

# **Using Your School Health Profiles Results**



## 2010 School Health Profiles Report

# USING YOUR SCHOOL HEALTH PROFILES RESULTS

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This booklet is designed to assist you with understanding the results in the School Health Profiles (Profiles) report and with presenting the results effectively. This booklet has two sections:

- **Understanding Your Profiles Results:** This section describes the content of the two major parts of your report binder—Results and Documentation.
- **Reporting Your Results:** This section includes guidelines for planning and developing reports, choosing the method for reporting, and using effective graphics. This section also describes additional data sources you can use to supplement your Profiles results.



## 2010 School Health Profiles Report

### Understanding Your Profiles Results

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Effective reporting of your Profiles results enables you to provide a broad audience with factual information on school health policies and practices in the following areas: school health education; physical education; school health policies related to HIV infection/AIDS, tobacco-use prevention, and nutrition; asthma management activities; and family and community involvement in school health programs. The data contained in your report can be used to provide the support for concrete recommendations to education agencies, public health officials, parents, and those who assist in the development of your school health programs.

The first section of this booklet describes the contents of the report binder, which consists of two types of information—Results and Documentation.

#### **Results**

- Background
- School-Level Impact Measures (SLIMs) Results
- Principal Survey Results Tables
- Principal Survey Results Charts
- Teacher Survey Results Tables
- Teacher Survey Results Charts
- Trend Analysis Report

#### **Documentation**

- Sample Description and Weighting Procedures
- Questionnaires
- Item Rationale
- Codebooks
- Data User's Guide

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## Results

### Background

The Background provides a brief explanation of the purpose of Profiles and the topics covered by the survey. There is also a description of the schools included in the survey, the response rates, and the weight status. (The difference between weighted and unweighted data is explained on page 10 of this booklet.) A sample background page follows.

**MEGATROPOLIS**  
**2010 School Health Profiles Report**  
**Background**

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The School Health Profiles (Profiles) assists state and local education and health agencies in monitoring and assessing characteristics of school health education; physical education; school health policies related to HIV infection/AIDS, tobacco-use prevention, and nutrition; asthma management activities; and family and community involvement in school health programs. Data from Profiles can be used to improve school health programs.

Two questionnaires are used to collect data - one for school principals and one for lead health education teachers. The two questionnaires were mailed to 407 regular secondary public schools containing any of grades 6 through 12 in Megatropolis during spring 2010. Usable questionnaires were received from 81% of principals and from 81% of teachers. Because the response rates for these surveys were greater than or equal to 70%, the results are weighted and are representative of all regular public secondary schools in Megatropolis having at least one of grades 6 through 12. Results from the principal and lead health education surveys are presented for the following types of schools in Megatropolis:

- High schools with a low grade of 9 or higher and a high grade of 10 or higher;
- Middle schools with a high grade of 9 or lower;
- Junior/senior high schools with a low grade of 8 or lower and a high grade of 10 or higher; and
- All schools.

The Profiles questionnaires were developed by the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention in collaboration with representatives of state, local, and territorial departments of health and education.

### SLIMs Results

Sites that received funding for Priorities 2, 3, or 4 of the CDC/DASH cooperative agreement (DP08-801) are required to “document the impact of their program activities by monitoring the percentage of schools in their jurisdiction that are implementing specific, effective...policies and practices.” The results from your 2010 Profiles survey can be used to monitor the effect of your program activities by comparing the SLIMs results from the 2008 and 2010 Profiles.

In this section of the report, tables provide each SLIM and the percentage of schools meeting the requirements for the SLIM. The SLIMs results are organized by funding priorities—Part I corresponds to Human Immunodeficiency Virus (HIV) Prevention (Priority 2), Part II corresponds to Coordinated School Health and Promotion of Physical Activity, Nutrition, and Tobacco-Use Prevention (Priority 3), and Part III corresponds to Asthma Management (Priority 4). The funding priority for each table is identified at the top of the page. The example that follows presents the results for the HIV prevention SLIMs. Below the title are two or three columns, depending on weight status and whether a census or a

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sample was used. The column on the left identifies the SLIM. The second column provides the percentage of schools meeting the SLIM. The 95% confidence interval, if available, will be found in the third column on the far right.

If one or both of your surveys were unweighted, SLIMs will still be calculated and reported. However, interpretation of the SLIMs will be limited due to the unweighted status of the data (see page 10 for an explanation of unweighted data). To indicate unweighted data, the SLIM description and result will be shaded. Also, because the data are unweighted, 95% confidence intervals will not be provided.

The 95% confidence interval can be used to determine whether or not there is a significant difference between the 2008 and 2010 SLIMs results. Compare the confidence intervals from 2008 and 2010. If they overlap, there is no significant change; if they do not overlap, there is a statistically significant difference between the 2008 SLIM result and the 2010 SLIM result. If a census was conducted, there will be no confidence intervals for the SLIMs. If you are interested in comparing results from a census, one method that has been used to determine meaningful differences between two percentages is an absolute difference of 10 percentage points.

Another method of comparing 2008 and 2010 SLIMs results is to calculate a linear trend. The results of such calculations can be found in your Trend Analysis Report (see pages 8 and 9).

<b>MEGATROPOLIS</b> <b>2010 School-Level Impact Measures (SLIMs)</b> <b>Weighted Principal and Teacher Survey Results</b> <b>Part I: Human Immunodeficiency Virus (HIV) Prevention SLIMs</b>		
School-Level Impact Measure (SLIM)	Percentage of Schools Meeting SLIM	95% Confidence Interval
HIV 1. The percentage of schools that address all of the following in a required course taught during grades 6, 7, or 8: <ul style="list-style-type: none"> <li>• The differences between HIV and AIDS.</li> <li>• How HIV and other STD are transmitted.</li> <li>• How HIV and other STD are diagnosed and treated.</li> <li>• Health consequences of HIV, other STD, and pregnancy.</li> <li>• The benefits of being sexually abstinent.</li> </ul>	91.3	86.5 - 94.5

While most questions remained unchanged in the 2010 Profiles questionnaires, a few changes, such as the addition of response options, were deemed necessary. These changes did impact a few of the SLIMs. In addition, some SLIM requirements changed. For certain SLIMs in 2008, meeting only one element of a list was necessary to meet the requirements. In 2010, it was necessary to meet all elements of that list to meet those SLIMs. For each affected SLIM, we report 2010 results for both the 2008 and 2010 versions of the SLIM. If you selected one of the SLIMs affected by the changes, be sure to use the 2008 version of the SLIM in the 2010 report to compare with the SLIM result in the 2008 report.

Please contact your CDC/DASH Project Officer for more information on how to interpret the results as part of your cooperative agreement.

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### Principal Survey Results Tables and Teacher Survey Results Tables

The report provides tables and charts of all your results. Each table uses the same format and can be found behind the tabs labeled “Principal Survey Results” and “Teacher Survey Results.” The example table below will help illustrate the format.

MEGATROPOLIS												
2010 School Health Profiles Report Weighted Principal Survey Results												
12. Percentage of schools in which all staff who teach health education topics are certified, licensed, or endorsed by the state in health education.												
	High Schools			Middle Schools			Junior/Senior High Schools			All Schools		
	Percent	95% Confidence Intervals	N	Percent	95% Confidence Intervals	N	Percent	95% Confidence Intervals	N	Percent	95% Confidence Intervals	N
a. Yes	98.5	97.8 - 99.8	118	98.3	96.4 - 99.4	209	-	-	-	98.4	97.2 - 99.2	327
b. No	1.5	0.2 - 2.2	118	1.7	0.6 - 3.6	209	-	-	-	1.6	0.8 - 2.8	327
c. Not applicable	0.0	†	118	0.0	†	209	-	-	-	0.0	†	327

The title of each table tells whether the data describe information from school principals or lead health education teachers, and whether the data are weighted or unweighted.

The question number and a summary of the question appear under the title. Response options for the question or subparts of the question are listed on the far left of the table. In some tables, question numbers are followed by the letter N (e.g., 21N). The data contained in these tables were derived from combining two or more response options to a single question or two or more questions or question subparts. Where this occurs, the response options, questions, or question subparts used in creating the combined variable are listed in a footnote.

The results are provided for **All Schools** regardless of weight status. However, if your data are weighted, each table also lists responses for three categories of schools:

- **High schools**, defined as those with a low grade of 9 or higher and a high grade of 10 or higher;
- **Middle schools**, defined as secondary schools with a high grade of 9 or lower; and
- **Junior/senior high schools**, defined as secondary schools with a low grade of 8 or lower and a high grade of 10 or higher.

Each category will have two or three columns: Percent, 95% Confidence Intervals (if applicable), and N. The **Percent** column shows the percentage of schools in each of the three categories that responded as described in the question summary at the top of each table. If the data are weighted, it is a weighted percentage; if the data are unweighted, it is an unweighted percentage. In the example table above, in 98.5% of high schools in the state, all staff who teach health education are certified, licensed, or endorsed by the state in health education.

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If you conducted a census of schools, the weighted percentage is considered the “true” value. If you have selected a sample of schools instead of a census and the data are weighted, the **95% Confidence Interval** for the percentage reported will be in the column following the percentage. The 95% confidence interval provides the range of values within which the “true” percentage lies. A 95% confidence interval means that if the survey were repeated many times, the “true” value would fall within the interval 95% of the time.

When the confidence interval is relatively narrow, you have a more precise indication of the percentage of schools with health education teachers who are certified, licensed, or endorsed in health education. Wider confidence intervals diminish the ability to report results with precision. In the example table on page 6, the confidence interval is 97.8 to 99.8. This means you can be 95% confident that the “true” percentage of schools could be as low as 97.8% or as high as 99.8%.

If you are interested in comparing two percentages, confidence intervals can also be used for comparisons. If the confidence intervals of two groups you are interested in comparing do NOT overlap, the results are considered significantly different. If the confidence intervals DO overlap, the two results are not considered significantly different. Using the results from the example table on page 6, we can compare the percentage of high schools (98.5%) to the percentage of middle schools (98.3%) in which all health education teachers are certified, licensed, or endorsed. The confidence interval for high schools is 97.8 to 99.5 and the confidence interval for middle schools is 96.4 to 99.4. The two confidence intervals do overlap—therefore, the percentage of high schools in which all staff who teach health education are certified, licensed, or endorsed by the state in health education is NOT significantly different from the percentage of middle schools in which this is the case.

If you conducted a census of schools, you will not have confidence intervals. If you are interested in comparing results from a census, one method that has been used to determine meaningful differences between two percentages is an absolute difference of 10 percentage points. For example, if the percentage of middle schools with a certain requirement is 67% and the percentage of high schools with that same requirement is 92%, that is a meaningful difference because the difference between 67 and 92 is greater than 10.

Statistical testing can also be used to determine significant differences between two percentages for both sample and census surveys. The CD-ROM included with this report binder contains copies of the data sets that can be used for this purpose. Please refer to the statistical software documentation for further guidance.

The **N** column shows the total unweighted number of observations for each category of school (high school, middle school, and junior/senior high school) and all schools. Stated another way, **N** is the number of schools in each category or overall that provided any response to the question or subparts of the question. For example, in the table on page 6, the principals in 118 high schools answered question 12.

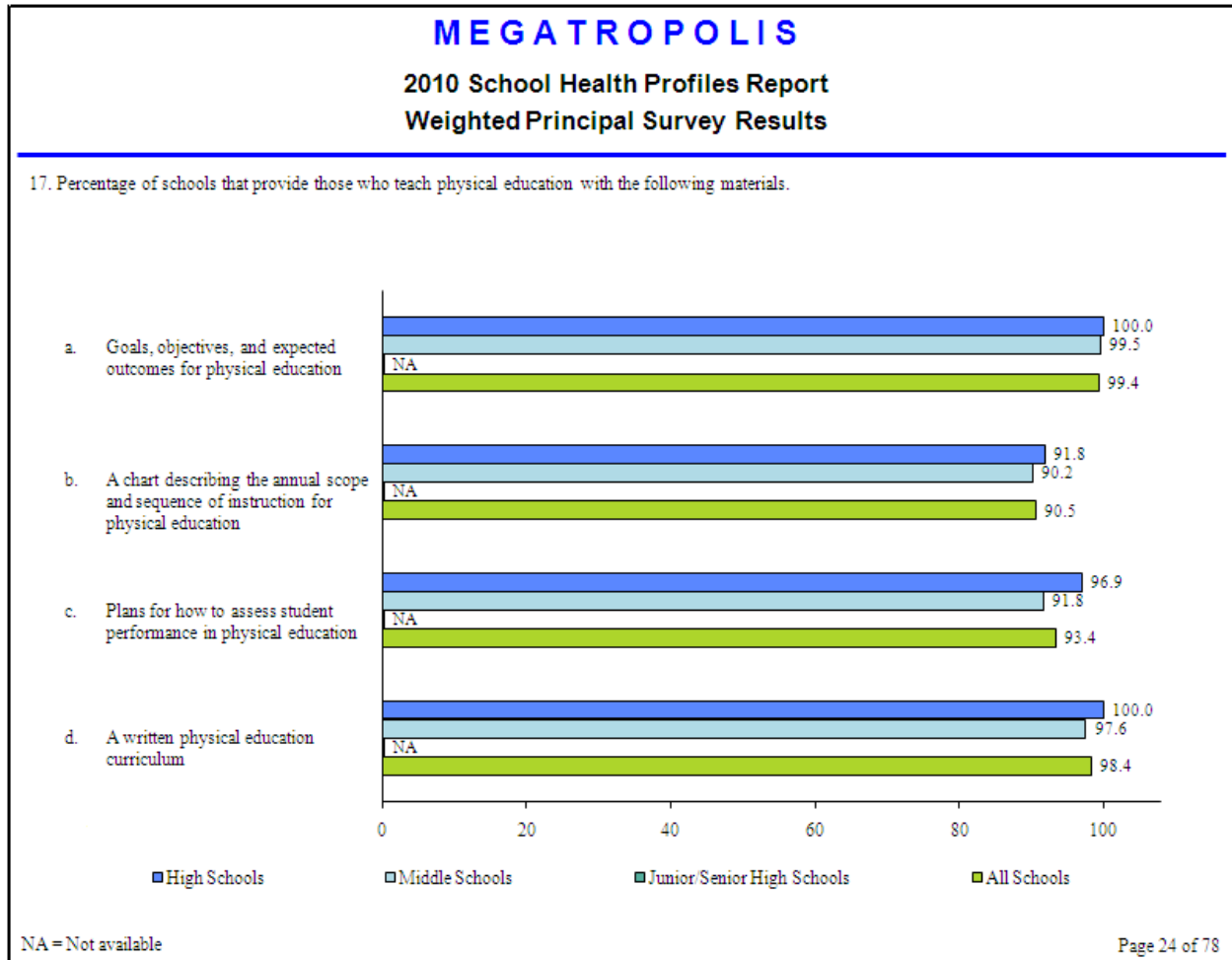
### Principal Survey Results Charts and Teacher Survey Results Charts

If the results are weighted, bar charts presenting the table results graphically are provided. The charts immediately follow the tables in the tabbed sections labeled “Principal Survey Results” and “Teacher Survey Results.” The question number and summary of the question appear below the title. The response options or subparts of the question are listed down the left margin of the chart. Each item in the chart

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contains four bars: one for each of three categories of schools (high school, middle school, and junior/senior high school) and one for all schools combined (all schools). Each bar represents the percentage of schools in each category and overall that responded to the question as described in the question summary at the top of each chart. For each bar, the percent is to the right of the bar.

A sample bar chart appears below. These bar charts are in a PowerPoint file on the CD that you received with your report. The charts are useful for creating presentations or adding to your own Profiles report.



### Trend Analysis Report

A Trend Analysis Report is generated for sites that have weighted Profiles data for at least one survey (Principal or Lead Health Education Teacher) in 2010 and in at least one other survey year since 1998. If you did not have weighted data in 2010, a Trend Analysis Report has not been included in your 2010 Profiles report.

