

Addressing Sexual Health in Schools: Policy Considerations

BY DANENE SORACE, MPP

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Debra Hauser, President

Advocates for Youth is dedicated to creating programs and advocating for policies that help young people make informed and responsible decisions about their sexual and reproductive health. Advocates provides information, training, and strategic assistance to youth-serving organizations, youth activists, policy makers, and the media in the United States and developing nations.

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Preface

Addressing Sexual Health in Schools: Policy Considerations brings together years of policy, research and advocacy efforts illuminating the need for young people to have access to the sexual health education and services they need to ensure their overall health and well-being. In recent years, many states and/or local school districts have adopted policies in support of sexual health education, and an increasing number of schools are establishing linkages and referrals to health service providers. To further support the adoption and implementation of policies addressing sexual health in schools, this compendium of policy considerations was developed as a technical resource for schools.

In the development of this resource, a list of potential policies addressing both sexual health education and access to services was generated and disseminated among a diverse group of national, state and local health and education professionals in the spring of 2012. Over the ensuing months, this initial list of potential policies was vetted for relevance and completeness. Next began the task of describing each policy consideration and identifying sample resources beginning with individual state policies that address sexual health education and access to sexual and reproductive health services utilizing the National Association of State Boards of Education's State School Health Policy Database. Within states, specific school district policies were identified and from this review, a set of policies emerged addressing policy considerations ranging from parental rights and involvement to the provision of sexual and reproductive health services.

It is important to note that many of the policy considerations presented here reflect current practice and not scientific research. Currently, there is a lack of evaluation addressing school-based sexual health policies with a few exceptions. Given this limitation, the policy considerations included here are just that – considerations. Further, there are gaps between practices that were identified during this process including the limited connections between sexual health education (i.e., curriculum, teacher training) and sexual and reproductive health services available within schools or communities.

In addition, access to sexual and reproductive health services in schools is limited. While there are 1,900 school-based or school-linked health centers in the United States, this represents less than 2 percent of all schools nationwide and many of school-based or school-linked do not offer sexual

and reproductive health services.^{1 2} There is still considerable work to be done to not only increase the number of school-based health centers and the number that offer sexual and reproductive health services but also capitalize on the existing school health infrastructure including school nurses, counselors and professional support services to provide sexual and reproductive health services. To support staff in providing these services, they need training and assistance in developing a robust linkage and referral process for sexual and reproductive health services. Finally, students themselves need to know how to identify and access reliable sexual health information and services.

Despite these limitations and current gaps, there is a great deal schools can do to address the sexual health needs of their students.

Introduction

Because human sexuality is a normal, natural part of human development and there are significant biological, social and emotional milestones that occur during the school-age years, schools will invariably be dealing with sexuality-related issues among their student population. When it comes to addressing sexual health education for students in grades K-12 as well as access to sexual and reproductive health services for older students, school leadership may:

- have concerns about potential controversy in establishing a K-12 sexuality education curriculum or access to services for older students
- recognize the need but may not have the resources or expertise readily available
- feel that sexuality education and access to services is not a priority or a role that schools should play.

All of these concerns are legitimate but they do not negate the need, or resulting consequences, for school administrators, teachers and other staff, students, parents and communities that opt for a “do little or nothing approach.” A school’s chief focus is on educational progress, and student health is a significant contributor to overall educational attainment. Simply put, “healthier students are better learners.”³ As such the primary goal of this document is to offer a resource to schools as they consider providing sexual health education and access to services in the school setting.

Developing a pro-active approach to sexual health education and services in schools, a component of a coordinated school health initiative, often begins with policy. Clear, consistent policies regarding K-12 sexuality education and access to sexual and reproductive health services for older students are essential in creating a school culture and climate that embraces the health and well being of students. To that end, this document was created as a resource to assist in developing:

- a planned, sequential K-12 sexuality education curriculum that is part of a school health education approach which addresses age-appropriate physical, mental, emotional and social dimensions of human sexuality
- a system for providing, linking or referring older students to sexual and reproductive health services

For the purposes of this resource, school policies refer to district level policies adopted by a board

of education and subsequent school administrative regulations and procedures to implement the policy. As such, key audiences for this resource include local school boards and local education agencies including administrators, teachers, school nurses and other relevant staff as well as parents, students and communities charged with formulating and/or implementing school policies that meet the needs of their communities and align with current practices. Local policy makers will need to vet each policy consideration against existing federal, state and local policies to ensure that they are not in conflict with one another. Please note that this resource is a guide and should not be a substitute for legal counsel. Legal counsel should be sought at the appropriate time to assure compliance with other state and/or local policies and regulations.

