention of sexually transmitted diseases
- 97.1% wanted instruction to include effectiveness and failure rates of birth control methods, including condoms
• 92.9% wanted instruction to include risks of oral sex.

(APPCNC, 2009)

These studies reflect the growing concern among NC parents about the ineffectiveness of abstinence-only sexual health education and its narrow focus on abstinence from sexually activity as the only effective means of preventing sexually transmitted disease and pregnancy, and gave rise to the need for comprehensive sex education that was evidence-based.

The General Assembly of North Carolina passed the Healthy Youth Act (HYA), House Bill 88, in 2009. This policy transitioned NC from abstinence-only to an abstinence-based comprehensive sexual health education. HYA directs school administrators to provide reproductive health and safety education that is based on scientific peer-reviewed materials in grades seven through nine. HYA also directs all schools to provide a means for parents to “opt out” (i.e., withdraw their student from the course). The school then has the responsibility to offer the student instruction on the components of healthy relationships, decision-making skills, transmission and all federal Food and Drug Administration (FDA)-approved methods of reducing the risk of contracting sexually transmitted diseases, effectiveness and safety of all FDA-approved contraceptive methods in preventing pregnancy in addition to instruction on preventing sexual assault and sexual abuse. (Healthy Youth Act of 2009). Comprehensive sex education covers essential sexual health topics more broadly and can include instruction about how to:

Avoid negative health consequences;

Communicate about sexuality and sexual health;

Understand healthy and unhealthy relationships;

Understand, value and feel autonomy over their bodies;

Respect others' right to bodily autonomy;
Show dignity and respect for all people regardless of sexual orientation or gender identity;

Protect their academic success.

(Advocates for Youth, n.d.)

NC’s move towards more a comprehensive policy, as reflected in the Healthy Youth Act of 2009, reflected research on the national level that supported the effectiveness of comprehensive sex education as compared to the abstinence-only approach. In 2007, The National Campaign to Prevent Teen and Unplanned Pregnancy reported a review of research findings that pointed to the effectiveness of comprehensive sex education at reducing sexual risk behaviors. The review found that:

*Two-thirds of the 48 comprehensive programs that supported both abstinence and the use of condoms and contraceptives for sexually active teens had positive behavioral effects. Many either delayed or reduced sexual activity, reduced the number of sexual partners, or increased condom or contraceptive use.*

*None of the comprehensive programs hastened the initiation of sex or increased the frequency of sex.*

*Comprehensive sex education programs worked for all youth populations: Comprehensive programs worked for both genders, for all major ethnic groups, for sexually inexperienced and experienced teens, in different settings, and in different communities.*

*Programs that were implemented with fidelity in the same type of setting and with similar youth were found to be just as effective as the originally evaluated program. Therefore, it was found that programs could be replicated and widely disseminated to youth across the country.*

(Kirby, *Emerging Answers, 2007*).

NC’s policy continued to endorse abstinence as the only sure way of preventing pregnancy, but the HYA expanded the content schools were permitted to cover, resulting in NC’s abstinence-based comprehensive sexual health education as the current policy. The components
of the HYA are state policy, however each local school administrative unit may enact ‘local control’ and interpret the policy based upon local opinion and political perspective. As a result, implementation differs widely across the state’s educational districts (Lightfoot, Taboada, Taggart, Tran & Burtaine, 2015). For example, this can result in condom demonstrations not being allowed in some district’s classrooms or teachers being prohibited from discussing homosexuality.

Sexual health education is the most effective means of ensuring students’ sexual health (Kendall, 2013) and therefore it is critical to support full and equitable implementation of evidence-informed comprehensive curricula in North Carolina’s public schools. Because it is not fully implemented across the state, it is also critical to understand the active barriers to implementing comprehensive sex education in North Carolina.

**Cultural Narrative Lacks Comfort with Discussion of Sexual Health**

It is imperative to strengthen and promote reproductive health and safety instruction so that it emerges from the realm of national discomfort. Research within the field of psychology has revealed that sexuality is a normal aspect of human life and sexual health is in close relationship with, “...psychological health, quality of life, and relational satisfaction....despite that assumption, we acknowledge that sex and sexuality are still considered taboo for many people” (Bancroft, 2009, p.150 :as cited by Cruz, Greenwald & Sandil 2017, p.557). Cruz et al. also identified that men and women have been, “socialized through sex-negative messages to attach shame and fear to sexuality” (p.557). Sex- negative is a term that frames sexual activity as “potentially harmful, dangerous, and/or problematic” in comparison to sex-positive which frames sexuality as a normal function of human development” (Bancroft, 2009, p.229: Cruz, Greenwald & Sandil 2017,p. 557). Nearly each of the 107,602,707,791 humans that has ever lived on earth
was created from sexual intercourse (Population Reference Bureau, 2011). Normalizing sexual health education is a key component of reducing the discomfort surrounding sexual health and this need has been echoed through the past century. In the 1919 report on The Problems of Sex Education in Schools, it was reported, “A larger majority of boys get their first permanent impressions about sex from improper sources before the age of 12. Many testify to the unfortunate effect of these early impressions received from older boys and undesirable sources” (p.161). In a 1937 report titled Let’s Lift the Taboo, Parran stated “…one large task is to dissociate syphilis and gonorrhea from morals” (Parran,1937, p. 69). In 1942, the Public Health Service (PHS) and the American Social Hygiene Association (ASHA) collaborated in publishing the statement, “educators must aid in cutting through false modesty and taboos connected with venereal disease” (Lord, 2010. p.82).