The Trend Analysis Report describes whether school health policies and practices measured by Profiles have increased, decreased, or stayed the same over time. The report contains three parts: variables from the Principal Survey, variables from the Lead Health Education Teacher Survey, and School-Level Impact Measures (SLIMs).

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The title at the top of each page indicates whether the data are from the Principal Survey, the Lead Health Education Teacher Survey, or the SLIMs. Each page contains three sets of columns: the variable, the prevalence for each survey year, and the change over time.

The first column is the **Variable**, which lists every 2010 Profiles question that has been included in at least one other Profiles survey year. The text reflects the response or responses of interest for the particular variable. The variables are organized by topic, such as School Health Coordination, HIV Infection and AIDS Prevention, Required Physical Education, Physical Education and Physical Activity, Tobacco-Use Prevention Policies, Nutrition-Related Policies and Practices, and Health Services.

The second set of columns provides the **Prevalence** estimate for each variable by year. The prevalence estimate is the percentage of schools that reported the response of interest described in the variable column. A blank for a given question or year signifies that weighted data were not obtained that year or that the question was not asked that year.

The third set of columns presents the results for **Changes Over Time**. This set of two columns indicates whether there was a significant *linear* and/or *quadratic* change in prevalence over time. Unlike using the overlapping confidence intervals or the absolute change in percent mentioned previously, statistical analyses have been used to test for change over time. These analyses use all available years of data. They do not simply consider only the oldest and the most recent data points. If there was a statistically significant change over time, a “Yes” will appear in the column; no significant change is indicated by a “No” in the column. Further explanation of how to interpret the trend analysis results is provided in the Trend Analysis Report User Documentation included with the report.

Note: If a census was conducted, statistical tests are not needed to determine significant changes in prevalence over time. Prevalence estimates are exact and changes over time can be judged by the absolute differences between prevalence estimates. Therefore, there will be no results in the linear or quadratic change columns for sites conducting a census.

MEGATROPOLIS							
2010 School Health Profiles Results Trend Report - Principal Survey							
	Prevalence Survey Year					Linear Change	Quadratic Change
	2002	2004	2006	2008	2010		
<b>Required Health Education</b>							
Percentage of schools that required health education for students in any of grades 6 through 12	99.0			98.0	99.0	No	Yes
Percentage of schools that required students to take only one health education course	19.6			26.6	23.6	No	Yes
Percentage of schools that required students to take two or more health education courses	75.1			70.3	79.3	No	Yes

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## Documentation

The information provided in the Documentation section of the report is useful when incorporating the results into reports or presentations and when doing further data analysis. The documentation describes the sample and the population represented by the results; the weight status and the calculation of the response rate; the rationale behind the questions included on the questionnaires; how the data were edited and analyzed; and how the data files, which are included on the CD-ROM that comes with the report, are formatted.

## Sample Descriptions and Weighting Procedures

The Principal Survey and the Teacher Survey are weighted separately. Each survey has a Sample Description and Weighting Procedures document in the binder. The document describes the type of schools surveyed (e.g., all regular secondary public schools having at least one of grades 6 through 12) and the method used to select the sample of schools. The number of principals/teachers in the sample, the number of eligible principals/teachers who returned the questionnaires, the response rate, and how the weights are calculated are also provided.

Being able to describe the population the results represent and provide support for generalizing the results to the population is important when presenting the results. Your ability to generalize the results of your Profiles is determined by whether your data are unweighted or weighted. If your survey response rate is less than 70%, your data are unweighted. If it is 70% or greater, you have used a scientifically selected sample, and you provided all necessary documentation, your data have been weighted.

If the data are **weighted**, the percentages refer to **all** schools in that category within your jurisdiction. For example, if the data are weighted and 30% of the schools in the high school category report they require health education, you can report that 30% of high schools in your jurisdiction require health education.

If the data are **unweighted**, the data in the tables refer **only** to those schools whose principals or teachers actually participated in the survey. For example, if you have unweighted data and 30% of schools in the sample report they require health education, you can report that 30% of the schools that participated in the survey require health education.

## Questionnaires and the Questionnaire Item Rationale

The questionnaires and Item Rationale have been included for your reference. The Item Rationale explains why each question was selected for inclusion and what the question can be used to assess. References are also provided as background for each question. There are separate Item Rationales for the Principal and Teacher questionnaires.

## Codebooks

There are three codebooks included with the report. You will find one codebook for each of the three data files on the CD-ROM—the Principal data file, the Lead Health Education Teacher data file, and the HIV

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SLIMs 4 and 10 data file, which includes data from both the Principal and Teacher surveys. The data for the remaining SLIMs are included in either the Principal or Teacher data file. Included in the codebooks are data locations, variable names, question codes, and labels—information necessary when conducting secondary data analysis.

### **Profiles Data User's Guide**

The Profiles Data User's Guide describes how all variables in the report are calculated. This includes the standard variables, supplemental variables (variables calculated from one or more than one question or response option), and the SLIMs. The editing protocol applied to the data, including recoding the data and applying missing value codes, is described. A sample SUDAAN program is also provided. The information in the Data User's Guide is useful for anyone interested in secondary data analysis, or just interested in how the data are edited and the results are calculated.

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### Reporting Your Results

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Reporting your results to the appropriate audiences in an effective and timely manner can:

- Increase commitments to support school health policies and programs;
- Help you make concrete, data-supported recommendations for school health policies and programs in your district or state;
- Enable you to respond more easily and effectively to public and media requests for information about school health policies and programs; and
- Encourage increased participation in future years.

This section includes guidelines for planning and developing reports, choosing the method for reporting, and using effective graphics. This section also describes additional data sources you can use to supplement your Profiles results.

### Planning and Developing Effective Reports and Choosing Methods of Reporting

When planning your report, consider the following:

- Audience;
- Content;
- Style and format; and
- Method of reporting.

Determining your **audience** is the first step in planning and developing your report or reports. A primary audience for your Profiles results is CDC, but legislators, school board members, and district/state administrators are other audiences for your Profiles. Education department officials and program staff, teachers, trainers, parents, and the community may also be interested in your results.

Your audience will determine the **content** of the report. Vary the materials you use for reporting to different audiences and consider the following for each group:

- Existing levels of knowledge;
- Key concerns and issues;
- Method of presentation most likely to draw that group's attention; and

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- Types of information most likely to motivate action.

Emphasize those aspects of your Profiles data that are most interesting to each audience. Focus on the most important points you want to make instead of overwhelming your audience with details. Provide only the level of detail the audience needs or has requested.

Your results will be more meaningful if presented with other relevant data. You may want to compare your district or state data to data that reflect general national results. Other potential sources of data include the following:

- Previous School Health Profiles results;
- The School Health Policies and Programs Study 2006;
- Your district or state Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS), and other student surveys;
- The national school-based YRBS and the national YTS;
- Your state Behavioral Risk Factor Surveillance System (BRFSS);
- Survey results from other states and cities and national organizations;
- Health outcome data; and
- National health statistics from federal agencies.

Examples of combining the YRBS results and the Profiles results can be found on the CDC/DASH web site (<http://www.cdc.gov/healthyyouth/profiles/index.htm>). If current YRBS and Profiles results were available, three fact sheets were created for sites on the topics of Childhood Overweight, HIV, and Tobacco Use.

Consider the **style and format**, as well as the content of the product you will target to each audience you want to reach. Organize your findings in a way that clarifies implications for each particular audience. Reports that contain visual images are more powerful than those with just written text.

Once you have selected the findings and determined a style and format that will have the most impact, the final step is to develop the appropriate **method** for dissemination. Keep in mind that using more than one method enhances your chance of reaching and persuading a broad audience.

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Some examples of formats that can be used include:

**Executive summary.** A two- or three-page executive summary should include all the relevant information generally needed for the reader to become informed about the subject. Use this reporting mechanism to make recommendations for change based on the reported information.

**Comprehensive report.** Include many or all findings and details from your Profiles in a comprehensive report. Use bullets, boxes, and graphics to emphasize what you want the reader to remember. Include your executive summary as an introduction. Organize the report by topic and include principal data and teacher data in each section as appropriate.

**Newsletter.** Use a newsletter to report information specifically addressed to certain groups of people, such as teachers, parents, or other professional or community groups. Contribute to existing newsletters or develop your own. Publishing in the state/district principal and teacher newsletters is a way of gaining support for future surveys.

**Fact sheets and brochures.** A single-page fact sheet or threefold brochure should focus on three or four key results. Fact sheets also might contain some information about your YRBS results. Include your project name, address, and telephone number. Fact sheets can be used easily to disseminate information widely.

**Visual presentation.** In addition to written reports, you may want visual presentations to report your results before an audience. Consider creating a PowerPoint presentation depicting the most important findings from your Profiles. Include text interspersed with graphs that focus on a single finding.

**Web site.** You may want to include your findings on an existing web site or create a web site so you can share your Profiles data more easily and with many interested parties.

### Using Effective Graphics

In reporting statistical data, graphic representation can be extremely useful in displaying results in an easy-to-understand manner. Graphics are charts, graphs, and other visual forms for presenting information. Graphic presentation of data is a powerful tool when effectively used. Graphic enhancements are often the sparks that bring life, attention, and interest to a report or presentation. Graphic images help demonstrate group differences and aid in the explanation of survey findings.

The remainder of this booklet has been developed to help you prepare accurate and effective graphics. It focuses primarily on graphics used in presentations, but the same guidelines can be used when including graphics in any report format, whether it be electronic or print. The guidelines are not intended to constrain creativity, but rather to encourage and support accuracy and consistency in the display of information. Your Profiles report CD-ROM contains graphs for all of your questions in a PowerPoint presentation format. If you want to add additional “slides” or modify this presentation, you can make these changes yourself or find out about services available in your education or health agency.

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## Planning Your Graphic Presentation

The first step to preparing effective graphic presentations is to ensure that they have a clear purpose. Think about what you are trying to say with the graphic. Keep your message simple and straightforward. Remember that your graphic presentation should highlight your major findings.

Graphic presentations provide an opportunity for you to acquaint various audiences with your program. You must know your audience members so you can design a presentation to best fit their needs. For example, knowing whether your graphics will be viewed by policy makers, such as district superintendents, or by parent groups will help you decide how to present your results.

A graphic's primary function is to inform. This can best be done when data are presented clearly and simply. Simple graphics that are easy to understand will communicate your survey findings much more effectively than tables of raw data. Ideally, your graphics should be both accurate and visually appealing.

Graphics within a presentation should have a consistent style and format. Although many type or font styles are available, using too many different styles can add an inconsistent, cluttered, unprofessional look to an otherwise clean and simple presentation. If you add "slides" to your Profiles report presentation, limit your choices to one or two fonts, and use boldface or italics for emphasis.

Another key factor to consider is the amount of information to convey in a single graphic. Too much information makes a graphic difficult to comprehend, which in turn detracts from your ability to demonstrate important programmatic needs. A series of simple graphics may be far more effective than a single complicated graph. However, be careful not to summarize the information to the point that it misrepresents the actual data.

Keeping presentation graphics as simple as possible forces you to interpret and discuss them in a conversational tone rather than reading them verbatim to your audience. Reading your PowerPoint "slides" is boring for both you and your audience. Your graphics should contain the framework rather than all the details of your presentation.

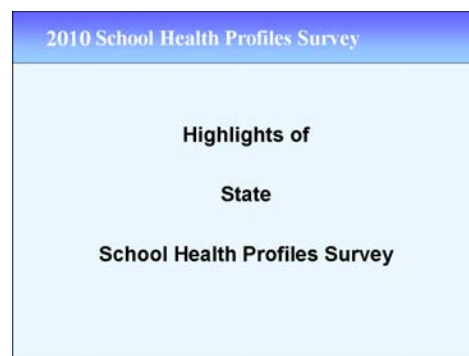
## Selecting Chart Types

Several types of charts can be used to display your data. Choose the one that will best highlight the point you want to make.

### *Text Charts*

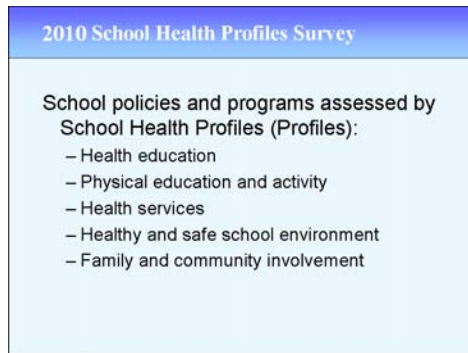
Use text charts to introduce nonnumeric data in a presentation, for example, to introduce or summarize your findings. Text charts should be short and precise in meaning, using the minimum number of short keywords needed to convey your message. Keep lines short by highlighting only the main idea. Limit text charts to eight lines, with no more than 8 to 10 words on a line. Paraphrase rather than use complete sentences. Use initial capital letters and lowercase (as in the example shown)

for the rest of the text. USING ALL UPPERCASE LETTERS MAKES TEXT DIFFICULT TO READ.



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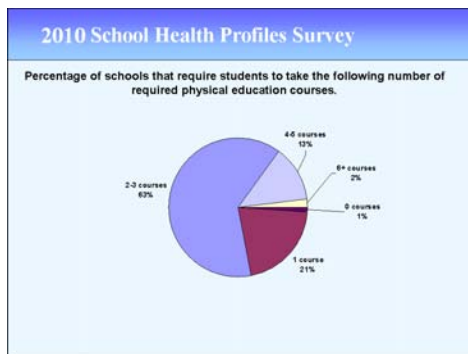
Avoid jargon. Be careful when using abbreviations or acronyms. For example, be sure your audience knows that Profiles stands for School Health Profiles.



Use bulleted lists to group and emphasize related ideas. If you have more than one bulleted list in your report or presentation, the symbol you choose for the bullets should be consistent for all of your graphics. Use a minimum number of indent levels, providing more detail verbally. To avoid monotonous presentations, be careful not to overuse bulleted lists.

### *Pie Charts*

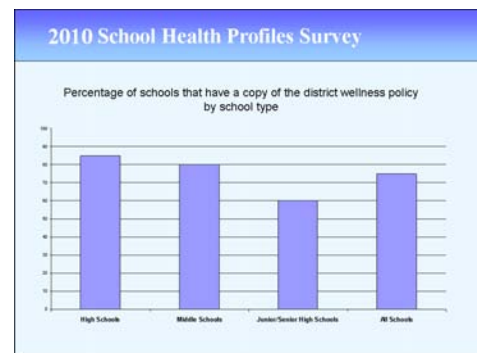
A pie chart is the graphic that answers simple questions about proportions. Each slice represents an individual part of a particular group. “Cutting” (separating) one of the slices emphasizes an element that is part of the whole. For clarity, place labels next to the slices, not in a legend. Include percentages or values in the labels to add detail to the interpretation. Pie charts should contain eight slices at most. When you have more than eight data values, use a bar chart. Use multiple pie charts cautiously; bar charts are more effective in comparing proportions among groups.



Arrange your data from the largest element to the smallest, unless you want to emphasize a particular element or there is a logical order to your categories or elements. Your most important element should start at the 3 o'clock position on the pie. The other elements should progress in importance in a counterclockwise direction, with each slice being a lighter color or shading. For the best color or pattern effects, work from dark to light. Fluctuating between dark and light makes it difficult to see pie shading differences.

### *Vertical Bar or Column Charts*

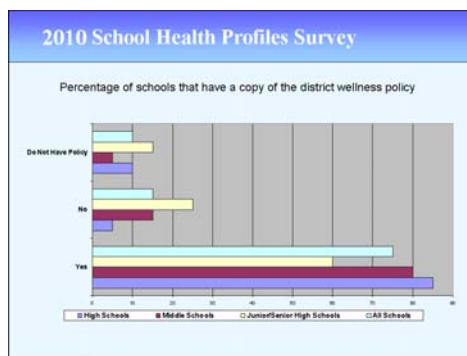
Vertical bars are used to present trends in data such as changes over time or differences among groups. Use bar charts for a relatively small number of discrete data points or groups. Use a clustered bar chart to compare data in more than one category. However, keep the number of clusters small, and limit the number of bars in each cluster to three or fewer.