State education agencies and non-governmental organizations can also use this document to: (1) consider how best to provide sexual health education and access to sexual and reproductive health services in schools; (2) inform associated regulatory or procedural requirements pertaining to existing law; or (3) provide local education agencies with information for those decision-makers to consider policy alignment with applicable state and federal law; and their adoption and implementation through technical assistance and training.

Rationale for Sexual Health Education and Access to Sexual and Reproductive Health Services

From the earliest days of formal education, public schools were recognized as important vehicles for promoting health.⁴ Today, schools remain a crucial component in the advancement of public health goals – including sexual health – given that:

(1) the majority of children and youth attend public institutions of education. Nearly 50 million students in grades K-12 attend some 13,600 public schools across the United States.⁵

(2) all children and youth will grow and develop physically, emotionally and socially as it relates to their sexual development.

(3) health and educational achievement are inextricably linked. Children with poor health are more likely to be absent from school, tardy or have poorer academic achievement in contrast to healthier students. Student health also impacts school drop out.^{6 7 8 9}

(4) the status of adolescent sexual health in the United States is poor in contrast to other industrialized nations.¹⁰ Each year in the US, nearly 740,000 women ages 15-19 become pregnant an additional 13,000 girls under the age of 15 become pregnant.¹³ While young people in the US ages 15-25 make up only one-quarter of the sexually active population, they contract about half of all sexually transmitted disease each year.¹⁴ HIV infection among young people ages 13-24 account for one in four of the estimated 50,000 new HIV infections each year.¹⁵

To further understand health risk-taking behavior among U.S. students, the Centers for Disease Control and Prevention’s Youth Risk Behavior Surveillance System (YRBSS) surveys a random sample of U.S. students about their health risk behaviors. Conducted every two years, and most recently in 2011, the Youth Risk Behavior Study reported that among students in grades 9-12 nationwide:

- 47 percent ever had sexual intercourse. Of these, 15 percent had intercourse with four or more partners during their life
- Nearly 34 percent are currently sexually active. Of these, 22 percent had consumed alcohol or used drugs before last sexual intercourse
- Nearly 10 percent had been hit, slapped or physically hurt on purpose by their boyfriend or girlfriend.¹⁸

In addition to the Centers for Disease Control and Prevention’s national Youth Risk Behavior Survey

(YRBS), 43 states and 21 large urban school districts administered their own surveys in 2011. To find out specific state or large school district data, please visit the [CDC’s Youth Online Interactive Data Tables](#) where queries can be done by site or health topic and across years.

Additionally, the Guttmacher Institute’s [Facts on American Teens’ Sexual and Reproductive Health](#) provides a summary of statistics about sexual activity, pregnancy, childbearing and other relevant data.

The policy considerations that follow are based on both the opportunity and need outlined above.

A CLOSER LOOK: TEEN PREGNANCY AND ACADEMIC ACHIEVEMENT

In regard to sexual health, there is probably no better or more understood example of the intersection of sexual health and academic achievement than teen pregnancy. Teen pregnancy often takes a particular toll on school connectedness for both partners, representing a major disruption in many teens’ lives and making it difficult to remain in and/or engaged in school. Pregnant and parenting teens have lower grades and higher dropout rates than their non-parenting peers.¹⁶ In fact, research shows that only 51 percent of pregnant and parenting teens graduate from high school as compared to 89 percent of their non-pregnant and parenting peers.¹⁷

Why is Policy Important?

A policy, in general, is a law, regulation, procedure or administrative action to advance a desired outcome. Relative to sexual health, the desired results are young people who have the information, education and skills to make healthy, responsible decisions and access sexual and reproductive health services.

In the area of sexual health education, policies often state whether sexuality or HIV education is required, how it is provided (e.g., medically accurate, comprehensive, age-appropriate) and who is providing it (e.g., trained, qualified professionals), the role of parents and course content. With access to services, policies include information as to when, how and by whom referrals are made as well as what services are available from what sources.