A review of the history of sex education in the United States reveals a pattern of persecution against school administrators and public health officials who championed the effort to normalize sexual health as a key component of a healthy child. When Dr. Ella Flagg Young, Superintendent of Chicago City Schools, developed the first sexual health education program in US schools in 1913, her initiative was met with skepticism and objection. Dr. Young’s vision was that if public schools could educate students about sex, “before they encountered vulgar sources” then there would be a higher probability that they would delay sexual debut, understand how to reduce the risk of sexually transmitted diseases and, “grow into healthy self-sufficient citizens (Jensen, 2010, p.49). Public concern was that sex education bred immorality. Young addressed the initial objections to sex education in schools and attempted to quell fear by emphasizing the interconnected nature of health and morality (Jensen, 2010 p.57). She also advocated for using terms like “wonderful” and “special” when referring to the reproductive
organs in an attempt to counteract the prevalent negative associations (Jensen, 2010, p.52). Unfortunately, stigma and the social narrative that teaching about sexual health was immoral brought an end to the Chicago Public Schools sex education program after only one school year. The Washington, D.C. Post Office Department declared that, due to the Comstock Law, the school system could not mail the lessons for parental review (Jensen, 2010 p.64). The Comstock Law, passed by Congress in 1873, “outlawed the interstate mailing, shipping, or importation of articles, drugs, medicines, and printed materials of “obscenities,” which applied to anything used “for the prevention of conception” (Bragdon, 2010, p.101). A loud minority were effective at voicing their objections to sex education in Chicago public schools and silenced the program.

More recently, as Surgeon General during the Clinton administration, Joycelyn Elders, an African-American pediatrician, refocused attention on the importance of comprehensive sex education. Her objectives were to reduce teen pregnancy and rates of sexually transmitted infections (STIs). In 1994 on World AIDS Day, Elders gave a speech that stressed comprehensive sex education, condom use, and in response to a reporter’s question about masturbation, she responded:

*Masturbation is part of human sexuality and it's a part of something that should be taught. But we have not even taught our children the very basics, and I feel that we have tried ignorance for a very long time. And it's time we try education*

(Elders, 1996).

Elders statement was met with political and religious uproar. Shortly after, Bill Clinton surrendered to political pressures and fired Elders and her tenure as the second woman and first African American Surgeon General ended (Sethna, 2010). Elders joined a long line of public health experts losing their jobs due to public expression and advocacy of federally funded sexual health education.
Sexual health education has yet to be fully accepted and normalized as part of the educational curriculum. Furthermore, after generations of timid sexual health education, discussion on healthy sexual development is not a normalized part of the American narrative. Young minds are curious and seek knowledge. Normal sexual development includes sexual thoughts, feelings and actions that emerge from changes during puberty (Kanagn, 1971). Adolescents seek knowledge regarding sex where they can find it. If they are not offered evidence based information about reproductive anatomy, physiology, how to care for their bodies and how to establish healthy behaviors, they will seek information elsewhere, as the data on pornography as an educational tool suggest. Upwards of 75% of adolescents who have access to the internet, use this resource to find health related information, especially sexual health information (Rideout, 2001). While the internet can be a useful tool for conveying accurate sexual health information, it has also become a mechanism for conveying sexual health messages that are not developmentally appropriate through pornography available on the web. Research has shown that by seventeen years of age, 93% of boys and 62% of girls have been exposed to pornography (Sabina, Wolak & Finkelhor, 2008; Sun, Bridges, Johnson, & Ezzell, 2016). Eighty-eight percent of scenes in pornography depict physical aggression and when attacked, 95% of recipients responded with expressions of pleasure or were void of response (Bridges, Wosnitzer, Scharrer, Sun & Liberman, 2010). Pornography is not a safe source for information. Those who view pornography are more likely to perceive violence against women as acceptable (Hald, Malamuth & Yuen, 2010). In addition, pornography normalizes male domination and prioritizes male sexual pleasure (Rothman, Kaczmarsky, Burke, Jansen, & Baughman, 2015). Pornography also offers a false understanding and portrayal of sex and potential consequences of unsafe sex due in part to a lack of discussion of STD’s or pregnancy and lack of use of
contraceptives (Bridges et al.). Comprehensive sexual health programs that provide access to
evidence-based medically accurate information about emotional and physical sexual
development are critical for the sexual health of adolescents.

**Health Education is Not a Priority**

In the US education system, there is an institutionalized division between the body and
the mind that is reflected in funding for health education and time spent on the topic within
classrooms. Burt Jenkins, the Health/Physical Education/Athletics Consultant for NCDPI,
reported that, “Healthful Living is the only graduation required class that has two sets of
standards and objectives that must be taught within a single class” (Jenkins, B, personal
communication. November 7, 2017). Instruction time for both health and physical education
standards and objectives, the components of Healthful Living, is split within a single nineteen-
week semester. Dr. Ameena Batada, Associate Professor in the Health and Wellness Department
at the University of North Carolina at Asheville, finds that, “We prioritize cognitive tasks in life
more generally and so value those types of learning in our classrooms. As such, our system sees
the arts and health as secondary, in funding and other resources” (A. Batada, personal
communication, November 7, 2017). The structural barrier of not enough class time was
documented in research that found nearly half (48%) cited lack of time as a prevalent
barrier (Eisenberg et al, 2013).

A Massachusetts report titled, *The Teaching of Hygiene in the Grades* found that, “The
American people do not yet seriously appreciate the fundamental importance of health for
healthy living...the school itself has little appreciation of the fundamental importance of health
education” (Andress, 1918, p.23). Research continues to emerge that presents how academic and
non-academic learning is intertwined and educators should develop curricula that unifies the
promotion of academic and social-emotional competence (Jones and Bouffard, 2010; sibley, Theodorakakis, Walsh, Foley, Petrie & Raczek, 2017). In the current compartmentalized model, the student’s body is expected to perform as a healthy vehicle in which the mind can gather information, learn and thrive. Each year, K-12 students are continuously being taught formulas for solving math equations, the structure to use as the foundation of writing, and diagrams that convey the cycles of life. Consequently, the Healthy Active Children Policy states that NC health education curriculum that teaches standards focused on how to cultivate healthy physical, emotional, mental and social behaviors was limited to half of one semester per year in middle school (Healthy Active Children Policy, 2016). The guidance for high schools is to teach health for part of one semester within the four years of high school (HYA, 2009). This circumstance has created an environment where students are not receiving adequate instruction on how to establish and maintain healthy behaviors, as reflected in the 2015 NC YRBS data reported above.