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### *Horizontal Bar Chart*

Horizontal bar charts are used to show comparisons among parts, groups, or categories. This type of chart will accommodate many values without visual clutter and can indicate exact quantities as well as proportions. Use the same color or fill pattern for all bars. To emphasize one bar, select a contrasting fill pattern or color. The Profiles charts are in this format.



### *Line Charts*

Line charts are used to show changes in data over time or to represent continuous measurements. Like bar charts, line charts answer questions about trends, and they can support an almost unlimited number of data points.

### *Titles and Labels*

Graphics should have clear, concise titles and subtitles. Both axes of a graph should be labeled with the names of the variables, and the scales should be indicated. Titles should be centered at the top or bottom of the graphic. All information necessary to understand the graphic should be included.

### **Production**

Graphics produced for paper copies and those created for computerized digital display require different design formats. It is important to consider the purpose and presentation medium when choosing among pattern, shading, and color options. Computer presentations benefit from use of color. Photocopying printed graphics (unless using a color copier) will obscure color or shading patterns.

### *Electronic Presentation*

You can present your results in the PowerPoint presentation format provided on your CD-ROM without any modification, or you can tailor the report to meet more specific needs. The PowerPoint presentation allows you to add transitions between slides, text builds, and even animation and sound. Transitions are special visual effects that appear when moving from slide to slide. Text builds allow you to show main bullet points on a slide one at a time. These special effects should be used sparingly. You need to preview your presentation to be sure that everything looks good.

When doing an electronic presentation, you will need a computer, a CD-ROM or a flash drive containing your "slides," and an LCD projector. In the future, LCD projectors connected to computers will probably become as commonplace as slide and overhead projectors. We are not there yet, however, so be prepared and bring your equipment. You may want to bring a printed version as a backup in case of equipment problems.

## 2010 School Health Profiles Report

### *Internet Web Site*

Presenting data on the Internet has become more commonplace. This format makes it readily available to many audiences. Having data available on the World Wide Web emphasizes the importance of the data and encourages an exchange of information to enhance analysis and presentation.

Preparing data for an Internet site is not difficult. Software packages are available to convert your paper presentation text and graphics into HTML (hypertext markup language) or PDF (portable document file), so it can be viewed on the Internet. Like your paper presentation, you will want to keep it simple and easy to read. Some formats will change in the HTML conversion, so take the time to adjust the format the way you like. Highlight important headings and keep basic facts bulleted. Converting to HTML will allow you to draw attention to links including appendices, tables, graphs, and pie charts, if you choose. By using hyperlinks, you can allow the user to move within your report or to jump to supplemental information available elsewhere on the Internet. Converting to PDF format will keep your document true to the original format.

### **Quality Assurance**

Quality assurance is the time and effort spent by the graphics developer to ensure that the message conveyed by the graphic is true to the data it represents. Adequate quality assurance ensures that a graphic represents data in a manner that is easily viewed and understood by the observer and is not in any way misleading or incorrect. If the graphic presentation is incorrect, the viewer will have a false sense of the data and their implications.

Proofread your charts. If possible, enlist one or more of your co-workers who are familiar with your Profiles to help with the proofing. Also, check that percentages sum to 100%, when applicable, and that counts sum to the total. If percentages do not sum to 100 due to rounding, be sure to document that in a footnote.

Make sure the numbers on your chart match the numbers in the original data and that they are presented in the correct category. Within a presentation, scale changes should be avoided whenever possible so that between-chart comparisons can be made. For example, you may have two charts side by side showing response rates. One may use a scale of 0 to 100. The second chart may zoom in on a scale of 60 to 100. A person comparing these two charts will probably get a distorted view of the data. If you need to enlarge a selected portion of a scale, be sure it is clearly labeled as such. The vertical scale of bar and line charts should include zero.

Answer the following questions when proofreading your charts:

- Is all the text there? (Did the computer truncate text on long lines?)
- Is the spelling correct? (If your graphics package has one, use the built-in spell check.)
- Is your message clear?
- Is the chart simple and easy to understand?
- Are the data accurate?

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- Would color enhance the presentation of the data?

Whether you are compiling a written report or preparing visuals for a presentation, graphics can be used to add emphasis to your message. Graphics can help make sure your readers or audiences leave with the message you want to convey. Effective use of graphics may help you generate interest in your program, gain support for conducting Profiles, and enhance your report or presentation.

# 2010 School Health Profiles Report

## Checklist for Effective Graphics

### Purpose

- Identify your audience(s).
- Specify your objectives.
- Ensure presentation methods match purpose and audience.

### Planning

- Create rough drafts first.
- Plan on making several drafts of all graphs.
- Remember that producing graphics sometimes takes longer than expected, so plan time accordingly.

### Appropriate Use

- Use graphics to highlight the intended material.
- Use the correct type of chart for your data.
- Be sure the chart demonstrates the comparisons you planned.

### Clarity

- Avoid unnecessary shadowing, 3D effects, and coloring.
- Minimize the number of fonts.
- Use bold and italic versions of fonts for highlighting.
- Avoid red and green adjacent to each other.
- Use accurate and complete labels.

### Simplicity

- Present the data without extraneous material.
- Avoid elaborate fill patterns.
- Avoid too many different patterns.
- Avoid overly decorative backgrounds.

### Consistency

- Use a similar style across all graphics.
- Use comparable scales for accurate comparison.

### Accuracy

- Check that data are correct.
- Check that spelling is correct.
- Double-check everything!

# **Principal Item Rationale**



# 2010 School Health Profiles Report

## Item Rationale

### Principal Survey

#### QUESTION:

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

#### RATIONALE:

This question assesses whether the school has conducted an assessment or diagnosis as a critical first step in improving implementation of policies, programs, or environmental strategies to effect change or improvement in school health.<sup>(1)</sup> Studies confirm that the School Health Index helps bring health issues to the school's attention, builds school commitment, identifies changes that do not require resources, encourages development of policy and action, raises awareness of federal policies, and helps schools set policies and standards that meet national health objectives.<sup>(2-6)</sup>

#### REFERENCES:

1. Goodman R, Steckler A, Kegler MC. Mobilizing organizations for health enhancement. In: Glantz K, Lewis FM, Rimer B. eds. *Health Behavior and Health Education*. San Francisco, CA: Jossey Bass Publishers, 1997, pp. 287-312.
2. Pearlman DN, Dowling E, Bayuk C, Cullinen K, Thacher AK. From concept to practice: using the School Health Index to create healthy school environments in Rhode Island elementary schools. *Preventing Chronic Disease* [serial online]. 2005;2(Special Issue):A09.
3. Staten LK, Teufel-Shone NI, Steinfeldt VE, et al. The School Health Index as an impetus for change. *Preventing Chronic Disease* [serial online]. 2005;2(1):A19.
4. Austin SB, Fung T, Cohen-Bearak A, Wardle K, Cheung LWY. Facilitating change in school health: a qualitative study of schools' experiences using the School Health Index. *Preventing Chronic Disease* [serial online]. 2006;3(2):A35.
5. Sherwood-Puzzello CM, Miller M, Lohrmann D, Gregory P. Implementation of CDC's School Health Index in 3 midwest middle schools: motivation for change. *Journal of School Health*. 2007;77:285-293.
6. Geiger BF, Petri CJ, Barber C. A university-school system partnership to assess the middle school health program. *American Journal of Health Studies*. 2004;19(3):158-163.

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### QUESTION:

2. The Elementary and Secondary Education Act requires certain schools to have a written School Improvement Plan (SIP). Many states and school districts also require schools to have a written SIP. Does your school's written SIP include health-related goals and objectives on any of the following topics?

### RATIONALE:

This question assesses whether the school has a School Improvement Plan (SIP) that includes health-related goals and objectives. Education reform efforts are linked to student health; healthy students are present in school and ready to learn, while poor health is a barrier to learning and a frequent cause of underachievement.<sup>(1)</sup> In turn, academic success is an indicator of overall student well-being and a strong predictor of adult health outcomes.<sup>(2-5)</sup> A number of national education organizations recognize the close relationship between health and education and the need to embed health into the educational environment for all students.<sup>(6-11)</sup> Including health-related goals and objectives in a SIP can help ensure that health programs, which can have a positive impact on educational attainment and student health-risk behavior participation,<sup>(12-19)</sup> are present in schools.

### REFERENCES:

1. McKenzie FD, Richmond JB. Linking Health and Learning: An Overview of Coordinated School Health Programs. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York: Teachers College Press, 1998, pp. 1-14.
2. Grossman M, Kaestner R. Effects of education on health. In: Behrman JR, Stacey N, eds. *The Social Benefits of Education*. Ann Arbor: University of Michigan Press, 1997.
3. Harper S, Lynch J. Trends in socioeconomic inequalities in adult health behaviors among U.S. states, 1990–2004. *Public Health Reports*. 2007;122(2):177–189.
4. Lewallen TC. Healthy learning environments. *ASCD INFOBrief*. 2004(38).
5. Vernez G, Krop RA, Rydell CP. The public benefits of education. In: *Closing the Education Gap: Benefits and Costs*. Santa Monica, CA: RAND Corporation, 1999, pp.13–32.
6. Association for Supervision and Curriculum Development. *The whole child and health and learning*. ASCD Adopted Positions. 2004. Available at: [http://www.ascd.org/news\\_media/ASCD\\_Policy\\_Positions/All\\_Adopted\\_Positions.aspx#whole\\_child](http://www.ascd.org/news_media/ASCD_Policy_Positions/All_Adopted_Positions.aspx#whole_child). Accessed June 10, 2009.

## 2010 School Health Profiles Report

7. Council of Chief State School Officers. *Assuring school success for students at risk: A policy statement of the Council of Chief State School Officers*. 1987. Available at: [http://www.ccsso.org/about\\_the\\_council/policy\\_statements/1713.cfm](http://www.ccsso.org/about_the_council/policy_statements/1713.cfm). Accessed June 8, 2009.
8. Council of Chief State School Officers. *Policy statement on school health*. 2004. Available at: <http://www.ccsso.org/content/pdfs/SchoolHealthPolicyStatement.pdf>. Accessed June 8, 2009.
9. National School Boards Association. *Beliefs and Policies of the National School Boards Association*. Alexandria, VA: National School Boards Association, 2009. Available at: <http://www.nsba.org/FunctionNav/AboutNSBA/NSBAGovernance/BeliefsandPolicies.aspx>. Accessed June 11, 2009.
10. National Association of State Boards of Education. *Public policy positions of the National State Boards of Education*. Alexandria, VA: National School Boards Association, 2009. Available at: <http://nasbe.org/index.php/about/37-policy-positions/492-public-policy-positions-2009>. Accessed June 11, 2009.
11. American Association of School Administrators. *AASA position statements. Position statement 3: Getting children ready for success in school*. 2006. *Position statement 18: Providing a safe and nurturing environment for students*. 2007. Available at: <http://www.aasa.org/files/PDFs/GovDocs/AASAPositionStatementsJuly2007reviewdates.pdf>. Accessed June 11, 2009.
12. Murray NG, Low BJ, Hollis C, Cross AW, Davis SM. Coordinated school health programs and academic achievement: A systematic review of the literature. *Journal of School Health*. 2007;77(9):589–600.
13. Society of State Directors of Health, Physical Education and Recreation. *Making the connection: Health and student achievement*. 2002. Available at: <http://www.thesociety.org/pdf/makingtheconnection.ppt>. Accessed June 8, 2009.
14. Taras H. Nutrition and student performance at school. *Journal of School Health*. 2005;75(6):199–213.
15. Taras H. Physical activity and student performance at school. *Journal of School Health*. 2005;75(6):214–218.
16. Taras H, Potts-Datema W. Childhood asthma and student performance at school. *Journal of School Health*. 2005;75(8):296–312.
17. Taras H, Potts-Datema W. Chronic health conditions and student performance at school. *Journal of School Health*. 2005;75(7):255–266.

## 2010 School Health Profiles Report

18. Taras H, Potts-Datema W. Obesity and student performance at school. *Journal of School Health*. 2005;75(8):291–295.
  19. Taras H, Potts-Datema W. Sleep and student performance at school. *Journal of School Health*. 2005;75(7):248–254.
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### QUESTION:

3. The Child Nutrition and WIC Reauthorization Act of 2004 requires school districts participating in federally subsidized child nutrition programs (e.g., National School Lunch Program or School Breakfast Program) to establish a local school wellness policy. Is your school required to report to your district each of the following types of information regarding implementation of the local wellness policy?

### RATIONALE:

This item addresses the school-level reporting requirements of the district's wellness policy. According to the Child Nutrition and WIC Reauthorization Act of 2004, each school division that participates in the National School Lunch Program (NSLP) shall establish a local (school) wellness policy (LWP) no later than the first day of the school year beginning after June 30, 2006, to cover all NSLP schools in the school division.<sup>(1)</sup> To be in compliance, school districts are required to establish component goals for nutrition education, physical activity, and other school-based activities; establish nutrition guidelines for all foods available on the school campus; and assure that the U.S. Secretary of Agriculture's guidelines for federally reimbursable school meals are being met.<sup>(1)</sup> Currently, there exist no minimum national standards for policy components, such as the nutritional value of competitive foods or the amount of time devoted to physical activity, which in turn has led to the creation of some extremely weak policies and has created a national landscape with considerable variability among districts.<sup>(2)</sup> Given the potential impact of school health policies on physical activity, diet, and the availability of foods and beverages,<sup>(3,4)</sup> it is important to have a grasp of school-level reporting requirements for communities and for state education and health agencies to provide technical assistance for development, implementation, and evaluation.<sup>(2)</sup>

### REFERENCES:

1. Child Nutrition and WIC Reauthorization Act of 2004. Public Law No. 108-265, 118 Stat. 730, § 204.
2. Story M, Nannery MS, Schwartz MB. Schools and obesity prevention: Creating school environments and policies to promote healthy eating and physical activity. *The Milbank Quarterly*. 2009;87(1):71–100.
3. French SA, Story M, Fulkerson JA, Gerlach AF. Food environment in secondary schools: a la carte, vending machines, and food policies and practices. *American Journal of Public Health*. 2003;93:1161-1167.

## 2010 School Health Profiles Report

4. Davee AM, Blum JE, Devore RL, et al. The vending and a la carte policy intervention in Maine public high schools. *Preventing Chronic Disease* [serial online]. 2005;2(Special Issue):A14.
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### QUESTION:

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

### RATIONALE:

This question assesses whether the school has identified a person responsible for coordinating a school's health program. It is critical to have one person appointed to oversee the school health program.<sup>(1)</sup> This individual coordinates school health activities, leads a school health committee or team, and integrates community-based programs with school-based programs.<sup>(2,3)</sup> Administration and management of school health programs requires devoted time, attention, training, and expertise.<sup>(4,5)</sup>

### REFERENCES:

1. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.
  2. Fetro JV. Implementing Coordinated School Health Programs in Local Schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York: Teachers College Press, 1998.
  3. American Cancer Society. *School Health Program Elements of Excellence: Helping Children to Grow Up Healthy and Able to Learn*. Atlanta, GA: American Cancer Society, 2000.
  4. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide*. Washington, DC: NASBE, 2000.
  5. American Cancer Society. *Improving School Health: A Guide to the Role of School Health Coordinator*. Atlanta, GA: American Cancer Society, 1999.
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## 2010 School Health Profiles Report

### QUESTIONS:

5. Is there one or more than one group (e.g., a school health council, committee, or team) at your school that offers guidance on the development of policies or coordinates activities on health topics?
6. Are each of the following groups represented on any school health council, committee, or team?