There are many benefits to having a clear, consistent set of school district policies pertaining to sexual health education and access to sexual and reproductive health services. They can:

- Meet a critical need among students
- Signal recognition that the health status of students is interrelated to academic achievement

- Provide direction and promote consistency. When a policy is incomplete or unclear, staff may not take suitable action to advance the well-being of students or may adopt practices that while well intentioned, may be inappropriate
- Mitigate controversy. Ideally, through the process of developing and revising school policies, decisions are made and a rationale is articulated regarding the district's decision to provide sexual health instruction as well as access to services that alleviates fear and mitigates controversy
- Ensure accountability and institutionalization of sexual health education and ongoing access to services

Well-thought out policies for school-based sexual health education and access to services developed collaboratively with parents, educators, administrators, students and other community members can ensure that the policies reflect the needs of students and the values of the community. An inclusive, thoughtful process to develop sexual health policies not only alleviates concerns but also can build lasting community support.

Understanding Policy Parameters

Before undertaking a policy review process at the local level, it is important to understand your state's existing policies. What is already required? Are your school district's policies currently in compliance with state law? What, if any, mechanisms for accountability to ensure that policies are being adhered to are in place?

SEXUAL HEALTH EDUCATION

Twenty states and the District of Columbia mandate both sexuality and HIV education. Two states mandate only sexuality education. Thirty-three states mandate HIV education.¹⁹ Additionally, about half of the states require parental notification and many others have specific content requirements (e.g., stressing abstinence, including information about contraception).²⁰

The majority of states have policies pertaining to School Health Advisory Committees (SHACs), advisory boards or other councils.²¹ SHACs are typically composed of key community stakeholders such as parents, clergy, school health professionals, students and teachers to support a district's overall health and wellness activities by providing guidance relative to policy and curricula review, selection, adoption and implementation. According to the 2006 School Health Policies and Programs Study (SHPPS), a national survey conducted by the Centers for Disease Control and Prevention's Division of Adolescent and School Health to assess school health policies and practices, nearly 75 percent of school districts have one or more school health councils.²²

To learn more about your state's laws, see:

- [National Association of State Boards of Education State School Health Policy Database](#) can provide detailed information about your state's laws pertaining to health education including HIV, STD and pregnancy prevention as well as graduation requirements for health education.
- [Sexuality Information and Education Council of the US \(SIECUS\) State Profiles](#). This resource provides detailed summaries of state laws as well as a summary of federal funding supporting implementation of sexuality education in specific states.
- [State Policies in Brief, Sex and HIV Education](#), published by the Guttmacher Institute and updated monthly, is an overview of state laws pertaining to sex and HIV education.

In addition to state law, state educational standards and other regulations (e.g., required professional development hours or approved materials or programs) also provide a framework for local districts in making policy decisions. Each state is unique with regard to standards and other regulations. Local school districts are not only challenged to enact policies that comply with state law but also to operationalize state laws, standards and other regulations into a meaningful, coherent policy framework that can be readily understood and implemented at a local level. For example, although many states require schools to provide medically accurate sexuality education, it is often up to local school districts to define what this means. The policy considerations here are intended to help local school districts meet their state policy requirements.

To learn more about your state's standards, visit your state's department of education website and search for health education standards. Sexual health education is typically embedded within health education standards. However, sexual health standards may also be found in other content areas like science, family and consumer science or cultural studies.

Other regulations applicable to sexual health education can also be clarified through your state department of education. You may need to speak to more than one individual within the state department of education. Sexual health education is typically divided among academic standards and instruction, health and medical services, student support services and possibly teacher licensing and professional development.

Some states and local school districts have a staff person who is designated as the HIV Prevention Coordinator. Funded by the Centers for Disease Control and Prevention's Division of Adolescent School Health, these individuals work to support sexual health education and access to services. To identify yours, visit:

- Division of Adolescent and School Health, Centers for Disease Control and Prevention <http://www.cdc.gov/healthyouth/partners/index.htm>

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

All states allow for the provision of health care services in school settings. Some states require specific health services (e.g., vision and hearing screening) while other states prohibit specific

health services (e.g., dispensing of contraceptives). Most states have no policy or neither require or prohibit HIV, STD and pregnancy testing and counseling. Typically, decisions regarding other health services to be offered to students and their provision, linkages to services and/or referrals are the purview of the local school boards.²³ To understand more about your state's school health services' policies:

- The Center for Health and Health Care in Schools has developed a [compendium of laws, rules, regulations and guidelines for school health by state](#). Inclusive of all health services typically provided by schools, the compendium provides a useful context for the level of services provided to public school students by state. Sexual and reproductive health services are typically not included reflecting the perceived controversial nature of providing these services within schools and a lack of model policies given that many situations arise in schools that require, at a minimum, referral to a sexual and reproductive health care provider.