**Teachers Are Not Receiving Adequate Pre-Service Training or Professional Development**

Nowhere else in education is a teacher expected to provide instruction on a subject in which she/he has not received adequate training than in sexual health education. This lack of training and preparation has created another form of discomfort that has inhibited sexual health education consistently over the past one hundred years. Teacher discomfort and lack of pre-service training is an influential factor in the avoidance of certain topics of instruction. Subjects that are most often excluded from discussion in the classroom are condom use and other contraceptive options, reproductive health services access, pregnancy options, sexual orientation, and sexual violence (Eisenberg, Madsen, Oliphant & Sieving, 2013. P.397). Researchers Barr et al., reported that, “nearly one third of teachers responsible for sexuality education report receiving no pre-service or in-service training in this area (Barr, Goldfarb, Russell, Seabert
Wallen & Wilson, 2014, p.397). Strengthening and promoting comprehensive sex education and preparing teachers well to deliver the content has the potential to soften the cultural barrier to discussing sex education.

There is over a century of documented concern about teacher preparedness for teaching sexual health education. In the 1919 Report on The Problems of Sex Education in Schools, the author expressed hope that the study’s findings would lead to teachers being offered a more comprehensive foundation of instructional knowledge on teaching sexual health education (USPHS, 1920). The Public Health Service did increase professional development opportunities in the 1920's but the effort was inadequate in improving teacher-preparedness (Lord, 2009).

James Frederick Rogers MD, Dr.PH, Consultant in Hygiene, United States Office of Education reported in 1940 that, “Health education is out-of-joint and teachers are running hither and yon, sometimes frantically, seeking aids in this seemingly elusive matter of health education” (Rogers, 1940, p.1). In 1961 the American Association for Health, Physical Education, and Recreation (AAPHER) published a report on School Health Practices in the United States stating that the organization is collaborating with colleges and universities to improve teacher preparedness with additional coursework in health (Creswell, 1961). It was recommended that elementary teachers should receive two-four semester hours of health and high school teachers should receive specific courses including anatomy, administration of health and principles of health, and that a network of support including superintendents, principals, health teachers and others need to collaborate in order to ensure progress in health education (Creswell, 1961).

The scarcity of support or knowledge about how to engage in professional development opportunities has fostered an environment where some teachers feel anxious about the subject matter (Henshaw, 2000, p.192). When a teacher has not had the opportunity to cultivate a sense
of self-efficacy and personal comfort about presenting on sexual health, they may avoid certain subjects all together (Eisenberg, Madsen, Oliphant & Sieving, 2013, p.397). A 2014 report on the development of teacher-preparation standards found that teacher training is the “most significant indicator in determining the comprehensiveness of the sexuality education instruction and the number of sexuality topics taught within any curriculum” (Barr, Goldfarb, Russell, Seabert, Wallen, & Wilson, 2014, p. 397). It is critical to support teachers with adequate pre-service training, professional development opportunities and support to attend such trainings in order to strengthen the foundation for health education in public schools.

**Qualitative Research**

**Study Design and Methods**

This qualitative study focused on gathering feedback from school administrators, health educators and classroom teachers via individual interviews to understand the current state of how the Healthful Living Essential Standards (HLES) are implemented in North Carolina middle and high schools.

The research plan, survey instruments, data collection and storage details were reviewed by the University of North Carolina Office of Human Research Ethics. This effort, Institutional Review Board (IRB) Study # 16-1937, was determined not to constitute human subjects research as defined under federal regulations [45 CFR 46.102 (d or f) and 21 CFR 56.102(c)(e)(l)] and was therefore deemed exempt from IRB approval.

Collection of personally identifying data such as name, age, email, etc., of interviewees was not collected or stored as part of this study database. Identification of participants was maintained at the district level and solely by category, such as School Administrator, Health Educator, or Teacher.
NC Healthy Schools is a section of NCDPI that works to support the health of students and staff in NC public schools with the framework of the Whole School, Whole Community, Whole Child Model (WSCC). This research was supported by a collaboration between UNC Chapel Hill and NC Healthy Schools who desired to assess how the HLES were being implemented in NC. In years past, graduate students had attempted to evaluate HLES with surveys but had poor response so there was no data on implementation of HLES.

Two sets of interview questions were developed, with the guidance of NC Healthy Schools: one for teachers and one for administrators. In essence, NC Healthy Schools wanted to know who was teaching health, what barriers they were experiencing and what resources were needed. The thirty-seven questions in the interview guide for administrators covered five categories: content, scheduling/time, professional development, policy/guidelines, barriers and support. The interview guide for educators included thirty-four questions clustered in four categories: content, scheduling/time, professional development, barriers and support. Using these two sets of guides, thirty-five interviews were completed in person or via telephone, each lasting approximately forty-five minutes each (Figure 1). Depending on if the interview was in person or conducted via telephone, verbal or written consent to record the interview was obtained, and then the set of questions respective to each group, teachers or administrators, were asked.