### RATIONALE:

These questions assess whether the school has a health committee or team and the composition of that team. The school health committee or team should represent a coalition of representatives from within and outside of the school community interested in improving the health of youth in schools.<sup>(1,2)</sup> Participation on such committees or teams can empower others through increased awareness and knowledge of the school health program, increase the chance of ownership and commitment, activate channels of communication, and increase involvement in decision making.<sup>(1-6)</sup> This includes parents and community members. Parent leaders help other parents understand and contribute ideas to issues and policies that affect the design and quality of school programs and opportunities for all children.<sup>(5)</sup>

### REFERENCES:

1. National Association of State Boards of Education. *Fit, Healthy, and Ready to Learn: A School Health Policy Guide*. National Association of State Boards of Education. Washington, DC: NASBE, 2000.
2. Shirer K. *Promoting Healthy Youth, Schools and Communities: A Guide to Community-School Health Councils*. Atlanta, GA: American Cancer Society, 2003.
3. Fetro JV. Implementing Coordinated School Health Programs in Local Schools. In: Marx E, Wooley S, eds. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York: Teachers College Press, 1998, pp. 15-42.
4. Green, LW, Kreuter MW. *Health Promotion and Planning: An Education and Environmental Approach*. California: Mayfield Publishing Company, 1991, pp. 271-274.
5. Redding S, Langdon J, Meyer J, Sheley P. *The Effects of Comprehensive Parent Engagement on Student Learning Outcomes*. Presentation at the Annual Convention of American Educational Research Association, San Diego, 2004.
6. Epstein LS. *School, Family, and Community Partnerships: Preparing Educators and Improving Schools*. Boulder, CO: Westview Press, 2001.

## 2010 School Health Profiles Report

### QUESTION:

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

### RATIONALE:

This question assesses professional development requirements for school staff on HIV, STD, and pregnancy prevention, specifically for youth at high risk. Youth at high risk include racial/ethnic minorities and those who participate in drop-out prevention, alternative education, or GED programs. Studies show that racial ethnic/minority students are more likely than white students to engage in sexual risk behaviors that can lead to HIV, STDs, and unintended pregnancy. For example, black, Hispanic/Latino, and American Indian students are more likely than white counterparts to have ever had sexual intercourse, to be currently sexually active (i.e., had sexual intercourse with 1 or more persons during the 3 months preceding the survey), to have had sexual intercourse before age 13 years, and to have had sexual intercourse with 4 or more persons during their life.<sup>(1-3)</sup> Additionally, the prevalence of these same sexual risk behaviors is higher among alternative high school students than among all high school students nationally, based on comparable estimates from the 1998 national Alternative High School Youth Risk Behavior Survey (ALT-YRBS) and 1997 Youth Risk Behavior Survey (YRBS).

As a result of differences in sexual behavior, high risk groups have different HIV, STD, and pregnancy prevention needs and health education and resources should be tailored to the specific population. Effective programs are appropriate for the age, sexual experience, gender, and culture of the youth.<sup>(5)</sup> Additionally, in order for such programs to be effective, educators must be trained to implement these programs with fidelity.<sup>(5)</sup> Professional development provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues.<sup>(6,7)</sup> Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching.<sup>(8)</sup>

### REFERENCES:

1. CDC. Youth risk behavior surveillance—United States, 2007. *MMWR*. 2008;57(SS-4):1–131.
2. Shaughnessy L, Branum C, Everett-Jones S. *Youth Risk Behavior Survey of High School Students Attending Bureau Funded Schools, 2001*. Washington, DC: Bureau of Indian Affairs, Office of Indian Education Programs, 2001. Available at: [http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content\\_storage\\_01/0000019b/80/19/78/77.pdf](http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/19/78/77.pdf). Accessed June 11, 2009.
3. Rutman S, Park A, Castor M, Taulii M, Forquera R. Urban American Indian and Alaska Native Youth: Youth Risk Behavior Survey 1997-2003. *Maternal and Child Health Journal*. 2008;12:S76-S81.

## 2010 School Health Profiles Report

4. CDC. Youth Risk Behavior Surveillance – National Alternative High School Youth Risk Behavior Survey, United States, 1998. *MMWR*. 1999;48(SS-7):1-44.
  5. Kirby D, Laris BA, Rolleri L. *Sex and HIV education programs for youth: Their impact and important characteristics*. Washington DC: Family Health International, 2006. Available at: <http://www.fhi.org/NR/rdonlyres/eg6dcdnypfc6lbcdq2jccju67o644svf3npgjtuagpsdimlkx7edlrojytwevjznjsfnkqflbak4hj/SexandHIVEducationProgramsKirby.pdf>. Accessed June 11, 2009.
  6. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.
  7. National Association of State Boards of Education (NASBE) & National School Boards Association (NSBA). *HIV Prevention in Schools: A Tool Kit for Education Leaders*. 2002. Available at: <http://nasbe.org/index.php/file-repository?func=startdown&id=787>. Accessed June 12, 2009.
  8. Hausman A, Ruzek S. Implementation of comprehensive school health education in elementary schools: focus on teacher concerns. *Journal of School Health*. 1995;65(3):81-86.
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### QUESTION:

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

### RATIONALE:

This question assesses whether the school has a gay/straight alliance or similar student-led club. Such clubs are critical to the well-being of students. Students in schools with a gay/straight alliance are less likely to feel unsafe at school, less likely to miss school, and more likely to feel like they belong at their school than students in schools with no such clubs.<sup>(1)</sup>

### REFERENCE:

1. Kosciw JG, Diaz EM, Greytak EA. *2007 National School Climate Survey: The experiences of lesbian, gay, bisexual and transgender youth in our nation's schools*. New York: GLSEN, 2008. Available at: [http://www.glsen.org/binary-data/GLSEN\\_ATTACHMENTS/file/000/001/1290-1.pdf](http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/001/1290-1.pdf). Accessed June 11, 2009.
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## 2010 School Health Profiles Report

### QUESTION:

9. Does your school engage in each of the following practices related to lesbian, gay, bisexual, transgender, or questioning (LGBTQ) youth?

### RATIONALE:

This question assesses whether the school includes activities and policies designed to create a safe school climate for lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth. A safe school climate is critical to the well-being and academic success of all students. A majority of teachers feel they have a responsibility to provide a safe environment for LGBTQ students.<sup>(1)</sup> In addition, students from schools with a policy that includes sexual orientation or gender report fewer problems with school safety in general.<sup>(1)</sup>

### REFERENCE:

1. Harris Interactive and GLSEN. *From Teasing to Torment: School Climate in America, A Survey of Students and Teachers*. New York: GLSEN, 2005. Available at: [http://www.glsen.org/binary-data/GLSEN\\_ATTACHMENTS/file/499-1.pdf](http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/499-1.pdf). Accessed June 11, 2009.
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### QUESTION:

10. Has your school adopted a policy that addresses each of the following issues on human immunodeficiency virus (HIV) infection or AIDS?

### RATIONALE:

This question assesses important components of school policies in place to address students and staff infected with HIV or AIDS. Students and staff infected with HIV or AIDS need policies protecting their rights.<sup>(1)</sup>

### REFERENCE:

1. National Association of State Boards of Education. *Someone at school has AIDS: a complete guide to education policies concerning HIV infection*. Alexandria, VA: National Association of State Boards of Education, 2001. Available at: <http://www.nasbe.org/index.php/component/content/article/78-model-policies/120-policies-concerning-students-and-staff-with-hiv-infection>. Accessed June 11, 2009.
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## 2010 School Health Profiles Report

### QUESTION:

11. Does your school have or participate in each of the following programs?...A student mentoring program? A safe-passages to school program? A program to prevent bullying? A program to prevent dating violence? A youth development program?

### RATIONALE:

These questions measure whether or not various injury prevention programs are being implemented. The Safe and Drug-Free School and Communities Act of 1994 provides federal funds for programs to prevent violence in and around schools.<sup>(1)</sup> Some evidence has demonstrated that students who participate in mentoring programs are less likely than their non-mentored peers to be involved in bullying or fighting, especially when such programs are implemented with at-risk youth.<sup>(2,3)</sup> Bullying prevention programs have also demonstrated effectiveness in decreasing levels of victimization. Programs that were most likely to be effective were those that were comprehensive and included elements such as parent training, improved playground supervision, and classroom management.<sup>(4,5)</sup> At least one dating violence prevention program has demonstrated effectiveness in decreasing rates of physical, serious physical, and sexual dating violence perpetration and victimization; moreover, these effects were maintained up to 4 years after program implementation.<sup>(6,7)</sup> Similarly, youth development programs have also demonstrated a positive impact on violence-related outcomes. For example, young people who participated in the Seattle Social Development program during their elementary school years were significantly less likely to be involved in a high variety of crime, to have sold illegal drugs in the past year, and to have an official lifetime court record at age 21.<sup>(8)</sup>

### REFERENCES:

1. Safe and Drug-Free Schools and Communities Act. 20 U.S.C. § 7101 et seq., 2005.
2. King KA, Vidourek RA, Davis B, McClellan W. Increasing self-esteem and school connectedness through a multidimensional mentoring program. *Journal of School Health*. 2002;72:294-299.
3. DuBois DL, Holloway BE, Valentine JC, Cooper H. Effectiveness of mentoring programs for youth: A meta-analytic review. *American Journal of Community Psychology*. 2002;30(2):157-197.
4. Ttofi MM, Farrington DP, Anna C, Baldry AC for the Swedish National Council for Crime Prevention. *Effectiveness of Programs to Reduce School Bullying*. Edita Norstedts Vasteras, 2008.
5. Frey KS, Hirschstein MK, Snell JL, Edstrom LV, MacKenzie EP, Broderick CJ. Reducing playground bullying and supporting beliefs: An experimental trial of the Steps to Respect program. *Developmental Psychology*. 2005;41(3):479-491.

## 2010 School Health Profiles Report

6. Foshee VA, Bauman KE, Arriaga XB, Helms RW, Koch GG, Linder GF. An evaluation of Safe Dates, an adolescent dating violence prevention program. *American Journal of Public Health*. 1998;88:45-50.
  7. Foshee VA, Bauman KE, Ennett ST, Linder GF, Benefield T, Suchindran C. Assessing the long-term effects of the Safe Dates program and a booster in preventing and reducing adolescent dating violence victimization and perpetration. *American Journal of Public Health*. 2004;94:619–624.
  8. Hawkins JD, Kosterman R, Catalano RF, Hill KG, Abbott RD. Promoting positive adult functioning through social development intervention in childhood. *Archives of Pediatrics & Adolescent Medicine*. 2005;159:25-31.
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### QUESTION:

12. Are all staff who teach health education topics at your school certified, licensed, or endorsed by the state in health education?

### RATIONALE:

This question addresses the necessary qualifications of staff who teach health education. The National Commission for Health Education Certification, Inc. supports Certified Health Education Specialists (CHES). CHES teachers are more likely than non-CHES teachers to teach about HIV and sexually transmitted disease prevention.<sup>(1)</sup> Studies in other disciplines reveal that nationally certified teachers, to a greater degree than non-certified teachers, possess pedagogical content knowledge that is more flexibly and innovatively employed in instruction; are more able to improvise and to alter instruction in response to contextual features of the classroom situation; understand at a deeper level the reasons for individual student success and failure on any given academic task; are more able to provide developmentally appropriate learning tasks that engage, challenge, and even intrigue students; are more able to anticipate and plan for difficulties students are likely to encounter with new concepts; are more easily able to improvise when things do not run smoothly; are more able to generate accurate hypotheses about the causes of student success and failure; and bring a distinct passion to their work.<sup>(2)</sup> The leading national organizations supporting school health education, including the American School Health Association and the American Association for Health Education, recommend that those who teach health education have professional preparation and state certification in health education.<sup>(3,4)</sup> The Joint Committee on National Health Education Standards recommends that local education agencies ensure that health education is taught by licensed/certified health education teachers with training in implementing the National Health Education Standards.<sup>(5)</sup>

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### REFERENCES:

1. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education*. 2004;35:2-10.
2. Bond L, Smith T, Baker WK, Hattie JA. *The certification system of the National Board for Professional Teaching Standards: A construct and consequential validity study*. University of North Carolina at Greensboro, Center for Educational Research and Evaluation, 2000. Available at: [http://www.nbpts.org/UserFiles/File/validity\\_1\\_-\\_UNC\\_Greepsboro\\_D\\_-\\_Bond.pdf](http://www.nbpts.org/UserFiles/File/validity_1_-_UNC_Greepsboro_D_-_Bond.pdf). Accessed June 11, 2009.
3. American Association for Health Education. *Certification of Health Education Teachers: A Position Statement of the American Association of Health Education (AAHE)*. 2005. Available at: [http://www.aahperd.org/AAHE/pdf\\_files/pos\\_pap/licensure.pdf](http://www.aahperd.org/AAHE/pdf_files/pos_pap/licensure.pdf). Accessed June 12, 2009.
4. American School Health Association. *ASHA Resolutions: Certification*. 2002. Available at: <http://www.ashaweb.org/files/public/Resolutions/Certification.pdf>. Accessed June 11, 2009.
5. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2<sup>nd</sup> Edition)*. Atlanta: American Cancer Society, 2007.

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## REQUIRED PHYSICAL EDUCATION

### QUESTIONS:

13. Is physical education required for students in any of grades 6 through 12 in your school?
14. Is a required physical education course taught in each of the following grades in your school?

### RATIONALE:

These questions measure the extent to which physical education is required for students in grades 6 through 12. Physical education provides students with the knowledge, attitudes, skills, behaviors, and confidence to adopt and maintain physically active lifestyles.<sup>(1,2)</sup> The importance of physical education in promoting the health of young people is supported by *Healthy People 2010* Objectives 22-8, 22-9, and 22-10.<sup>(3)</sup>

## 2010 School Health Profiles Report

### REFERENCES:

1. National Association for Sport and Physical Education. *Moving into the Future: National standards for physical education*. 2nd ed. Reston, VA: National Association for Sport and Physical Education, 2004.
  2. Lee SM, Burgeson CR, Fulton JE, Spain CG. Physical education and activity: results from the School Health Policies and Programs Study 2006. *Journal of School Health*. 2007;77(8):435-463.
  3. U.S. Department of Health and Human Services. *Healthy People 2010*. 2<sup>nd</sup> ed. with *Understanding and Improving Health and Objectives for Improving Health*, 2 vols. Washington, DC: U.S. Department of Health and Human Services, 2000.
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### QUESTION:

15. Can students be exempted from taking required physical education for one grading period or longer for each of the following reasons?

### RATIONALE:

This question examines whether students are allowed to be exempt from physical education based upon participation in non-physical activities or interscholastic sports. Exemptions from required physical education do not allow students to participate in comprehensive, standards-based physical education; this practice diminishes the importance of physical education and its role in assisting students with establishing physically active lifestyles and developing various motor, movement, and behavioral skills unique to being physically educated.<sup>(1)</sup>

### REFERENCE:

1. National Association for Sport and Physical Education. *Opposing substitution and waiver/exemption for required physical education*. Reston, VA: National Association for Sport and Physical Education, 2006. Available at: [http://www.aahperd.org/naspe/pdf\\_files/pos\\_papers/OpposingSubstitutionWaiverExemptions.pdf](http://www.aahperd.org/naspe/pdf_files/pos_papers/OpposingSubstitutionWaiverExemptions.pdf). Accessed June 11, 2009.
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### PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

#### QUESTION:

16. During the past two years, did any physical education teachers or specialists at your school receive professional development (e.g., workshops, conferences, continuing education, or any other kind of in-service) on physical education?