Understanding Local Policy Process

At the school district level, K-12 public schools are generally governed by local school boards (with the exception of Hawaii which does not have a local school board system). Local school boards are typically composed of 5 to 7 members who elected by the public or, in some cases, appointed by other government officials. School boards can provide critical support and leadership concerning sexual health education and access to sexual and reproductive health services.

Local school boards are responsible for ensuring that each school in their district is in compliance with the laws and policies set by the state and federal government. Generally, they entrust the day-to-day operations of their district to the district superintendent and typically are responsible for hiring, supervising, and when necessary, disciplining or firing the superintendent. Local school boards also have broad decision and rule-making authority with regards to the operations of their local school district, including determining the school district budget and priorities; curriculum decisions such as the scope and sequence of classroom content in all subject areas; and textbook approval authority.²⁴

- [How Schools Work & How to Work with Schools: A Primer for Professionals who Serve Children and Youth](#). Developed by the National Association of State Boards of Education, this resource provides a framework for understanding public education and how best to partner with schools to promote student health.

As mentioned above, SHACs are required or encouraged in a majority of states and the District of Columbia. Some states require a specific composition of members (e.g., parents, clergy, health educator, etc.) SHACs are beneficial in informing policies and practices and reviewing curricula, materials and other resources pertaining to sexuality and HIV/STD and pregnancy prevention. Members of a SHAC can also advocate on behalf of sexual health education and access to sexual and reproductive health services and ensure that appropriate resources are available to support implementation and ensure accountability.

- [Promoting Healthy Youth, Schools and Communities: A Guide to Community School Health Councils](#). Published by the American Cancer Society, this resource provides a step-by-step guide to developing a school health advisory council.

- [Effective School Health Advisory Councils: Moving from Policy to Action](#). Developed by the North Carolina Healthy Schools and Public Schools of North Carolina this “how-to” manual was developed to assist in developing or revitalizing an existing SHAC.
- [Putting It All Together: Program Guidelines and Resources for State Mandated HIV/AIDS Prevention Education in California Middle and High Schools](#). While specific to California, this guide to planning and implementing an HIV/STD prevention program outlines nine components of a successful program applicable to any school district.
- [School Health Advisory Council: A Guide for Texas School Districts](#). This guide, also state specific, answers common questions about SHACs including their purpose and structure as well as how to conduct effective meetings.

Policy Overview: Sexual Health Education

While each school district is unique in terms of its student population, community and resources, all schools teach students who are growing and developing physically, emotionally and socially as it relates to their sexual development. As such, it is suggested that schools consider adopting a set of policies to help guide staff in the provision of sexual health education that is:

- Planned, age- and developmentally-appropriate and sequential for students in K-12
- Part of a larger coordinated school health initiative
- Inclusive of physical, mental, emotional and social dimensions of human sexuality
- Focused on improving knowledge and skill-building to help students maintain and improve their sexual health by delaying sexual initiation, reducing sexual health-related risk behaviors, and preventing disease and pregnancy.
- Aligned with state and national health education standards and the [National Sexuality Education Standards: Core Content and Skills, K-12](#).
- Developed and implemented in conjunction with parents, staff, students, administrators and other community members
- Medically-accurate and bias free
- Evidence-based or evidence-informed²⁵

If a plan of instruction is implemented, it is recommended that local boards of education review it periodically using data such as information about student knowledge and behavior; the latest scientific information; and research about effective education strategies. It is further useful to regularly assess the curricula and materials for medical accuracy, completeness and consistency with the state's/district's educational goals and standards, and alignment to the relevant state and national standards.

Ideally, staff responsible for sexual health education will have the requisite knowledge and skills to effectively deliver sexual health education and can involve parents by offering information about the program and opportunities for them to engage in the instructional program.

Below are two example policies that reflect the above policy elements:

- [Oregon School Boards Association Selected Sample Policy](#)
- [Austin Independent School District](#)

PARENTAL RIGHTS AND INVOLVEMENT

Parents and guardians are critical partners in education, especially sexual health education. As such, parents are typically notified when sexual health education will occur, informed about what course material will be provided, and given the opportunity to review curricula and to excuse their child from instruction without penalty for all or part of the instruction.

Below is a summary of policy options pertaining to parental rights.