Participants

Over two-hundred administrators and educators were contacted utilizing convenience sampling with thirty-five agreeing to participate in the study (N=35) (Figure 1). Participants were distributed evenly across the state with at least two administrators and at least two health education teachers from each NC State Board of Education District. The districts and corresponding participants are:
• **Northeast Region / District 1**: 2 Health Teachers & 2 Administrators  
  Beaufort, Bertie, Camden, Chowan, Currituck, Dare, Gates, Halifax, Hertford, Hyde,  
  Martin, Northampton, Pasquotank, Perquiman, Pitt, Roanoke Rapids, Tyrrell,  
  Washington, Weldon

• **Southeast Region / District 2**: 2 Health Teachers & 4 Administrators  
  Brunswick, Carteret, Craven, Duplin, Greene, Jones, Lenoir, New Hanover, Onslow,  
  Pamlico, Pender, Wayne

• **North Central Region / District 3**: 2 Health Teachers & 2 Administrators  
  Chapel Hill-Carrboro, Chatham, Durham, Edgecombe, Franklin, Granville, Harnett,  
  Johnston, Lee, Nash, Orange, Person, Vance, Wake, Warren, Wilson

• **Sandhills Region / District 4**: 2 Health Teachers & 4 Administrators  
  Bladen, Clinton, Columbus, Cumberland, Hoke, Montgomery, Moore, Richmond,  
  Robeson, Sampson, Scotland, Whiteville

• **Piedmont Triad Region / District 5**: 2 Health Teachers & 4 Administrators  
  Alamance, Asheboro, Caswell, Davidson, Davie, Elkin, Forsyth, Guilford, Lexington,  
  Mount Airy, Randolph, Rockingham, Stokes, Thomasville, Surry, Yadkin

• **Southwest Region / District 6**: 2 Health Teachers & 4 Administrators  
  Anson, Cabarrus, Cleveland, Gaston, Iredell, Kannapolis, Lincoln, Mecklenburg,  
  Mooresville, Rowan, Stanly, Union

• **Northwest Region / District 7**: 2 Health Teachers & 4 Administrators  
  Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Hickory, McDowell,  
  Mitchell, Newton-Conover, Catawba, Wilkes, Yancey

• **Western Region / District 8**: 2 Health Teachers & 3 Administrators  
  Asheville, Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon,  
  Madison, Polk, Rutherford, Swain, Transylvania
Analysis and Results

The interviews were transcribed verbatim and coded by hand utilizing an inductive approach. Data-driven inductive analysis is a “process of coding the data without trying to fit it into a pre-existing coding form” (Braun & Clarke, 2006, p.12). Transcripts were read multiple times to identify codes and, subsequently, develop an initial set of themes related to each interview question. These initial themes were used to generate overarching themes, related to the topics of barriers to and supportive factors of health education, as well as identified needs; these were highlighted and coded as red for ‘barrier’, green for ‘support’ and yellow for ‘need’. After themes were identified, quotes were extracted that exemplified the common sub-themes. Where possible, the proportion of respondents indicating a common sub-theme was calculated.

Specific themes, to be discussed more fully below, included the ideology that health education is not a priority, teachers are not receiving adequate pre-service training or professional development, funding is not sustained, local control inhibits reproductive health and
safety content, health and physical education should be separated and positive factors including: state and local organizations, and healthful living coordinators are a major asset.

**Dissemination of Results**

Aggregate data were summarized and presented to the North Carolina Department of Public Instruction (NCDPI) and the North Carolina State Board of Education to identify adjustments and recommend improvements to the implementation of the Healthful Living Essential Standards.

**Findings**

In my discussion of the findings, this first section will report on the results from closed-ended interview questions that summarize the characteristics of health education teachers in NC, their training, professional development, resources available to them, as well as content covered. Direct quotes from both interviewed teachers and administrators are included when the individual’s words captured a group thought. Respondents included physical education teachers, health/PE teachers, science teachers, principals, assistant principals and healthful living coordinators across the state (Figure 1). Some of those interviewed answered questions with brevity and fear of saying the ‘wrong thing’ about sex education policy and practice. Others elaborated at length, seemingly excited to share their story confidentially and grateful for an open ear in a cultural environment that feels like they are alone on an “island” trying to teach health. The second section will discuss the overarching themes that emerged from my analysis of these interviews.

The first research question addressed who are the educators. Eighty-nine percent of the educators with whom I spoke hold a dual health and physical education teaching license (Figure
2). There were also teachers who were only licensed to teach physical education and an academic teacher.

Figure 2: Results of Interview Question, “Who is Responsible for Teaching Health Education?”

Who is Responsible for Teaching Health Education in Your School/District?

- Academic Teacher
  - 3%
- PE Teacher
  - 8%
- Teachers with a Health/PE Teaching License
  - 89%

The second question asked if all students were receiving health education upon which 88% of respondents reported “Yes.” (Figure 3). Some respondents, often a principal, were not knowledgeable of the day to day operations of the health/PE classroom therefor did not know if all students were receiving health. Of the group, only 3% said “No” and that was in reference to there not being sufficient services for children with a disability to receive health education in that particular school.
The third research question addressed who is teaching reproductive health and safety (Figure 4). Answers ranged widely including: health/PE teachers, faith-based representatives and guidance counselors. This question highlighted differences in opinion about who should be teaching this unit. Some respondents felt it imperative to have only health/PE teachers provide instruction because of the inferred trust the teacher-student relationship had already created. Others felt equally strong that vetted community partners should offer instruction because of concerns that the ‘sex talk’ would hinder the relationship between students and health/PE teachers. This difference in opinion may be an area to explore more fully in future research.
Figure 4: Results of Interview Question, “Who is Responsible for Teaching Reproductive Health and Safety Education in Your School/District?”

While the licensure suggests that teachers are prepared to teach health education, the findings indicate that 88% of health/PE teachers did not receive sexuality education courses for their health education degree at their university or college (Figure 5). Of the 12% who responded “Yes”, only one had received instruction as part of her undergraduate degree. The others who responded “Yes” had a graduate degree in public health.
In addition, 34% of interviewees did not recall when they last received professional development for health (Figure 6) and 37% have not received professional development for reproductive health and safety in five or more years (Figure 7). This circumstance resulted in a lack of knowledge about current policy changes such as the Healthy Youth Act of 2009 that transitioned NC from abstinence-only to abstinence-based sex education. A few teachers and administrators emphatically shared their erroneous belief that they knew that state policy was abstinence-only and as a school they strictly abided by such policy.