#### RATIONALE:

This question examines professional development for PE teachers. Physical education teachers should have professional development opportunities that teach concepts of quality physical education instruction. PE teachers who participate in staff development programs are more likely to use recommended teaching methods such as holding group discussions, implementing physical activity stations, videotaping student performances, testing students' knowledge related to PE, giving fitness tests, and explaining to students the meaning of fitness scores.<sup>(1-3)</sup> Professional development for PE teachers provides skills to increase the quality of PE classes through student engagement in physical activity and the content of lessons taught.<sup>(4-6)</sup>

#### REFERENCES:

1. National Association for Sport and Physical Education. *National standards for beginning physical education teachers*. Reston, VA: National Association for Sport and Physical Education, 2001.
  2. National Association for Sport and Physical Education. *Moving into the future: National standards for physical education*. Reston, VA: National Association for Sport and Physical Education, 2004.
  3. Davis K, Burgeson CR, Brener ND, McManus T, Wechsler H. The relationship between qualified personnel and self-reported implementation of recommended physical education practices and programs in U.S. schools. *Research Quarterly for Exercise and Sport*. 2005;76(2):202-211.
  4. McKenzie TL, Feldman H, Woods SE, et al. Children's activity levels and lesson context during third-grade physical education. *Research Quarterly for Exercise and Sport*. 1996;66(3):184-193.
  5. Kelder S, Mitchell PD, McKenzie TL, et al. Long-term implementation of the CATCH physical education program. *Health Education and Behavior*. 2003;30(4):463-475.
  6. McKenzie TL, Marshall SJ, Sallis JF, Conway TL. Student activity levels, lesson context, and teacher behavior during middle school physical education. *Research Quarterly for Exercise and Sport*. 2000;71(3):249-259.
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### QUESTION:

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

### RATIONALE:

This question measures the type of information and support materials PE teachers are given in order to implement PE classes. According to NASPE, quality physical education is guided by and should include a written PE curriculum; goals, objectives, and expected outcomes; scope and sequence of instruction for PE; and plans for age-appropriate student assessment.<sup>(1-3)</sup>

### REFERENCES:

1. National Association for Sport and Physical Education. *Moving into the future: National standards for physical education*. Reston, VA: National Association for Sport and Physical Education, 2004.
2. National Association for Sport and Physical Education. *What constitutes a quality physical education program?* Reston, VA: National Association for Sport and Physical Education, 2003. Available at: [http://www.aahperd.org/naspe/pdf\\_files/pos\\_papers/qualityPePrograms.pdf](http://www.aahperd.org/naspe/pdf_files/pos_papers/qualityPePrograms.pdf). Accessed June 11, 2009.
3. Centers for Disease Control and Prevention. *Physical Education Curriculum Analysis Tool*. Atlanta, GA: U.S. Department of Health and Human Services, 2006.

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### QUESTION:

18. Does your school offer opportunities for students to participate in intramural activities or physical activity clubs? (Intramural activities or physical activity clubs are any physical activity programs that are voluntary for students, in which students are given an equal opportunity to participate regardless of physical ability.)

### RATIONALE:

This question measures the extent to which students are provided the opportunity to participate in physical activities outside of the regular school day. According to NASPE, intramural activities, physical activity clubs, and recreation clubs contribute to young people's physical and social development. Additionally, intramural activities or physical activity clubs offer students the opportunity to be involved in planning and implementing such programs and offer safe and structured opportunities to be physically active.<sup>(1-6)</sup>

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### REFERENCES:

1. National Association for Sport and Physical Education. *Guidelines for after-school physical activity and intramural programs*. Reston, VA: National Association for Sport and Physical Education, 2002. Available at [http://www.aahperd.org/naspe/pdf\\_files/pos\\_papers/intramural\\_guidelines.pdf](http://www.aahperd.org/naspe/pdf_files/pos_papers/intramural_guidelines.pdf). Accessed June 11, 2009.
  2. Hellison D. Physical activity programs for underserved youth. *Journal of Science & Medicine in Sport*. 2000;3(3):238-42.
  3. Kelder S, Hoelscher DM, Barroso CS, et al. The CATCH Kids Club: a pilot after-school study for improving elementary students' nutrition and physical activity. *Public Health Nutrition*. 2005;8(2):133-40.
  4. Pate RR, Saunders RP, Ward DS, Felton G, Trost SG, Dowda M. Evaluation of a community-based intervention to promote physical activity in youth: lessons from Active Winners. *American Journal of Health Promotion*. 2003;17(3):171-82.
  5. Trevino RP, Yin Z, Hernandez A, Hale DE, Garcia OA, Mobley C. Impact of the Bienestar school-based diabetes mellitus prevention program on fasting capillary glucose levels: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*. 2004;158(9):911-7.
  6. Pate RR, O'Neill JR. After-school interventions to increase physical activity among youth. *British Journal of Sports Medicine*. 2009;43:14-18.
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### QUESTION:

19. Outside of school hours or when school is not in session, do children or adolescents use any of your school's indoor physical activity or athletic facilities for community-sponsored physical activity classes or lessons?

### RATIONALE:

This question measures the extent to which students have access to the school's facilities for sports teams or other physical activity programs. School spaces and facilities should be available to young people before, during, and after the school day, on weekends, and during summer and other vacations. Access to these facilities increases visibility of schools, provides youth, their families, and community members a safe place for physical activity, and might increase partnerships with community-based physical activity programs. Community resources can expand existing school programs by providing program staff as well as intramural and club activities on school grounds. For example, community agencies and organizations can use school facilities for after-school physical fitness programs for children and adolescents, weight

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management programs for overweight or obese young people, and sports and recreation programs for young people with disabilities or chronic health conditions.<sup>(1-3)</sup>

### REFERENCES:

1. CDC. Guidelines for school and community programs to promote lifelong physical activity among young people. *MMWR*. 1997;46(RR-6).
  2. Sallis JF, Conway TL, Prochaska JJ, et al. The association of school environments with youth physical activity. *American Journal of Public Health*. 2001;1:618-20.
  3. Evenson KR, McGinn AP. Availability of school physical activity facilities to the public in four U.S. communities. *American Journal of Health Promotion*. 2004;18:243-50.
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## TOBACCO-USE PREVENTION POLICIES

### QUESTIONS:

20. Has your school adopted a policy prohibiting tobacco use?
21. Does the tobacco-use prevention policy specifically prohibit use of each type of tobacco for each of the following groups during any school-related activity?
22. Does the tobacco-use prevention policy specifically prohibit tobacco use during each of the following times for each of the following groups?
23. Does the tobacco-use prevention policy specifically prohibit tobacco use in each of the following locations for each of the following groups?
24. Does your school have procedures to inform each of the following groups about the tobacco-use prevention policy that prohibits their use of tobacco?
25. Does your school's tobacco-use prevention policy include guidelines on what actions the school should take when students are caught smoking cigarettes?
26. At your school, who is responsible for enforcing your tobacco-use prevention policy?
27. Do each of the following criteria help determine what actions your school takes when students are caught smoking cigarettes?
28. When students are caught smoking cigarettes, how often are each of the following actions taken?

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

### **RATIONALE:**

These questions measure the extent to which schools develop, implement, and enforce a policy that creates a totally tobacco-free environment within the school experience for both young people and adults, as outlined in the CDC *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*<sup>(1)</sup> to achieve the *Healthy People 2010* Objective 27-11 of creating smoke-free and tobacco-free schools.<sup>(2)</sup> The Pro-Children Act of 1994, reauthorized under the No Child Left Behind Act of 2001, prohibits smoking in facilities where federally funded educational, health, library, daycare, or child development services are provided to children under the age of 18.<sup>(3,4)</sup>

Because tobacco use is the most preventable contributor to mortality in the United States, it is important to restrict use or exposure to tobacco products at an early age.<sup>(1)</sup> The existence and enforcement of a school policy creates a tobacco-free environment that models acceptable behavior and sends a clear message to students, teachers, staff, parents, and visitors that the use of tobacco is socially unacceptable.<sup>(5)</sup> Environmental interventions aimed at reducing use of tobacco in homes, public places, and worksites lead to reduction of tobacco use.<sup>(6)</sup> Likewise, tobacco-free school policies are associated with lower rates of student smoking.<sup>(5,7-9)</sup>

Prohibiting any use of any tobacco product at all times, whether or not school is in session, and regardless of whether students are present, protects students and staff from the harmful effects of secondhand smoke (a mixture of smoke from the burning end of tobacco products and the smoke exhaled by smokers). The 2006 U.S. Surgeon General's report, *The Harmful Effects of Involuntary Exposure to Tobacco Smoke*, outlines a large body of research findings which demonstrate that breathing secondhand smoke is harmful to health.<sup>(10)</sup> Evidence shows that there is no safe level of secondhand smoke exposure, and even the most advanced ventilation systems cannot eliminate secondhand smoke or its harmful effects.<sup>(10)</sup> A complete ban of indoor smoking at all times in a facility (such as a school building) is the only effective approach to controlling involuntary inhalation of secondhand smoke.<sup>(10)</sup>

### **REFERENCES:**

1. CDC. Guidelines for school health programs to prevent tobacco use and addiction. *MMWR*. 1994; 43(RR-2):1-18.
2. U.S. Department of Health and Human Services. *Healthy People 2010. 2nd ed. with Understanding and Improving Health and Objectives for Improving Health, 2 vols.* Washington, DC: U.S. Department of Health and Human Services, 2000.
3. Pro-Children Act of 1994. 20 U.S.C. §6081-6084, 1994.
4. No Child Left Behind Act or Pro-Children Act of 2001. Public Law No. 107-110, 115 Stat. 1773. § 4301-4304, 2001.

## 2010 School Health Profiles Report

5. Brownson RC, Koffman DM, Novotny TE, Hughes RG, Eriksen MP. Environmental and policy interventions to control tobacco use and prevent cardiovascular disease. *Health Education Quarterly*. 1995;22(4):478-98.
  6. Levy DT. The effects of tobacco control policies on smoking rates: a tobacco control scorecard. *Journal of Public Health Management and Practice*. 2004;10(4):338-53.
  7. Wakefield MA, Chaloupka FJ, Kaufman NJ, et al. Effect of restrictions on smoking at home, at school, and in public places in teenage smoking: cross sectional study. *British Medical Journal*. 2000;321:310-311.
  8. Charlton A, While D. Smoking prevalence among 16-19 year olds related to staff and student smoking policies in sixth forms and further education. *Health Education Journal*. 1994;53:191-215.
  9. Pentz MA, Brannon BR, Carlin VL, et al. The power of policy: the relationship of smoking policy to adolescent smoking. *American Journal of Public Health*. 1989;79:857-62.
  10. U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.
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### QUESTION:

30. During the past two years, has your school done each of the following activities?...Gathered and shared information with students and families about mass-media messages or community-based tobacco-use prevention efforts? Worked with local agencies or organizations to plan and implement events or programs intended to reduce tobacco use?

### RATIONALE:

This question measures the extent to which the school coordinates its efforts with other tobacco-use prevention efforts in the community that target young people. CDC's *Best Practices for Comprehensive Tobacco Control Programs—2007* provides evidence-based guidance to assist in planning and establishing comprehensive and effective tobacco control programs that include efforts to prevent youth initiation and reduce youth tobacco use.<sup>(1)</sup> School programs can be effective, but maintaining those effects presents a challenge, especially with the many other influences encouraging tobacco use originating outside of the school environment. The strongest evidence of success for school-based tobacco-use prevention efforts has been shown with those that are coordinated or delivered in conjunction with mass media and community tobacco control

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efforts, creating an environment of support for a tobacco-free lifestyle and delivering messages that are mutually reinforced.<sup>(1)</sup> The Surgeon General has reported that 20-40% of tobacco use by youth can be prevented by educational strategies conducted in conjunction with community- and media-based activities.<sup>(2)</sup> In 2004, the Task Force for the Community Guide to Preventive Services found “strong evidence for the use of school-based interventions when delivered in conjunction with mass media and community activities.”<sup>(3)</sup> The Task Force recommendations were based on a subset of studies that showed evidence in reducing tobacco use among youth when multiple channels were used to support the in-school health education efforts. Receiving consistent messages across community contexts and over time has been shown to enhance the maintenance of health education program effects.<sup>(4,5)</sup>

### REFERENCES:

1. U.S. Department of Health and Human Services. *Best Practices for Comprehensive Tobacco Control Programs—2007* Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2007.
2. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.
3. Task Force on Community Preventive Services. Changing risk behaviors and addressing environmental challenges: tobacco. In: Zaza S, Briss PA, Harris KW, eds. *The guide to community preventive services: what works to promote health?* New York: Oxford University Press, 2005:12-15. Available at: <http://www.thecommunityguide.org/tobacco/Tobacco.pdf>. Accessed June 11, 2009.
4. Sussman S. School-based tobacco use prevention and cessation: where are we going? *American Journal of Health Behavior*. 2001;25(3):191-9.
5. Lantz PM, Jacobson PD, Warner KE, et al. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control*. 2000;9:47-63.

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### QUESTION:

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

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### RATIONALE:

These questions measure the extent to which schools provide access to tobacco-use cessation services, as outlined in the *CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*<sup>(1)</sup> to achieve the *Healthy People 2010* Objectives 27-5 and 27-7 of increasing tobacco-use cessation attempts among adult and adolescent smokers.<sup>(2)</sup> Nicotine addiction can occur at an early age for some adolescent tobacco users.<sup>(3)</sup> People who begin using tobacco at an early age are more likely to develop higher levels of addiction in adulthood.<sup>(3)</sup> Adolescent tobacco users suffer similar symptoms of withdrawal to those of adults when attempting to quit.<sup>(4)</sup> Many young people want to quit but have tried and failed.<sup>(5)</sup> Some are unaware of or do not have access to cessation services. Others underestimate the power of addiction and do not feel that quitting would require professional assistance; therefore recruitment into formal programs can be difficult.<sup>(6)</sup> School health providers as a routine part of care should assess the tobacco-use status of students, and if they identify a student's use of tobacco, they should provide self-help materials and refer them to a tobacco-use cessation program provided on site or in the community.<sup>(7-9)</sup> Also, providing a brief clinical intervention has been shown to encourage cessation among both adults and adolescents.<sup>(9)</sup>

### REFERENCES:

1. CDC. Guidelines for school health programs to prevent tobacco use and addiction. *MMWR*. 1994; 43(RR-2):1-18.
2. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.
3. U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.
4. Centers for Disease Control and Prevention. Reasons for tobacco use and symptoms of nicotine withdrawal among adolescent and young adult tobacco users—United States, 1993. *MMWR*. 1994; 43:746-750.
5. Eaton DK, Kann L, Kinchen S, et al. Youth risk behavior surveillance—United States, 2005. *MMWR*. 2006;55(SS-5).
6. Milton MH, Maule CO, Yee SL, et al. *Youth Tobacco Cessation: A Guide for Making Informed Decisions*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.

## 2010 School Health Profiles Report

7. Allensworth DD. Guidelines for adolescent preventive services: a role for the school nurse. *Journal of School Health*. 1996;66(8):281-285.
  8. Donovan KA. Smoking cessation programs for adolescents. *Journal of School Nursing*. 2000;16(4):36-43.
  9. Fiore MC, Jaén CR, Baker TB, et al. *Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline*. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.
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### NUTRITION-RELATED POLICIES AND PRACTICES

#### QUESTIONS:

33. When foods or beverages are offered at school celebrations, how often are fruits or non-fried vegetables offered?
34. Can students purchase snack foods or beverages from one or more vending machines at the school or at a school store, canteen, or snack bar?
35. Can students purchase each of the following snack foods or beverages from vending machines or at the school store, canteen, or snack bar?
36. Does your school limit the package or serving size of any individual food and beverage items sold in vending machines or at the school store, canteen, or snack bar?