PARENTAL NOTIFICATION

Twenty-two states and the District of Columbia require schools to notify parents/guardians before students receive sexuality education.²⁶ Typically, parental notification occurs in tandem with an opportunity for parents to review curricula and materials, participate in a parent education workshop and opt their child in or out of sexual health instruction (see below).

PARENTAL CONSENT

Parents typically have two ways to consent to their child's participation in sexual health education: passive consent (i.e., opt-out) or active consent (i.e., opt-in). Passive consent or opt-out provisions require a parent or guardian to notify the school district if they do not want their child to participate in sexuality education instruction. Otherwise, the student will receive instruction. Thirty-five states and the District of Columbia have opt-out provisions.²⁷

Active consent or opt-in provisions require parents to affirmatively give consent for their child to participate in sexuality education. Only three states require active parental consent for sexual health instruction.²⁸ Typically, a permission form is sent home with the student at the beginning of the school year or two weeks in advance of instruction requiring parents to authorize their child to attend a class(es) devoted to sexual health education. The form often provides parents the option to allow their child to attend all, some or none of the sexuality education instruction.

If a parent elects to withdraw their child from some or all of sexual health instruction, some districts may require parents to review course material or provide instruction at home. Students whose parents opt them out of sexuality education instruction may be required to complete an alternate assignment and remain in school.

Below are sample policies and parental notification letters:

- **Folsom Cordova Unified School District** (CA) provides a handbook on parental rights and responsibilities highlighting state requirements for notification, review and procedure for opting their child out of sexual health and HIV/AIDS instruction.
- **Milford Public Schools** (MA) policy addresses parental notification and opt-in and provides sample letter to parents with provision to provide alternate assignment should a parent withdraw their student from sexuality/HIV education.
- **New York City Department of Education**, as mandated by New York State, requires parents to provide instruction within their home if a parent/guardian chooses to opt a student out of sexuality/HIV education.
- **Clear Creek Amana School District** (IA) requires parents to review the curriculum before opting a student out and specifically list the objectives to which a parent objects.

CURRICULUM REVIEW

Allowing parents/guardians to review sexuality education curriculum in advance can often allay concerns they may have about the age-appropriateness of content. During the parental notification process, parents may be invited to attend an open house to review content and teaching strategies, participate in a parent workshop, or schedule a time to review curricula at the school district offices.

PARENTAL INVOLVEMENT AND FAMILY ENGAGEMENT

Parents are key partners in education as voters, advocates, volunteers and consumers of public education. There is a growing body of research linking parent/family engagement with learning outcomes and more focused attention being paid to developing effective family engagement policies and practices.^{29 30} Whether through the Elementary and Secondary Education Act (formerly known as No Child Left Behind), Title 1, Part A, Section 1118 which requires local education agencies to adopt and implement a parent involvement policy³¹ or individual state laws, there is widespread recognition that parents and families are critical partners in learning.³²

Ensuring that parents are engaged as partners in sexual health education is no exception. Research has shown that good, quality parent-child communication about sexuality can delay the initiation of sexual activity and increase the use of contraception, including condoms.³³

There are various ways in which schools can promote parent involvement and engagement around sexual health including:

- involving parents in a school health advisory council
- assigning homework to students as part of their sexual health unit that encourages communication about sexual health topics. Research has shown that parent-child homework assignments connected to curricula can positively impact students' sexual behaviors.³⁴
- distributing resource materials to parents at the start of sexual health unit and sharing ideas about how to begin conversations with their children about sexuality
- implementing a parent-child communication program to complement the curriculum

Resources to aid in developing, selecting or adapting a parent involvement/family engagement model to support communication about sexual health include:

PARENT SUPPORT FOR SEXUALITY EDUCATION

National and state surveys repeatedly show that parents overwhelmingly support sexuality education in public school.^{35 36 37 38} More recently, Mississippi (2011) and North Carolina (2009) conducted parent opinion polls and found that among parents of public school children, 92 percent supported sexuality education instruction.^{39 40}

Further, in 2004, National Public Radio (NPR), the Kaiser Family Foundation and the Kennedy School of Government released a national poll that indicated:

-Ninety-three percent of parents of junior high school students and 91 percent of parents of high school students believe it is very or somewhat important to have sexuality education as part of the school curriculum.

-Ninety-five percent of parents of junior high school students and 93 percent of parents of high school students believe that birth control and other methods of preventing pregnancy are appropriate topics for sexuality education programs in schools.