A teacher expressed her frustration with what seemed to her like insufficient professional development opportunities when she said, "I get a lot of emails about curriculum education but when it comes to health education there's not a lot available or things to attend. I would love to see more professional development." Many agreed, including an administrator who said, "We have some really big challenges with the new standards, the district did not take steps to create a pacing guide. They shared the standards but that is it." In addition, a principal elaborated on the
lack of comfort present in a classroom when a teacher has not received adequate pre-service training. She said, "Sometimes our staff is so uncomfortable teaching it that the kids feel it, and the lesson gets lost."

Figure 6: Results of Interview Question, “How Often Do You Receive Professional Development for Health?”

```plaintext
How Often Do You Receive Professional Development For Health?

- Do not know: 12
- Once in the last five or more years: 6
- Once a year: 7
- Two times a year: 4
- Three or more times a year: 3
- Once in the last three years: 1
- Once in the last two years: 0
```

Figure 7: Results of the Interview Question, “How Often Do You Receive Professional Development for Reproductive Health and Safety?”

```plaintext
How Often Do You Receive Professional Development For Reproductive Health and Safety Education?

- Do not know: 13
- Once in the last five or more years: 13
- Once a year: 5
- Once in the last three years: 4
- Once in the last two years: 0
- Two times a year: 0
- Three or more times a year: 0
```
When asked, "What resources are used to teach the five health strands" (Figure 8), teachers and administrators responded that they primarily referenced the DPI’s web page and/or the NC School Health Training Center’s flash drive which contains the program Successfully Teaching Health. Although only five responded that they do not know what resources are used, one teacher shared her frustration, stating, "I think that the state needs to invest more into training, teachers, and resources if kids are going to understand health."

Figure 8: Results of the Interview Question, “What Resources Are Used to Teach Reproductive Health and Safety?”

Teachers and administrators consistently requested support such as up-to-date text books as well as active and engaging resources for teaching health. One third of those surveyed reported that their textbooks were out of date. One health teacher expressed her concerns saying, “The textbook is from 2008. I have not asked for new books because I know that the core subjects need textbooks and I am thinking that health is not a priority.” The belief that health was not a priority was a common theme among health educators. There were requests from teachers for support with both curriculum and implementation. Additional requests included trusted resources.
because, as a teacher timidly shared, “I do not know where to look or what to trust. I would appreciate a list of vetted expert community partners that I could invite into the classroom.” There was a sense of untapped potential within many health teachers. They had passion to teach health and a desire to cover the standards and objectives but were not always clear what resources they should trust and how to be most effective as is reflected in this teacher’s comment, “I need to know a better way to teach health and get the kids actively engaged.”

Another important question is whether instruction time is shared evenly between health and physical education (Figure 9). To understand the target for instruction time, teachers consult the Healthy Active Children Policy which states that health and physical education should be split evenly. This split represents about nine and a half weeks each, over the course of a nineteen-week semester. Interviews revealed that 34% of schools surveyed offer health for about seven weeks. In addition, 34% of those surveyed also stated that class time was shared evenly. However, there was often discrepancy between what an administrator and a teacher in the same school reported. Administrators were more likely to report that health and PE share instruction time evenly but teachers reported that health received less time. An administrator with a background in health education reported:

*Health is the only subject that is universal to each and every student, regardless of race, gender or socioeconomic status, yet it is not emphasized as an important part of a child’s education. What message are we giving kids when math and science are yearly requirements but health is crammed into one semester.*
Inconsistencies in the allocation of instruction time for health education has created an environment that perpetuates an even greater imbalance in instruction time for reproductive health and safety. Class time for instruction ranges from one hour a year to ten forty-five minute classes a year (Figure 10) with average of five to seven hours a year of instruction. As the curricular content for the sixth-grade interpersonal communication and relationships (which includes reproductive health and safety) listed below makes clear, there is a lot to cover and the limited timeframes and lack of standardization across districts results in significant variation across classrooms, schools, and districts:

Classify behaviors as either productive or counterproductive to group functioning.

Implement verbal and non-verbal communication skills that are effective for a variety of purposes and audiences.

Use strategies to communicate care, consideration, and respect for others.

Explain the impact of early sexual activity outside of marriage on physical, mental, emotional, and social health.
Summarize the responsibilities of parenthood.

Use effective refusal skills to avoid negative peer pressure, sexual behaviors, and sexual harassment.

Use resources in the family, school, and community to report sexual harassment and bullying.

Summarize strategies for predicting and avoiding conflict.

Design nonviolent solutions to conflicts based on an understanding of the perspectives of those involved in the conflicts.

Explain the signs of an abusive relationship and access resources for help.

Identify the challenges associated with the transitions in social relationships that take place during puberty and adolescence.

Summarize the relationship between conception and the menstrual cycle

(HLES, n.d.).

Figure 10: Results of Interview Question, “How Much Time is Designated for Reproductive Health and Safety?”

<table>
<thead>
<tr>
<th>How Much Time is Designated for RHS?</th>
<th>10 Forty-five minute classes a year</th>
<th>5 Forty-five minute classes a year</th>
<th>Do not know</th>
<th>2 3 Forty-five minute classes a year</th>
<th>15 Forty-five minute classes a year or more</th>
<th>None at all</th>
<th>1 hour a year</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>11</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

36
HYA directs school administrators to provide a means for parents to withdraw their student from the course. The majority of those interviewed responded that they do offer an opt-out letter for parents. A small percentage (n=3, <10%) did not offer an opt-out letter or did not know the school’s policy on the letter (Figure 11).