#### RATIONALE:

These questions address the extent to which schools are making more nutritious foods available to students, limiting portion sizes, and not offering less nutritious foods and beverages. Many schools offer foods and beverages in after-school programs, school stores, snack bars, or canteens<sup>(1)</sup> and these foods sold in competition to school meals are often relatively low in nutrient density and relatively high in fat, added sugars and calories.<sup>(2)</sup> Competitive foods are widely available in many elementary schools, in most middle schools, and in almost all secondary schools.<sup>(1,3,4)</sup> Given that schools offer numerous and diverse opportunities for young people to learn and make consumption choices about healthful eating, schools should provide a consistent environment that is conducive to healthful eating behaviors.<sup>(5)</sup> To help improve dietary behavior and reduce overweight among youths, schools should offer appealing and nutritious foods in school snack bars and vending machines and discourage sale of foods high in fat, sodium, and added sugars, and beverages and foods containing caffeine on school grounds.<sup>(6-8)</sup> Because students' food choices are influenced by the total food environment, the simple availability of healthful foods such as fruits and vegetables may not be sufficient to prompt the choice of fruits and vegetables when other high-fat or high-sugar foods are easily accessible.<sup>(9,10)</sup>

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However, offering a wider range of healthful foods can be an effective way to promote better food choices among high school students.<sup>(11)</sup> Taken together, such findings suggest that restricting the availability of high-calorie, energy dense foods in schools while increasing the availability of healthful foods might be an effective strategy for promoting more healthful choices among students at school.<sup>(5)</sup>

### REFERENCES:

1. O'Toole T, Anderson S, Miller C, Guthrie J. Nutrition services and foods and beverages available at school: results from the School Health Policies and Programs Study. *Journal of School Health*. 2007;77(8):500-521.
2. U.S. Department of Agriculture. *Foods sold in competition with USDA school meal programs: a report to congress*. Food and Nutrition Service, 2001. Available at: [http://www.fns.usda.gov/cnd/lunch/\\_private/CompetitiveFoods/report\\_congress.htm](http://www.fns.usda.gov/cnd/lunch/_private/CompetitiveFoods/report_congress.htm). Accessed June 11, 2009.
3. Brener ND, Kann L, O'Toole TP, Wechsler H, Kimmons J. Competitive foods and beverages available for purchase in secondary schools – selected sites, United States, 2006. *MMWR*. 2008;57(34):935-938.
4. U.S. Government Accountability Office. *School meal programs: Competitive foods are widely available and generate substantial revenues*. Report to Congressional Requesters GAO-05-563, 2005. Available at: <http://www.gao.gov/new.items/d05563.pdf>. Accessed June 12, 2009.
5. Food and Nutrition Board, Institute of Medicine, Committee on Prevention of Obesity of Children and Youth--Schools. In: JP Koplan, CT Liverman, VI Kraak, eds. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: National Academy Press, 2005, pp. 237–284.
6. Wechsler H, McKenna ML, Lee SM, Dietz WH. The role of schools in preventing childhood obesity. *The State Education Standard*. 2004;5(2):4-12.
7. Pilant VB, American Dietetic Association. Position of the American Dietetic Association: local support for nutrition integrity in schools. *Journal of the American Dietetic Association*. 2006;106(1):122-33.
8. Institute of Medicine. *Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth*. Washington, DC: Institute of Medicine of the National Academies, 2007.
9. Cullen KW, Eagan J, Baranowski T, Owens E, deMoor C. Effect of a la carte and snack bar foods at school on children's lunchtime intake of fruits and vegetables. *Journal of the American Dietetic Association*. 2000;100:1482–1486.

## 2010 School Health Profiles Report

10. Kubik MY, Lytle LA, Hannan PJ, Perry CL, Story M. The association of the school food environment with dietary behaviors of young adolescents. *American Journal of Public Health*. 2003;93:1168–1173.
  11. French SA, Story M, Fulkerson JA, Hannan P. An environmental intervention to promote lower fat food choices in secondary schools. Outcomes of the TACOS study. *American Journal of Public Health*. 2004;94(9):1507-1512.
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### QUESTION:

37. During this school year, has your school done any of the following?...Priced nutritious foods and beverages at a lower cost while increasing the price of less nutritious foods and beverages? Collected suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating? Provided information to students or families on the nutrition and caloric content of foods available? Conducted taste tests to determine food preferences for nutritious items? Provided opportunities for students to visit the cafeteria to learn about food safety, food preparation, or other nutrition-related topics?

### RATIONALE:

This question addresses the variety of methods schools can use to promote healthy eating. Students' food choices are influenced by the total food environment. The simple availability of fruits and vegetables may not be sufficient to prompt the choice of these items when items high in fat and/or added sugar are also available.<sup>(1)</sup> Even when fruit and vegetable items are available, they compete in the context of a vast array of other food items, mostly high in fat and sugar, that are competitively priced.<sup>(2)</sup> Schools should employ effective or promising strategies in the school setting to promote healthy eating, such as pricing strategies,<sup>(3,4)</sup> input from stakeholders,<sup>(5)</sup> provision of nutrition information,<sup>(6)</sup> taste tests, and using the cafeteria as a learning laboratory.<sup>(7)</sup>

### REFERENCES:

1. Kubik MY, Lytle LA, Hannan PJ, Perry CL, Story M. The association of the school food environment with dietary behaviors of young adolescents. *American Journal of Public Health*. 2003;93:1168–1173.
2. Cullen KW, Eagan J, Baranowski T, Owens E, deMoor C. Effect of a la carte and snack bar foods at school on children's lunchtime intake of fruits and vegetables. *Journal of the American Dietetic Association*. 2000;100:1482–1486.
3. French SA, Story M, Jeffery RW, Snyder P, Eisenberg M, Sidebottom A. Pricing strategy to promote fruit and vegetable purchase in high school cafeterias. *Journal of the American Dietetic Association*. 1997;97:1008–1010.

## 2010 School Health Profiles Report

4. French SA, Jeffery RW, Story M, et al., Pricing and promotion effects on lowfat vending snack purchases: the CHIPS study. *American Journal of Public Health*. 2001;91:112–117.
  5. Food and Nutrition Service, U.S. Department of Agriculture, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, and U.S. Department of Education. *Making It Happen: School Nutrition Success Stories*. Alexandria, VA: U.S. Department of Agriculture, 2005.
  6. Food and Nutrition Board, Institute of Medicine, Committee on Prevention of Obesity of Children and Youth – Schools. In: JP Koplan, CT Liverman, VI Kraak, eds. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: National Academy Press; 2005, pp. 237–284.
  7. American Dietetic Association. Position of the American Dietetic Association, Society for Nutrition Education, and American School Food Service Association – Nutrition services: an essential component of comprehensive school health programs. *Journal of the American Dietetic Association*. 2003;103: 505–514.
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### QUESTIONS:

38. At your school, are candy, meals from fast food restaurants, or soft drinks promoted through the distribution of products, such as t-shirts, hats, and book covers to students?
39. Does your school prohibit advertisements for candy, fast food restaurants, or soft drinks in each of the following locations?

### RATIONALE:

These questions addresses prohibiting marketing of less nutritious foods to students while at school or at school-sponsored events. In 2006, 23.3% of schools allowed the promotion of candy, meals from fast food restaurants, or soft drinks through the distribution of coupons for free or reduced price, 14.3% allowed the promotion of these products through sponsorship of school events, and 7.7% did so through publications such as a school newsletter or newspaper.<sup>(1)</sup> Many contracts for soft drink or other vending products have provisions to increase the percentage of profits schools receive when sales volume increases, and this is a substantial incentive for schools to promote soft drink consumption by adding vending machines, increasing the times they are available, and marketing the products to students.<sup>(2,3)</sup> In some districts, these incentives have led schools to aggressively promote student purchases of soft drinks.<sup>(4)</sup> Research suggests that exposure to advertisements may have adverse effects on children’s eating habits.<sup>(5)</sup> Food advertisements have been found to trigger food purchase by parents, have effects on children’s product and brand preferences, and have an effect on consumption behavior.<sup>(6)</sup> Further, younger children do not generally understand the difference between information and advertising,<sup>(7)</sup> such that children may interpret school-based advertising to mean that teachers or other adults endorse the use of the advertised product. Given that schools provide a captive audience of students, the

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Institute of Medicine (IOM) report on food marketing to children and youth recommends that schools should promote healthful diets for children and youth in all aspects of the school environment (e.g., commercial sponsorships, meals and snacks, curriculum), and outlines the importance of prohibiting advertising of less nutritious foods.<sup>(8)</sup>

### REFERENCES:

1. O'Toole T, Anderson S, Miller C, Guthrie J. Nutrition services and foods and beverages available at school: results from the School Health Policies and Programs Study. *Journal of School Health*. 2007;77(8):500-521.
  2. U.S. Department of Agriculture. *Foods sold in competition with USDA school meal programs: a report to congress*. Food and Nutrition Service, 2001. Available at: [http://www.fns.usda.gov/cnd/lunch/\\_private/CompetitiveFoods/report\\_congress.htm](http://www.fns.usda.gov/cnd/lunch/_private/CompetitiveFoods/report_congress.htm). Accessed June 11, 2009.
  3. Texas Department of Agriculture. *Square Meals: Nourishing Children's Bodies and Minds. School Vending Contract Survey*. Available at: [http://www.squaremeals.org/fn/render/channel/items/0,1249,2348\\_2515\\_0\\_0,00.html](http://www.squaremeals.org/fn/render/channel/items/0,1249,2348_2515_0_0,00.html). Accessed June 11, 2009.
  4. Nestle M. Soft drink "pouring rights:" marketing empty calories to children. *Public Health Reports*. 2000;115:308-319.
  5. Horgen KB, Choate M, Brownell KK. Television and food advertising: targeting children in a toxic environment. In: Sinder DG, Singer JL, eds. *Handbook of Children and the Media*. Thousand Oaks, CA: Sage Publications, 2001, pp. 447-461.
  6. Hastings G, Stead M, McDermott L, et al. *Review of Research on the Effects of Food Promotion to Children*. Glasgow, UK: Center for Social Marketing, University of Strathclyde, 2003. Available at: <http://www.food.gov.uk/multimedia/pdfs/foodpromotiontochildren1.pdf>. Accessed June 12, 2009.
  7. Wilcox BL, Kunkel D, Cantor J, Dowrick P, Linn S, Palmer E. *Report of the APA Task Force on Advertising and Children*. Washington, DC: American Psychological Association, 2004.
  8. Committee on Food Marketing and the Diets of Children and Youth. *Food marketing to children and youth: threat or opportunity?* Washington, DC: Institute of Medicine of The National Academies Press, 2006.
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### HEALTH SERVICES

#### QUESTION:

40. Is there a full-time registered nurse who provides health services to students at your school? (A full-time nurse means that a nurse is at the school during all school hours, 5 days per week.)

#### RATIONALE:

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

#### REFERENCE:

1. U.S. Department of Health and Human Services. *Healthy People 2010*. 2<sup>nd</sup> ed. with *Understanding and Improving Health and Objectives for Improving Health*, 2 vols. Washington, DC: U.S. Department of Health and Human Services, 2000.
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#### QUESTION:

41. At your school, how many students with known asthma have an asthma action plan on file? (Students with known asthma are those who are identified by the school to have a current diagnosis of asthma as reported on student emergency cards, medication records, health room visit information, emergency care plans, physical exam forms, parent notes, and other forms of health care clinician notification.)

#### RATIONALE:

This question addresses the need for clear, written guidance about the needs of individual students with asthma. Assessment of successful school-based asthma management programs suggest these plans play an important role in providing school staff, students, and families with an understanding of an individual student's asthma management needs at school, including how to respond in an emergency. Additionally, the use of an asthma action plan at school results in affected students experiencing significant improvement in several health-related outcomes, including a decrease in the frequency of asthma-related nighttime awakenings, number of days of restricted activity, and frequency of acute medical treatment.<sup>(1,2)</sup> Schools should have asthma action plans on file for all students with known asthma. These plans help schools meet the needs of students with asthma during the school day and at school-related activities. Based upon current research, federal agencies and other national organizations have provided additional guidance and recommendations related to the collection and implementation of individualized

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plans. Plans should be developed by a primary care provider and be provided by parents. They should include individualized emergency protocol, medications, environmental triggers and emergency contact information. School staff should actively solicit copies of asthma action plans from families and/or asthma care providers. When necessary, school nurses can construct asthma action plans based on information from the family and medication orders. A constructed plan should be sent to the asthma care provider for confirmation that it is appropriate.<sup>(3-7)</sup>

### REFERENCES:

1. Erickson CD, Splett PL, Mullett SS, Jensen C, Belseth SB. The healthy learner model for student chronic condition management-Part II: The Asthma Initiative. *Journal of School Nursing*. 2006;22(6):319-329.
  2. Gillies J, Barry D, Crane J, et al. A community trial of a written self management plan for children with asthma. *New Zealand Medical Journal*. 1996;109(1015):30-33.
  3. CDC. *Strategies for Addressing Asthma Within a Coordinated School Health Program, With Updated Resources*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2006.
  4. National Association of School Nurses (NASN). *Position Statement: Medication Administration in the School Setting*. 2003. Available at: <http://www.nasn.org/Default.aspx?tabid=230>. Accessed June 11, 2009.
  5. National Asthma Education and Prevention Program. *Students with Chronic Illnesses: Guidance for Families, Schools and Students*. National Heart, Lung, and Blood Institute, 2002. Available at: <http://www.nhlbi.nih.gov/health/public/lung/asthma/guidfam.htm>. Accessed June 11, 2009.
  6. National Asthma Education and Prevention Program. *Managing Asthma: A Guide for Schools*. National Heart, Lung, and Blood Institute, 2003. Available at: [http://rover.nhlbi.nih.gov/health/prof/lung/asthma/asth\\_sch.htm](http://rover.nhlbi.nih.gov/health/prof/lung/asthma/asth_sch.htm). Accessed June 11, 2009.
  7. U.S. Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute. *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma – Summary Report*. National Heart, Lung, and Blood Institute, 2007. Available at: <http://www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf>. Accessed June 12, 2009.
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### QUESTION:

42. At your school, which of the following events are used to identify students with poorly controlled asthma?

### RATIONALE:

This question examines the type of information schools use to monitor and then assess the need for additional case management of students with known asthma. Assessment of successful school-based asthma management programs reveal that this type of tracking and case management can contribute to the medical management of students with asthma.<sup>(1-4)</sup> This information can subsequently be used by schools to focus their asthma programs on students with poorly managed asthma as demonstrated by frequent school absences, school health office visits, emergency department visits, or hospitalizations.<sup>(5,6)</sup>

### REFERENCES:

1. Splett PL, Erickson CD, Belseth SB, Jensen C. Evaluation and sustainability of the healthy learners asthma initiative. *Journal of School Health*. 2006;76(6):276-282.
  2. Erickson CD, Splett PL, Mullett SS, Jensen C, Belseth SB. The healthy learner model for student chronic condition management-Part II: The Asthma Initiative. *Journal of School Nursing*. 2006;22(6):319-329.
  3. Levy M., Heffner B, Stewart T, Beeman G. The efficacy of asthma case management in an urban school district in reducing school absences and hospitalizations for asthma. *Journal of School Health*. 2006;76(6):320-324.
  4. Taras H, Wright S, Brennen J, Campana J, Lofgren R. Impact of school nurse case management on students with asthma. *Journal of School Health*. 2004;74(6):213-219.
  5. CDC. *Strategies for Addressing Asthma Within a Coordinated School Health Program, With Updated Resources*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2006.
  6. Barbot O, Platt R, Marchese C. Using preprinted rescue medication order forms and health information technology to monitor and improve the quality of care for students with asthma in New York City Public Schools. *Journal of School Health*. 2006;76(6):329-332.
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### QUESTION:

43. Does your school provide each of the following services for students with poorly controlled asthma?

### RATIONALE:

This question examines whether schools provide intensive case management for students with poorly controlled asthma. Schools should ensure that case management is provided by a trained professional for students with frequent school absences, school health office visits, emergency department visits, or hospitalizations due to asthma.<sup>(1-7)</sup> Assessment of successful school-based asthma management programs reveal that monitoring and then providing case management can contribute to the medical management of students with asthma.<sup>(3,8)</sup> Case management activities help students better manage their asthma, and have been shown to decrease hospitalizations, emergency department visits, and school absences among students with severe, persistent, or poorly controlled asthma.<sup>(9,10)</sup>

### REFERENCES:

1. CDC. *Strategies for Addressing Asthma Within a Coordinated School Health Program, With Updated Resources*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2006.
2. Erickson CD, Splett PL, Mullett SS, Jensen C, Belseth SB. The healthy learner model for student chronic condition management-Part II: The Asthma Initiative. *Journal of School Nursing*. 2006;22(6):319-329.
3. Taras H, Wright S, Brennen J, Campana J, Lofgren R. Impact of school nurse case management on students with asthma. *Journal of School Health*. 2004;74(6):213-219.
4. National Association of School Nurses (NASN). *School Nursing Management of Students with Chronic Health Conditions*. 2006. Available at: <http://www.nasn.org/Default.aspx?tabid=351>. Accessed June 12, 2009.
5. Taras H, Duncan P, Luckenbill D, Robinson J, Wheeler L, Wooley S, eds. *Health, Mental Health, and Safety Guidelines for Schools*. Elk Grove Village, IL: American Academy of Pediatrics, 2004.
6. Tinkelman D, Schwartz A. School-based asthma disease management. *Journal of Asthma*. 2004;41(4):455-62.
7. Wheeler LS, Merkle SL, Gerald LB, Taggart VS. Managing asthma in schools: lessons learned and recommendations. *Journal of School Health*. 2006;76(6):340-344.
8. Splett PL, Erickson CD, Belseth SB, Jensen C. Evaluation and sustainability of the healthy learners asthma initiative. *Journal of School Health*. 2006;76(6):276-282.