-Approximately 75 percent of parents believed that the topic of sexual orientation should be included in sexuality education programs and “discussed in a way that provides a fair and balanced presentation of the facts and different views in society.”

-Eighty-eight percent of parents of junior high school students and 85 percent of parents of high school students believe information on how to use and where to get contraceptives is an appropriate topic for sexuality education programs in schools.⁴¹

- [Parent-Child Communication Programs: Helping Parents Become Knowledgeable and Comfortable as Sex Educators](#), developed by Advocates for Youth, provides a summary of evidence-based programs for in- and out-of-school settings
- Michigan State's [Talk Early, Talk Often](#) Initiative provides workshops to parents to help support them in talking with their children about sexuality
- Centers for Disease Control and Prevention's [Parent Engagement](#) web site provides a synopsis of research as well as a guide and fact sheets about engaging parents in school health.

CURRICULUM SELECTION AND MATERIALS REVIEW

Local boards of education are charged with determining and approving curricula and course of study. There are many reasons why local school boards or their designees undertake a curriculum selection or review process including a new state policy, a regular review of curricula and/or programs, a specific need identified within the district or alignment with a school district strategic plan.

There are also a myriad of considerations – both policy and procedural – as it relates to curriculum selection and materials review. Typically, a standing committee like a school health advisory committee, curriculum review committee, HIV Materials Review Panel or other ad-hoc committee may be established to review relevant policy, standards, sexuality education curricula, materials and resources and make a recommendation to the school board.

The curriculum selection and review process – sometimes referred to as mapping and alignment – typically commences with a review of state laws and standards (i.e., what students should know and be able to do upon the completion of a specified grade level). The mapping and alignment

process also addresses additional parameters including, but not limited to: target population, identified needs within the district, target grade level(s), learning objectives, curricula and training costs, and time requirements.

Below are relevant standards and tools to assist in the mapping and alignment process:

- [National Health Education Standards developed by the Joint Committee on National Health Education Standards](#) and led by the American Cancer Society provide a framework for PreK-12 Health Education to help guide school districts in aligning curriculum, instruction and assessment.
- [National Sexuality Education Standards: Core Content and Skills, K-12](#). Developed by the Future of Sex Education Initiative, the National Sexuality Education Standards provide guidance on the essential minimum core content for sexuality education that is developmentally and age-appropriate for students in grades K-12.
- [National Sexuality Education Standards Mapping Template](#) developed by the Future of Sex Education Initiative can assist in aligning curricula with the National Sexuality Education Standards.
- [Health Education Curriculum Analysis Tool \(HECAT\)](#).⁴³ Developed by the Centers for Disease Control and Prevention, the HECAT is designed to assist schools in conducting a review of health education curricula based on the National Health Education Standards and CDC's Characteristics of an Effective Health Education Curriculum. The HECAT includes specific topical modules, including one on sexual health.
- [Sex and HIV Education Programs for Youth: Their Impact and Important Characteristics](#)⁴⁴ summarizes 17 effective characteristics shown to affect behavior change.
- [Tool to Assess the Characteristics of Effective Sex and STD/HIV Education Programs](#)⁴⁵ provides a ready use resource to assess, select, improve or design a sex or STD/HIV education program.
- [Reducing Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum Based Programs](#), published by ETR Associated, outlines the risk and protective factors related to sexual risk behavior and use of instructional principles most likely to improve targeted factors.

Individual states have also developed curriculum assessment tools to assist local districts in aligning their curricula to state law and standards.

- Connecticut Department of [Education Compliance Checklist](#) which summarizes state health education requirements for content and implementation, required certifications for teachers of health education, recommended amount of instructional time and key program elements

ABOUT HIV MATERIALS REVIEW BOARDS:

Every state and local education agency that accepts federal funding from the Centers for Disease Control and Prevention must have an HIV Materials Review Panel. Materials include written materials (e.g., curricula, training materials, pamphlets); audiovisual materials (e.g., motion pictures, videos); pictorials (posters and similar educational materials using photographs, slides, drawings or paintings); and electronic resources (e.g., Websites, PDF files and PowerPoint files).⁴² **These committees are charged with ensuring that materials are age and culturally appropriate as well as medically accurate.**