**Figure 11: Results of Interview Question, “Do You Offer an Opt-Out Letter Concerning Reproductive Health and Safety?”**

The majority, 88% of respondents, shared that they provide instruction in contraceptive methods (Figure 12). The 9% that were unsure if contraceptive methods were being discussed were administrators. Both teachers and administrators expressed their concern about the sensitivity of the subject matter and how content would be received by parents in the community, sharing statements such as, “They are worried about parent push back and what are people going to think. This is such a hot topic that it is almost like, ‘let’s just not talk about it and it will not happen’ kind of mentality.”
Condoms are a FDA approved method of reducing the risk of contracting sexually transmitted diseases and preventing pregnancy, however only 52% of those interviewed reported that condom demonstrations were occurring in the classroom (Figure 13). A health teacher shared his thoughts on wanting evidence-based teaching tools for skill-building exercises like condom demonstrations. He said, “Misinformation (like inaccurate condom demonstrations) in health education can be life changing, more so than if you mess up on a math problem.” Another teacher discussed fears about condom demonstrations. He said, “Number one barrier to sex-education is the fear of the unknown.”
Figure 13: Results of the Interview Question, “Are Condom Demonstrations Allowed?”

![Image](image_url)

In a display of progress, 88% of schools in which interview participants work teach students about HIV/AIDS and STI’s (Figure 14) and 66% offer instruction on what constitutes sexual assault, sexual abuse and consent (Figure 15).

Figure 14: Results of the Interview Question, “Are HIV/AIDS and STI’s Discussed?”

![Image](image_url)
The findings reveal both success and failures in the implementation of HLES in NC middle and high schools. Next is a discussion of the themes that arose from the interviews that highlight specific barriers and sources of support from teachers and administrators across the state.

**THEMES**

Five themes that included both barriers and support in regards to the implementation of HLES emerged from the analysis of the interview data with administrators and teachers.

**Theme #1 Not Enough Time to Teach**

North Carolina’s policy to couple health education and physical education into one nineteen-week semester is a disservice to the state. HLES are not covered adequately nor are students receiving a sufficient amount of time for physical activity. Both PE and health are
critical aspects of adolescent development. Health class receives only about six weeks of
instruction time and, within that, RHS receives but a fraction of that time. As a health teacher
interviewed described it, “There is a tradition I see where health takes a backseat to PE.”
This sentiment, that health and physical education should be separated into two semesters, was
shared by almost every health educator interviewed. Another interviewee lamented, “I know it is
pie in the sky, but if there were a health class that was not attached to or associated with PE, it
would be a stronger curriculum.” This basic structural barrier of a lack of instructional time
prevents North Carolina’s middle and high school students from receiving information and skill
building exercises that support the creation of healthy behaviors across the lifespan.

Within this already limited time frame, the current system is also not allocating adequate
time to teach RHS. In a parent opinion of sexuality education reported in 2006, 49% of parents
responded that they believed that sex education in elementary school should be offered eight to
eighteen hours a semester (one hour a week, every other week, over a quarter). When asked how
much time should be allotted for sex education in middle schools, 28% responded one hour a
week throughout the school year and 28% responded one hour a week over the course of one
semester. In addition, when asked about high school class time, 43% responded that students
should receive sex education one hour a week throughout the school year (Ito, Gizlice, Owen-
O’Dowd, Foust, Leone & Miller, 2006. p 637). As my findings show, schools are not spending
enough or even adequate time on sex education within the health curriculum.

Teachers and administrators in my study seem to concur with the parents surveyed in the
Ito et al., 2006 study in seeing the need to spend more time on RHS. One way to do this would
be to separate health and PE. Both courses of study have individual standards and objectives to
meet and not having enough time to teach either of the content areas to the fullest capacity
results in adolescents losing a valuable opportunity to learn critical knowledge and build and
practice skills to reduce risk and establish healthy behaviors.

Theme #2 No Sustainable Source of Funding

The second barrier was that there is no sustainable source of funding. Time and time
again, teachers and administrators talked about an impactful program or an excellent health
educator that the students related to and were inspired by, but then funding was cut and the
students lost this valuable resource. An administrator shared his experience:

We had this great program with a local university but funding dried up and the book we
have not does not cover the five health strands. Grants run out and so do services. We
always need more money time and training.

Inconsistencies in funding sometimes also resulted in the elimination of the healthful
living coordinator position or similar position that managed health education. An administrator
expressed:

We used to have someone who was on top of health and reproductive health but the
money ran out in her position was dissolved. We used to have a planning meeting before
the school year started with the health department where we would go over what we
would teach for reproductive health and safety but we haven't had that in quite a few
years and it be nice to have that back.

The lack of funding was also revealed in a lack of physical space to teach health.

Teachers expressed concern about not having a consistent space to hold class.

We call it nomad health because we have to find a teacher who has planning so we can
use her classroom. I am trying to teach the kids to be an advocate for health and there is
nowhere for any of that information or posters (they create) to be hung. We do not have a
classroom.

Overall, those interviewed felt that health education struggles to establish itself as an
integral part of the classroom curriculum, as reflected in funding and resources that are
inconsistent and too often non-existent. This circumstance lead to a hesitancy on the part of
teachers to trust that their current work in health was valued or reluctance to take initiative on a
new project that may quickly lose funding.