## 2010 School Health Profiles Report

9. Levy M., Heffner B, Stewart T, Beeman G. The efficacy of asthma case management in an urban school district in reducing school absences and hospitalizations for asthma. *Journal of School Health*. 2006;76(6):320-324.
  10. Evans R, Gergen PJ, Mitchell H, et al. A randomized clinical trial to reduce asthma morbidity among inner-city children: results of the National Cooperative Inner-City Asthma Study. *Journal of Pediatrics*. 1999;135(3):332-338.
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### QUESTION:

44. How often are school staff members required to receive training on recognizing and responding to severe asthma symptoms?

### RATIONALE:

This question examines professional development for school staff. Because asthma can be life-threatening, it is essential to assist those involved in monitoring and managing children with asthma at school to provide timely, appropriate care. Therefore, all school staff members should be provided with basic information about asthma so that they can support students' asthma management and appropriately respond to asthma emergencies.<sup>(1-7)</sup>

### REFERENCES:

1. CDC. *Strategies for Addressing Asthma Within a Coordinated School Health Program, With Updated Resources*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2006.
2. Splett PL, Erickson CD, Belseth SB, Jensen C. Evaluation and sustainability of the healthy learners asthma initiative. *Journal of School Health*. 2006;76(6):276-282.
3. Erickson CD, Splett PL, Mullett SS, Jensen C, Belseth SB. The healthy learner model for student chronic condition management-Part II: The Asthma Initiative. *Journal of School Nursing*. 2006;22(6):319-329.
4. National Asthma Education and Prevention Program. *Students with Chronic Illnesses: Guidance for Families, Schools and Students*. National Heart, Lung, and Blood Institute, 2002. Available at: <http://www.nhlbi.nih.gov/health/public/lung/asthma/guidfam.htm>. Accessed June 11, 2009.
5. Taras H, Duncan P, Luckenbill D, Robinson J, Wheeler L, Wooley S, eds. *Health, Mental Health, and Safety Guidelines for Schools*. Elk Grove Village, IL: American Academy of Pediatrics, 2004.
6. Wheeler LS, Merkle SL, Gerald LB, Taggart VS. Managing asthma in schools: lessons learned and recommendations. *Journal of School Health*. 2006;76(6):340-344.

## 2010 School Health Profiles Report

7. National Asthma Education and Prevention Program. *Resolution on Asthma Management at School*. National Heart, Lung, and Blood Institute, 2005. Available at: <http://www.nhlbi.nih.gov/health/public/lung/asthma/resolut.htm>. Accessed June 11, 2009.
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### QUESTIONS:

45. Has your school adopted a policy stating that students are permitted to carry and self-administer asthma medications?
46. Does your school have procedures to inform each of the following groups about your school's policy permitting students to carry and self-administer asthma medications?
47. At your school, who is responsible for implementing your school's policy permitting students to carry and self-administer asthma medication?

### RATIONALE:

These questions address the need for schools to have policies and procedures to support students in receiving the asthma medications they may need at school. Many students with asthma require preventive or quick-relief medicine at school. Students with asthma have had serious episodes and have died at school when they did not have access to quick-relief medicine.<sup>(1)</sup> Access to medications is critical and it must meet usual safety guidelines for medication storage.<sup>(2,3)</sup> To ensure compliance with federal, state, and many local laws and guidelines, schools should ensure that students have immediate access to asthma medications, as prescribed by a physician and approved by parents.<sup>(4)</sup> Several national guidance documents, along with evaluations of successful school-based asthma programs, have provided additional information that addresses the process and methods for self-carry policies. Policies should include medication storage in a safe, controlled, and accessible location, and appropriate attention should be given to expiration dates and safe disposal.<sup>(5-8)</sup>

### REFERENCES:

1. Greiling AK, Boss LP, Wheeler LS. A preliminary investigation of asthma mortality in schools. *Journal of School Health*. 2005;75 (8):286-290.
2. National Association of School Nurses. *Position Statement: Medication Administration in the School Setting*. 2003. Available at: <http://www.nasn.org/Default.aspx?tabid=230>. Accessed June 11, 2009.
3. American Academy of Pediatrics, Committee on School Health. Guidelines for the administration of medication in school. *Pediatrics*. 2003;112(3)697-699.

## 2010 School Health Profiles Report

4. CDC. *Strategies for Addressing Asthma Within a Coordinated School Health Program, With Updated Resources*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2006.
5. National Asthma Education and Prevention Program. *Students with Chronic Illnesses: Guidance for Families, Schools and Students*. National Heart, Lung, and Blood Institute, 2002. Available at: <http://www.nhlbi.nih.gov/health/public/lung/asthma/guidfam.htm>. Accessed June 11, 2009.
6. National Asthma Education and Prevention Program. *Resolution on Asthma Management at School*. National Heart, Lung, and Blood Institute, 2005. Available at: <http://www.nhlbi.nih.gov/health/public/lung/asthma/resolut.htm>. Accessed June 11, 2009.
7. National Asthma Education and Prevention Program. *When Should Students with Asthma or Allergies Carry and Self-Administer Emergency Medications at School? Guidance for Health Care Providers Who Prescribe Emergency Medications*. National Heart, Lung, and Blood Institute, 2005. Available at: [http://www.nhlbi.nih.gov/health/prof/lung/asthma/emmer\\_medi.htm](http://www.nhlbi.nih.gov/health/prof/lung/asthma/emmer_medi.htm). Accessed June 11, 2009.
8. National Association of School Nurses. *The Use of Asthma Rescue Inhalers in the School Setting*. 2005. Available at: <http://www.nasn.org/Default.aspx?tabid=202>. Accessed June 11, 2009.

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## FAMILY AND COMMUNITY INVOLVEMENT

### QUESTION(S):

48. During the past two years, have students' families helped develop or implement policies and programs related to each of the following topics?
49. During the past two years, have community members helped develop or implement policies and programs related to each of the following topics?

### RATIONALE:

These questions emphasize the importance of engaging family and community members in school health programs. Parent leaders help other parents understand and contribute ideas to issues and policies that affect the design and quality of school programs and opportunities for all children.<sup>(1)</sup> School programs that engage parents and link with the community yield stronger positive results. Studies aimed at preventing childhood overweight, treating childhood overweight, or promoting physical activity and healthy eating have demonstrated more success when targeting the parent and child versus targeting the child alone.<sup>(2,3)</sup> School-based tobacco prevention programs and community interventions involving parents and community

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organizations have a stronger impact over time when working in tandem rather than as separate, stand-alone interventions.<sup>(4)</sup> Collaboration with parent groups, community organizations, and other agencies can help to build broad-based support for school health programs, especially when they address topics that can be emotionally charged, such as HIV, other STD, and pregnancy prevention.<sup>(5)</sup> Without parental support of HIV, other STD, and pregnancy prevention education programs and policies, they cannot be sustained.<sup>(5-7)</sup> Collaborative asthma interventions require a team effort and involve the whole school community: school administrators, faculty, and staff, as well as students, parents, and local community organizations.<sup>(8,9)</sup>

### REFERENCES:

1. Epstein LS. *School, Family, and Community Partnerships: Preparing Educators and Improving Schools*. Boulder, CO: Westview Press, 2001.
2. Golan M, Crow S. Targeting parents exclusively in the treatment of childhood obesity: long-term results. *Obesity Research*. 2004;12:357-361.
3. Epstein LH, Voloski A, Wing RR, McCurley J. Ten-year outcomes of behavioral family-based treatment for childhood obesity. *Health Psychology*. 1994;13:373-83.
4. Lantz PM, Jacobson PD, Warner KE, et al. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control*. 2000;9:47-63.
5. Council of Chief State School Officers. Joint Work Group. *Essential tips for successful collaboration*. Washington, DC: Author, 2004.
6. Council of Chief State School Officers. *What Education Leaders Should Know About Forming Partnerships to Prevent Sexual-Risk Behaviors in School-Aged Youth*. Washington, DC: Author, 2005.
7. Kirby D, Laris BA, Roller L. *Sex and HIV education programs for youth: Their impact and important characteristics*. Washington, DC: Family Health International, 2006. Available at: <http://www.fhi.org/NR/rdonlyres/eg6dcdnypfc6lbcqd2jccju67o644svf3npgjtuagpsdimlkx7edlrojytwevjznjsfnkqflbak4hj/SexandHIVEducationProgramsKirby.pdf>. Accessed June 11, 2009.
8. National Asthma Education and Prevention Program. *Students with Chronic Illnesses: Guidance for Families, Schools and Students*. National Heart, Lung, and Blood Institute, 2002. Available at: <http://www.nhlbi.nih.gov/health/public/lung/asthma/guidfam.htm>. Accessed June 11, 2009.
9. Wheeler LS, Merkle SL, Gerald LB, Taggart VS. Managing asthma in schools: lessons learned and recommendations. *Journal of School Health*. 2006;76(6):340-344.

# **Teacher Item Rationale**



**2010 School Health Profiles Report**  
**Item Rationale**  
**Lead Health Education Teacher Survey**

**REQUIRED HEALTH EDUCATION COURSES**

**QUESTIONS:**

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

**RATIONALE:**

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

**REFERENCES:**

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

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**QUESTION:**

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

**RATIONALE:**

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

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### QUESTION:

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

### RATIONALE:

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

### REFERENCE:

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

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

### RATIONALE:

This question addresses the extent to which schools have a health education curriculum that is based on, or is consistent with, current national health education standards.<sup>(1)</sup>

### REFERENCE:

1. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2<sup>nd</sup> Edition)*. Atlanta, GA: American Cancer Society, 2007.
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### REQUIRED HEALTH EDUCATION

#### QUESTION:

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

#### RATIONALE:

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

#### REFERENCE:

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

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

#### RATIONALE:

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

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#### QUESTION:

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

#### RATIONALE:

This question measures the tobacco-use prevention curricula content, and relates to the *Healthy People 2010* Objective 7-2 of providing school health education to prevent health problems among middle, junior high, and high school students including those from tobacco use.<sup>(1)</sup> Since most smoking is initiated by persons less than 18 years old, programs that prevent onset of smoking during the school years are crucial.<sup>(2)</sup> School-based tobacco prevention programs that address multiple psychosocial factors related to tobacco use among youth and that teach the

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skills necessary to resist those influences have demonstrated consistent and significant reductions or delays in adolescent smoking.<sup>(2-9)</sup> Social influence programming has reduced smoking onset by as much as 50%, with effects lasting up to 6 years, and with effects including reduction of the use of other tobacco products as well.<sup>(4)</sup>

In addition, this question measures the extent to which schools are complying with the components of the National Health Education Standards, which provide a framework for decisions about the lessons, strategies, activities, and types of assessment to include in a health education curriculum.<sup>(10)</sup>

### REFERENCES:

1. U.S. Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2<sup>nd</sup> ed. Washington, DC: U.S. Government Printing Office, 2000.
2. U.S. Department of Health and Human Services. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.
3. U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2000.
4. Sussman S. School-based tobacco use prevention and cessation: where are we going? *American Journal of Health Behavior*. 2001;25(3):191-9.
5. Dent CW, Sussman S, Stacy AW, Craig S, Burton D, Flay BR. Two-year behavior outcomes of project towards no tobacco use. *Journal of Consulting and Clinical Psychology*. 1995;63(4):676-677.
6. Botvin GJ, Baker E, Dusenbury L, Botvin EM, Diaz T. Long-term follow-up results of a randomized drug abuse prevention trial in a white middle-class population. *Journal of the American Medical Association*. 1995;273(14):1106-1112.
7. Lantz PM, Jacobson PD, Warner KE, Wasserman J, Pollack HA, Berson J, Ahlstrom A. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control*. 2000;9:47-63.
8. Rooney BL, Murray DM. A meta-analysis of smoking prevention programs after adjustment for errors in the unit of analysis. *Health Education Quarterly*. 1996;23(1):48-64.
9. Bruvold WH. A meta-analysis of adolescent smoking prevention programs. *American Journal of Public Health*. 1993;83(6):872-80.

## 2010 School Health Profiles Report

10. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2<sup>nd</sup> Edition)*. Atlanta, GA: American Cancer Society, 2007.
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### QUESTION:

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

### RATIONALE:

These questions measure the HIV prevention curricula content. HIV and sex education programs can increase knowledge about how to avoid HIV and STD infection and unintended pregnancy. While knowledge provides a foundation for human action, knowledge alone is not sufficient to change behavior. Both knowledge and skills are important components of behavioral change.<sup>(1, 2)</sup> Thus, efforts to increase knowledge alone about modes of transmission and strategies for prevention do not directly lead to behavior change.<sup>(3)</sup> To reduce HIV, other STDs, and unintended pregnancy, programs must address perceptions of risk, intentions, communication, and skills, in addition to HIV and STD knowledge.<sup>(4)</sup>

Adolescents have different HIV prevention needs than do adults. However, because of the variability among youth with respect to cognitive and social maturity and sexual experience, interventions must be tailored to meet the unique needs of younger versus older youth or sexually naive versus experienced teens. HIV prevention interventions also have to be matched to the cognitive level of adolescents and should be designed to improve behavioral skills for risk reduction, decision making, planning, and problem solving.<sup>(5)</sup>

Part of a program's effectiveness involves its organization and presentation of activities and materials in an age appropriate and logical sequence. A typical logical sequence includes basic information about HIV, other STDs, and pregnancy, including susceptibility and severity of HIV, other STDs, and pregnancy; discussion of behaviors to reduce vulnerability; knowledge, values, attitudes and barriers related to these behaviors; and skills needed to perform these behaviors.<sup>(6)</sup> Messages in these effective programs are appropriate to the age, sexual experience, gender and culture of the youth.<sup>(4)</sup>

### REFERENCES:

1. Ajzen I. From intention to actions: A theory of planned behavior. In: Kuhl J, Beckman J, eds. *Action control from cognition to behavior*. New York: Springer-Verlag, 1985, pp. 11-29.
2. Bandura A. *Social foundations of thought and action*. Englewood Cliffs, NJ: Prentice Hall, 1986.

## 2010 School Health Profiles Report

3. Coyle SL, Boruch RF, Turner CF, eds. *Evaluating AIDS prevention programs, Expanded Edition*. Washington, DC: National Academy Press, 1991.
  4. Kirby D, Laris BA, Roller L. *Sex and HIV education programs for youth: Their impact and important characteristics*. Washington DC: Family Health International, 2006.  
Available at:  
<http://www.fhi.org/NR/rdonlyres/eg6dcdnypfc6lbcdq2jccju67o644svf3npgjtuagpsdimlkx7edlrojtwevjznjsfnkqflbak4hj/SexandHIVEducationProgramsKirby.pdf>. Accessed June 11, 2009.
  5. Pedlow CT, Carey MP. Developmentally appropriate sexual risk reduction interventions for adolescents: rationale, review of interventions, and recommendations for research and practice. *Annals of Behavioral Medicine*. 2004;27(3):172-184.
  6. Kirby D, Roller L, Wilson MM. *Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs*. Washington, DC: Healthy Teen Network, 2007.
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### QUESTION:

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

### RATIONALE:

This question measures the curricula content related to nutrition and dietary behavior. Comprehensive, sequential nutrition education using the classroom and the lunchroom can reinforce healthful eating behaviors.<sup>(1, 2)</sup> Nutrition education should be part of a comprehensive school health education curriculum and include concepts to promote healthy eating.<sup>(3, 4)</sup> This list of 15 nutrition topics is based on CDC guidelines<sup>(5)</sup> and the *School Health Index*.<sup>(6)</sup>

### REFERENCES:

1. Food and Nutrition Board, Institute of Medicine, Committee on Prevention of Obesity of Children and Youth, Schools. In: JP Koplan, CT Liverman and VI Kraak, eds. *Preventing Childhood Obesity: Health in the Balance*. Washington, DC: National Academy Press, 2005, pp. 237–284.
2. American Dietetic Association, Society for Nutrition Education, and American School Food Service Association. Nutrition services: an essential component of comprehensive school health programs. *Journal of Nutrition Education and Behavior*. 2003;35(2):57-67.

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3. Ralston K, Buzby J, Guthrie J. *A Healthy School Meal Environment*. United States Department of Agriculture, Economic Research Service, Food Assistance and Nutrition Research Report Number 34-5, 2003. Available at: <http://www.ers.usda.gov/publications/fanrr34/fanrr34-5/fanrr34-5.pdf>. Accessed June 8, 2009.
  4. U.S. Department of Agriculture. *Changing the Scene: Improving the School Nutrition Environment*. 2000. Available at: <http://www.fns.usda.gov/tn/Resources/changing.html>. Accessed June 8, 2009.
  5. CDC. Guidelines for school health programs to promote lifelong healthy eating. *MMWR*. 1996;45(RR-9):1-33.
  6. CDC. *School health index*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006. Available at: <http://www.cdc.gov/healthyyouth/shi>. Accessed June 8, 2009.
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### QUESTION:

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

### RATIONALE:

This question measures the extent to which physical activity concepts are taught in a required health education course. Health education that includes physical activity concepts increases the likelihood of students increasing their participation in physical activity,<sup>(1)</sup> reinforces what has been taught in physical education,<sup>(2)</sup> and assists students in achieving the National Health Education Standards.<sup>(3)</sup>

### REFERENCES:

1. Hoelscher D, Feldman H, Johnson C, et al. School-based health education programs can be maintained over time: results from the CATCH institutionalization study. *Preventive Medicine*. 2004;38(5):594-606.
  2. Pate RR, Davis MG, Robinson TN, Stone EJ, McKenzie TL, Young JC. Promoting physical activity in children and youth: a leadership role for schools. *Circulation*. 2006;114:1-11.
  3. The Joint Committee on National Health Education Standards. *National Health Education Standards: Achieving Excellence (2<sup>nd</sup> Edition)*. Atlanta, GA: American Cancer Society, 2007.
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### HIV PREVENTION

#### QUESTION:

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

#### RATIONALE:

This question measures whether a school addresses HIV, other STD, and pregnancy prevention through targeted efforts reaching those identified as most at-risk. Risk for HIV infection is especially notable for youth of minority races and ethnicities. African-Americans are the largest group of people affected by HIV/AIDS, accounting for 51% of all HIV/AIDS cases diagnosed in 2007.<sup>(1)</sup> And, although only 17% of teenagers (ages 13-19) in the United States are African-Americans, they accounted for 72% of new HIV/AIDS cases diagnosed in 34 states with confidential name-based reporting among teens in 2007.<sup>(2)</sup> In 2004, HIV/AIDS was the number one cause of death for African-American women aged 25-34 years and the number three cause of death for all African-Americans aged 35-44.<sup>(3)</sup> In addition, the HIV/AIDS epidemic is a serious threat to the Hispanic/Latino community. Hispanics/Latinos comprise 15% of the U.S. population, but accounted for 17% of all new HIV infections occurring in the United States in 2006. During the same year, the rate of new HIV infections among Hispanics/Latinos was three times that of whites.<sup>(4)</sup>

Data from CDC's 2007 National Youth Risk Behavior Survey (YRBS) show that, compared with white students and Hispanic/Latino students, black students have the highest rates of several sexual risk behaviors: 66.5% of black students had ever had sexual intercourse, compared with 43.7% percent of white students and 52.0% of Hispanic/Latino students; 46.0% of black students were currently sexually active (i.e., had sexual intercourse with 1 or more persons during the 3 months preceding the survey), compared with 32.9% of white students and 37.4% of Hispanic/Latino students; 16.3% of black students had had sexual intercourse before age 13 years, compared with 4.4% of white students and 8.2% of Hispanic/Latino students; and 27.6% of black students had had sexual intercourse with 4 or more persons during their life, compared with 11.5% of white students and 17.3% of Hispanic/Latino students.<sup>(5)</sup>

In addition to effective curricula, access to valid information and products, as well as access or referral to health, social, and psychological services to prevent HIV, other STDs, and pregnancy are especially important in ethnic/racial minority communities where the higher prevalence of HIV, other STDs, and pregnancy reflects both risky adolescent sexual behaviors and system barriers to quality prevention services.<sup>(6)</sup> Factors which may influence adolescents' access to care include health insurance, cost, convenience, confidentiality, and demographic factors such as age, gender, and ethnicity.<sup>(7-9)</sup>

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### REFERENCES:

1. CDC. *HIV/AIDS Surveillance Report, 2007*. Vol. 19. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2009. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2007report/pdf/2007SurveillanceReport.pdf>. Accessed June 8, 2009.
  2. CDC. *HIV/AIDS Surveillance in Adolescents and Young Adults (through 2007)*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2009. Available at: <http://www.cdc.gov/hiv/topics/surveillance/resources/slides/adolescents/index.htm>. Accessed June 8, 2009.
  3. Heron MP. Deaths: Leading causes for 2004. *National Vital Statistics Reports*. 2007;56(5):1-96.
  4. Hall HI, Song R, Rhodes P, et al. Estimation of HIV incidence in the United States. *JAMA*. 2008;300:520-529.
  5. CDC. Youth risk behavior surveillance—United States, 2007. *MMWR*. 2008;57(SS-4):1-131.
  6. Gilliland L, Scully, J. STI-HIV prevention: a model program in a school-based health center. *Nursing Clinics of North America*. 2005;40:681-688.
  7. Ginsburg KR, Slap GB, Cnaan A, et al. Adolescents' perceptions of factors affecting their decisions to seek future healthcare. *JAMA*. 1995;273:1913-8.
  8. Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE. Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future healthcare. *JAMA*. 1997;278:1029-34.
  9. Lieu T, Newacheck P, McManus M. Race, ethnicity, and access to ambulatory care among U.S. adolescents. *American Journal of Public Health*. 1993;83:960-5.
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### QUESTION:

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

### RATIONALE:

This question assesses whether the school uses inclusive curricula or supplementary materials for lesbian, gay, bisexual, transgender, and questioning youth. Some students who engage in same-sex sexual behavior are at greater risk for HIV, STD, and unintended pregnancy.<sup>(1)</sup> Furthermore, research indicates reduced risk behaviors for some lesbian, gay, and bisexual youth when using inclusive HIV instruction in schools.<sup>(2)</sup>

### REFERENCES:

1. Garofalo R, Katz E. Health care issues of gay and lesbian youth. *Current Opinion in Pediatrics*. 2001;13(4):298-302
2. Blake SM, Ledsy R, Lehman T, Goodenow C, Sawyer R, Hact T. Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: the benefits of gay-sensitive HIV instruction in schools. *American Journal of Public Health*. 2001;91(6):940-946.

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## COLLABORATION

### QUESTION:

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

### RATIONALE:

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

### REFERENCE:

1. Allensworth D, Kolbe L. The comprehensive school health program: state of the art. *Journal of School Health*. 1987;63:14–20.

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### QUESTION:

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

### RATIONALE:

This question measures whether schools are providing health information to students' families. School programs that engage parents and link with the community yield stronger positive results. Studies aimed at preventing childhood overweight, treating childhood overweight, and promoting physical activity and healthy eating have demonstrated more success when targeting the parent and child versus targeting the child alone.<sup>(1, 2)</sup> School-based tobacco prevention programs and community interventions involving parents and community organizations have a stronger impact over time when working in tandem rather than as separate, stand-alone interventions.<sup>(3)</sup> Assessments of successful school-based asthma management programs indicate that with increased knowledge, parents can assist their children in better managing their asthma.<sup>(4-6)</sup> Parents also are teenagers' primary sex educators, able to capitalize on teachable moments when youth may be more open to learning new information.<sup>(7)</sup> Parents can continue prevention messages delivered in school, thereby enhancing the likelihood of sustained behavioral changes.<sup>(8)</sup> Increased communication affects both parenting and health practices of parents. Communicating information on healthy lifestyles aims to reinforce the child's coursework at school, facilitate communication with parents about school activities, and increase parent knowledge of healthy living.<sup>(9, 10)</sup>

### REFERENCES:

1. Golan M, Crow S. Targeting parents exclusively in the treatment of childhood obesity: long-term results. *Obesity Research*. 2004;12:357-361.
2. Epstein LH, Voloski A, Wing RR, McCurley J. Ten-year outcomes of behavioral family-based treatment for childhood obesity. *Health Psychology*. 1994;13:373-83.
3. Lantz PM, Jacobson PD, Warner KE, Wasserman J, Pollack HA, Berson J, Ahlstrom A. Investing in youth tobacco control: a review of smoking prevention and control strategies. *Tobacco Control*. 2000;9:47-63.
4. Splett PL, Erickson CD, Belseth SB, Jensen C. Evaluation and sustainability of the healthy learners asthma initiative. *Journal of School Health*. 2006;76(6):276-282.
5. Erickson, CD, Splett PL, Mullett SS, Jensen C, Belseth SB. The healthy learner model for student chronic condition management-Part II: The Asthma Initiative. *Journal of School Nursing*. 2006;22(6):319-329.
6. Levy M, Heffner B, Stewart T, Beeman G. The efficacy of asthma case management in an urban school district in reducing school absences and hospitalizations for asthma. *Journal of School Health*. 2006;76(6):320-324.

## 2010 School Health Profiles Report

7. Szapocznik J, Coatsworth JD. An ecodevelopmental framework for organizing risk and protection for drug abuse: A developmental model of risk and protection. In: Glantz M, Hartel CR, eds. *Drug Abuse: Origins and Interventions*. Washington, DC: American Psychological Association, 1999, pp. 331-366.
  8. Pequegnat W, Szapocznik J. The role of families in preventing and adapting to HIV/AIDS: Issues and answers. In: Pequegnat W, Szapocznik J, eds. *Working with families in the era of HIV/AIDS*. Thousand Oaks, CA: Sage Publications, 2000.
  9. Nader PR, Sellers De, Johnson CC, Perry CL, Stone EJ, Cook KC, Bebchuk J, Luepker RV. The effect of adult participation in a school-based family intervention to improve children's diet and physical activity: the Child and Adolescent Trial for Cardiovascular Health. *Preventive Medicine*. 1996;25:455-464.
  10. Perry CL, Luepker RV, Murray DM, Kurth C, Mullis R, Crockett S, Jacobs DR. Parent involvement with children's health promotion: the Minnesota Home Team. *American Journal of Public Health*. 1988;78(9):1156-1160.
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## PROFESSIONAL DEVELOPMENT

### QUESTION:

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

### RATIONALE:

This question measures the extent to which professional development has been received by the lead health teacher responsible for teaching about HIV/AIDS. As new information and research on prevention is available, those responsible for teaching about HIV/AIDS should periodically receive continuing education about HIV and other STD infections to assure they have the most current information about how widespread HIV and other STDs are, effective prevention and health education intervention strategies, and priority populations identified as most at-risk for HIV and other STD infection.<sup>(1-3)</sup>

Effective implementation of school health education is linked directly to adequate teacher training programs.<sup>(4)</sup> School health education designed to decrease students' participation in risk behaviors requires that teachers have appropriate training to develop and implement school health education curricula.<sup>(4)</sup> Staff development activities for health education teachers need to focus on teaching strategies that both actively engage students and facilitate their mastery of critical health information and skills.<sup>(5)</sup>

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### REFERENCES:

1. Kirby D, Laris BA, Rolleri L. *Sex and HIV education programs for youth: Their impact and important characteristics*. Washington, DC: Family Health International, 2006. Available at: <http://www.fhi.org/NR/rdonlyres/eg6dcdnypfc6lbcq2jccju67o644svf3npgjtuagpsdimlkx7edlrojytwevjznjsfnkqflbak4hj/SexandHIVEducationProgramsKirby.pdf>. Accessed June 11, 2009.
  2. Center for AIDS Prevention Studies (CAPS) and the AIDS Research Institute, University of California, San Francisco. *What Works Best in Sex/HIV Education?* San Francisco: University of California San Francisco, 2006.
  3. Council of Chief State School Officers. *What Education Leaders Should Know About Forming Partnerships to Prevent Sexual-Risk Behaviors in School-Aged Youth*. Washington, DC: Author, 2005.
  4. Allensworth, D. Health education: state of the art. *Journal of School Health*. 1993;63:14–20.
  5. National Commission on the Role of the School and the Community to Improve Adolescent Health. *Code Blue: Uniting for Healthier Youth*. Alexandria, VA: National Association of State Boards of Education, 1990.
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### QUESTIONS:

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

### RATIONALE:

These questions address the importance of professional development for teachers. It is vitally important that teachers be well prepared when they begin teaching and that they continue to improve their knowledge and skills throughout their careers.<sup>(1)</sup> Educators who have received professional development in health education report increases in the number of health lessons taught and their confidence in teaching.<sup>(2)</sup> Professional development increases educators'

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confidence in teaching subject matter and provides opportunities for educators to learn about new developments in the field and innovative teaching techniques, and to exchange ideas with colleagues.<sup>(3,4)</sup> Districts that have made improvements in their professional development activities have seen a rise in student achievement.<sup>(5,6)</sup> Staff development is associated with increased teaching of important health education topics.<sup>(7)</sup> The Institute of Medicine's Committee on Comprehensive School Health Programs in Grades K-12 recommended that health education teachers should be expected to participate in ongoing, discipline-specific in-service programs in order to stay abreast of new developments in their field.<sup>(8)</sup>

### REFERENCES:

1. Public Education Network. *Teacher Professional Development: A Primer for Parents and Community Members*. Washington, DC: Public Education Network, 2004.
  2. Hausman A, Ruzek S.. Implementation of comprehensive school health education in elementary schools: focus on teacher concerns. *Journal of School Health*. 1995;65(3):81-86.
  3. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.
  4. National Association of State Boards of Education (NASBE) & National School Boards Association (NSBA). *HIV Prevention in Schools: A Tool Kit for Education Leaders*. 2002. Available at: <http://nasbe.org/index.php/file-repository?func=startdown&id=787>. Accessed June 12, 2009.
  5. Togneri W, Anderson SE. *Beyond Islands of Excellence: What Districts Can Do to Improve Instruction and Achievement in all Schools*. Washington, DC: Learning First Alliance, 2003.
  6. Miles KH, Darling-Hammond L. *Rethinking the Allocation of Teaching Resources: Some Lessons From High-Performing Schools*. Philadelphia: Consortium for Policy Research in Education, 1997.
  7. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education*. 2004;35:2-10.
  8. Institute of Medicine. *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press, 1997.
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### PROFESSIONAL PREPARATION

#### QUESTIONS:

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

#### RATIONALE:

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

#### REFERENCES:

1. National Commission on the Role of the School and the Community to Improve Adolescent Health. *Code Blue: Uniting for Healthier Youth*. Alexandria, VA: National Association of State Boards of Education, 1990.
  2. Jones SE, Brener ND, McManus T. The relationship between staff development and health instruction in schools in the United States. *American Journal of Health Education*. 2004;35:2-10.
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