Theme #3 Local Control Inhibits Implementation of RHS

_The School Health Advisory Council meets and we listen to what the communities felt about sex education and some of the traditions that they felt needed to be left out like homosexuality. The curriculum is now a mixture of the state requirements and what we felt locally was best for our community and for our kids._

There was a consistent and powerful message concerning how evidence-based sexual
health programs are diluted and diffused as they move from policy to the classroom, especially in
rural areas. State policy offers guidance on implementation but does not police Local Education
Agencies (LEAs). Each LEA makes recommendations for implementation of RHS objectives to
district schools based upon local opinion and cultural beliefs, one of the main reasons for the
variation in implementation of sex education across the state. Local control over curriculum
decisions can result in students receiving a curriculum that is not always based on science and
may not be effective at reducing sexual risk behaviors. This cultural environment also breeds
fear in the minds of health education teachers as reflected in this response

_It was made clear to me that if I do a condom demonstration and a student takes a condom, then I will lose my job. Number one barrier to sex-education is the fear of the unknown. I think we need condom demonstrations but is not allowed and that is above my paygrade._

As described earlier, the Healthy Youth Act directs schools to offer instruction on
sexually transmitted diseases, all federal Food and Drug Administration (FDA) –approved
methods of reducing the risk of contracting sexually transmitted diseases, effectiveness and
safety of all FDA-approved contraceptive methods in preventing pregnancy in addition to
instruction on preventing sexual assault and sexual abuse. All materials must be age appropriate,
based on peer-reviewed scientific research and stress the benefits of abstinence until marriage
Healthy Youth Act of 2009). As my interview findings suggest, LEAs vary in how much they interpret and implement these instructions.

For example, condoms are a FDA approved method of reducing the risk of contracting sexually transmitted diseases and preventing pregnancy, however only 52% of those interviewed reported that condom demonstrations were occurring in the classroom (Figure 13). Local control by district boards of education and superintendents affects full implementation of the HYA and inhibits teachers from using evidence-informed curricula to guide health class. In some areas, students were bussed off of campus to the basement of a church in order to be compliant with local control that prohibited condom demonstrations in schools but wanted to adhere to HYA guidelines and provide students an opportunity to practice this critical risk reduction skill-building exercise.

Another topic that teachers struggle with is how and when to teach about consent within an abstinence-based comprehensive sex education approach. A high school health teacher raised this issue during the interview:

They are in high school and they should know what consent is by now.

In reflecting out loud, she caught the dangers of her assumption and corrected herself:

Oh, I guess I really do not know what they have learned and I really need to add in information on consent.

Local control by LEA’s of the implementation of RHS is a strong barrier to North Carolina’s public school students receiving the information that state HYA policy dictates as what is to be provided.
Theme #4 Teachers Are Not Receiving Adequate Pre-Service Training or Professional Development

North Carolina’s health/PE teachers expressed a strong desire to be highly qualified in their content area and to provide their students with an excellent education. Unfortunately, they are not receiving enough pre-service training at their university or college in order to attain self-efficacy with teaching RHS. One teacher commented:

_I did not receive any information in college about how to teach sex education, just anatomy. I was not prepared to teach reproductive health and safety. I was (only) given a three-ring binder._

Teachers expressed both personal discomfort and fear of parental or community pushback regarding teaching RHS. Some teachers had genuine concerns that they would be relieved from their teaching position if they did not follow local policy exactly. They were not willing to risk their job so they opted to not teach certain subject matter that might be controversial within the local community. In addition, regular professional development in each district are not always in place. Moreover, as teachers transfer to a new district or to NC from another state, they need to be updated on local policy and procedures which necessitates ongoing professional development. An administrator shared her thoughts about the challenge of keeping up with professional development needs of teachers:

_A few years ago, we had a great training, but as new teachers come in, they are not really clear on it so we need to go over it again, so we have consistency._

Many teachers and administrators were clear about what was needed in order to improve their knowledge about and comfort level with teaching RHS. A long-time health teacher requested more professional development to stay relevant given emerging issues:
It would be helpful to get training on (preventing) human trafficking. That is the new thing that was just added….but we did not have any training… any time that they add something to the objectives, then we as teachers need to have professional training. Fundamentally, teachers know that they need support with RHS but are unclear as to how to access it.

**Theme #5 Strongest source of support for health education in schools is a Healthful Living Coordinator**

There were consistent messages across the interview participants about what is supportive of health education. The strongest source of support for health education in schools, reported by both administrators and teachers, is the presence of a Healthful Living Coordinator, Student Health Coordinator or similar position. Individuals in these positions provide essential support, including offering professional development opportunities, receiving and distributing up-to-date information from the DPI’s Healthy Schools Team, collaborating with community partners, writing grants, and advocating for the health of students. They are able to “communicate the needs of health and (know) how to get support.” A health teacher elaborated:

*Our healthful living coordinator has written grants for classroom resources and finds professional development opportunities. She is just tremendous.*

The NC Healthy Schools Team at DPI is also an immensely valuable asset. The team actively promotes the health of students and staff across the state. NC Healthy Schools is the battery behind the success of the healthful living coordinators and student health coordinators.

*I go to the healthful living coordinator meetings and I am in constant contact with the DPI’s Healthy Schools Team. They do a great job of sending out information.*

The North Carolina School Health Training Center was also mentioned repeatedly throughout the interviews for being an valuable source of support. The Center provides enriching evidence-
based programs such as Making Proud Choices and Successfully Teaching Health, and they offer continued support for teachers and administrators, as described by a teacher:

One of the reasons that I love Successfully Teaching Health book is because you do not have to have a huge amount of experience in health education. There are resources, worksheets and assignments all ready.

Another asset is passionate administrators and educators. Many of these women and men are leaders in and out of the classroom and are truly modeling the Healthful Living content. An administrator reported:

If we have a teacher who is uncomfortable with one of the units, we put her in contact with someone who can teach that section. We try to make sure there are no barriers to health education.

Supportive factors that strengthen implementation of HLES are clear. The remaining question is how to unite resources with the need.

Strengths

Directions for Future

In order to positively influence the health of a community, we do not need to influence each and every person. We do however need to identify the change agents and leaders and inspire them so that they can positively influence their community. NC public schools offer a platform on which teachers, administrators and students can act as leaders of health. This leadership in health has the potential to ripple out into the greater community and support the establishment and sustainability of healthy behaviors.

People learn and make health related decisions based upon their personal life experiences but also based upon role models around them according to the Social Cognitive Theory (SCT) (Glanz & Bishop, 2010). SCT is evidence of the strength of health leadership. Full and equitable
implementation of HLES in public schools has the potential to fashion far-reaching influence on NC public health. These findings are useful in bringing awareness to the barriers to implementation of HLES as well as existing strengths. In hopes that these findings can be used to improve how HLES are delivered, I offer the following recommendations for consideration.

**Recommendations to Public Health Leaders**

**Recommendation One:** Separating health and physical education into two semester long courses offered each year will provide adequate time in the classroom to teach the Healthful Living Essential Standards, in accordance with the Healthy Active Children Policy and the Healthy Youth Act. It is critical for health and physical education courses to be separated into two separate courses to eliminate the competition for instruction time.

**Recommendation Two:** Enhance and disseminate a portal for resources and materials related to Reproductive Health and Safety. Each educational region will have an easily accessible list of approved resources and experienced community partners for teaching health education and a structure for sharing and updating the list with middle and high schools quarterly to ensure that all administrators and educators receive the information.

**Recommendation Three:** Provide additional professional development and support for teachers to attend trainings. Adequate pre-service training and professional development would include time to sufficiently cover all standards, evidence-based methods of providing instruction, delivering the material as well as opportunities to personally reflect and arrive at a place of comfort with their sexual health. Offering adequate training will enhance teachers’ capacities and help them become “competent in teaching methodology, theory, practice of pedagogy, content, and skills, specific to sexuality education (Barr et al, 2014). It is also critical to provide instructional scaffolding for training of teachers in a systematic manner. Finally, it is important
to ensure that there is consistent communication between the Department of Public Instruction and North Carolina’s middle and high schools concerning professional development specifically regarding health and reproductive health and safety. Contact information for administrators and health educators will be updated annually to ensure that the professional development opportunities reach the intended audience and information will be disseminated through multiple channels.

Recommendation Four: Government action is necessary to include health education in the Every Student Succeeds Act (ESSA) and to add health education to the Common Core. Federally mandating health education will provide guidance to schools about what health standards should be taught; resources and curricula for educators and facilitate standardized health education teacher certification. This health policy change will ultimately ensure that students receive adequate time in the health classroom for students to receive evidence-based, up-to-date material that it is delivered by thoroughly trained health education teachers.

Limitations

There are several potential limitations in this research. First, participants are a sample of the population and do not represent all teachers and administrators. Secondly, volunteer bias may be present in the research. Some teachers and administrators who volunteered to be a part of the study noted that they had a background in health education. This circumstance may mean that participants were biased towards the positive impact of health education and may not reflect the average perspective of a NC teacher or administrator. Lastly, administrators were knowledgeable of state policy and may have offered what they perceived as the appropriate answer based upon what should be occurring in the classroom. However, some administrators also acknowledged
that they were not active enough in the classroom in order to completely validate their answer. In some instances, teachers and administrators in the same school offered contradictory answers.

Conclusion

At present, North Carolina’s public school teachers and administrators tell a story of encountering strong barriers as they work to implement Healthful Living Essential Standards and specifically Reproductive Health and Safety in middle and high schools. This report brings light to the need to address the structural, societal and policy barriers that inhibit implementation of HLES and RHS. These barriers are not new to health education and unfortunately many have stood strong for over a century. At the intrapersonal, interpersonal and community levels, health must be prioritized. The genesis of prioritizing health at the intrapersonal level is adopting the belief that health is accessible. At the interpersonal and community levels, teachers and administrators need adequate class time, ample pre-service training, regular professional development, a sustained source of health education funding, and a Healthful Living Coordinator for each county.

NC Healthy Schools is a team of highly skilled and passionate women and men whose individual strengths come together to successfully lead North Carolina’s public schools with integrating education and health. They provide guidance on curricula, resources and professional development to district level Healthful Living Coordinators, student health coordinators, teachers and administrators. The perspectives shared within this research supports the need for these coordinators statewide, who can disseminate the curricula, resources and professional development support provided by NC Healthy Schools, rather than in only the school districts that have the funding to afford this resource.
Mandating health education and including it in the Every Student Succeeds Act while simultaneously providing adequate resources for implementation of HLES, HYA and HACP has the power to improve academic success and health outcomes for students who are educated in the public-school system. Further, the teachers and administrators that were interviewed also expressed strong support for the implementation of HLES, HYA and HACP.

This moment offers a ripe opportunity to reach the one and a half million students enrolled in North Carolina’s public schools and invigorate both the health and academic achievement of these young women and men. Imagine an educational system that embodies the interconnectedness of academic achievement and health along with a school day that balances instruction and guidance on the holistic nature of students’ mental, physical, and emotional development.

The North Carolina State Board of Education’s vision states, “Every public school student will graduate ready for post-secondary education and work, prepared to be a globally engaged and productive citizen.” The insufficient federal and state support for implementing the Healthful Living Essential Standards undermines this vision. However, we have the opportunity to nurture a culture of health in North Carolina schools by investing in health education.

*The biggest thing is that we need to focus on is the whole child. If we have a woman who is 25 and has AIDS because she had unprotected sex or man who is 21 and is addicted to heroin, all these areas should be targeted in health. It doesn't matter if they earned an “A” in chemistry or what they got in math 1 or English 2. None of that means anything if they are on their deathbed before they are 30. So, I think we need to refocus on what we consider core and what is truly core to me is health education.*

*(Chris Meadows NCAE 2014 Principal of the Year)*
References