- Michigan Department of Education has developed a [HIV/STI and Sexuality Education Curriculum Evaluation Tool](#) that provides a framework for district to review curricula so they align with what students need, community standards, the law and research and best practices.
- Determining what curricula and other resources to review can be aided by:
 - a) State-based lists of recommended or approved curricula and other resources that have been vetted by the state department of education, including the state-level HIV Materials Review Panel. These lists can be based on medical accuracy, age appropriateness, scientific evidence, alignment with state education standards or other criteria and are offered to public school districts as a starting point to curriculum selection.
 - b) Lists of evidence-based interventions. There is a growing emphasis on evidence-based interventions in all aspects of instruction and sexual health education is no exception. Evidence-based interventions generally refer to those programs that have been empirically shown to result in a specific behavior change within a particular population, including but not limited to, postponement of sexual intercourse, reduction in frequency of sexual intercourse and/or number of partners and increased use of contraceptives, including condoms.
- Washington State Office of Superintendent of Public Instruction and Department of Health [Sexual Health Education Curriculum Report](#) outlines the state's comprehensive review process and findings of commonly used sexuality and HIV prevention curricula.
- [Iowa Department of Education](#) offers examples of age-appropriate and research-based materials school districts can use to update their human growth and development curricula in compliance with Iowa Code.
- California uses [Positive Prevention: HIV/STD Education for California Youth](#) because it has been piloted throughout the state and meets the education code pertaining to HIV/STD prevention.

There are various lists generated by both government and non-governmental organizations that use various criteria, intervention foci (i.e., HIV, STD and/or pregnancy prevention), targeted populations, implementation settings (i.e., school and/or community based organizations) and age ranges in making a determination about which interventions to include on their list. Two examples from federal agencies include:

Centers for Disease Control and Prevention's [Registries of Programs Effective in Reducing Youth Risk Behaviors](#), which includes programs that address HIV and teen pregnancy prevention, and the prevention of other risk taking behaviors.

Department of Health and Human Services, Office of Adolescent Health, [List of Evidence-based Teen Pregnancy Prevention Program Models](#), which is regularly updated and includes a searchable database.

Based on the Office of Adolescent Health's list of evidence-based interventions, there are six evidence-based sexuality education interventions developed specifically for use in a school setting including:

- Middle School:
 - Making a Difference
 - Making Proud Choices
 - Draw the Line/Respect the Line
 - It's Your Game: Keep It Real
- High School:
 - Reducing the Risk
 - Safer Choices

To achieve similar behavioral outcomes, evidence-based interventions require implementation with fidelity (i.e., implementing as prescribed with few, if any, modifications). School districts may or may not be able to use evidence-based interventions with fidelity due to time constraints, state laws which may preclude one or more lessons (e.g., condom demonstration) or because they do not meet certain criteria set out in state health education standards. Some adaptations can be made to update data/statistics and ensure role plays and other interactive activities are culturally relevant and current; however, changing the sequence of lessons or activities, modifying lessons or eliminating lessons is not ideal as this may compromise or negate one or more of the components that make them effective.

For more on adaptations see the Resource Center for Adolescent Pregnancy Prevention's (ReCAPP) [Making Adaptations to Evidence-Based Pregnancy and STD/HIV Prevention Programs](#) where you can find adaptation kits for certain curricula as well as general adaptation guidance.

In addition to the six evidence-based interventions noted above, there are other evidence-based interventions not developed specifically for schools that are being adapted for school-based settings. For more on information on specific adaptations, you can review the intervention implementation report for each of the [31 approved evidence-based interventions](#) on the Office of Adolescent Health list by clicking on the name of the program.

MEDICAL ACCURACY AND BIAS FREE

A widely accepted definition of medical accuracy is that information provided to students be “verified or supported by research conducted in compliance with scientific methods and published in peer-reviewed journals, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, such as the Centers for Disease Control and Prevention, the American Public Health Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.”⁴⁶ Twelve states require that sex education be medically accurate.⁴⁷ In some other states, HIV curricula must be approved at the state level to ensure medical and scientific accuracy.

- [Washington State](#) has developed a list of model curricula and resources to ensure medical accuracy. If a district chooses to use something else, they must have it approved by Department of Health, Office of HIV.

School districts that do not have a state policy governing medical accuracy can adopt a policy that defines medical accuracy. Some districts go further to require materials to be reviewed on a periodic basis by a school health advisory committee or staff for medical accuracy.

In addition to medical accuracy, school districts are encouraged to ensure that sexuality education presented to students does not reflect conscious or unconscious bias against gay, lesbian, bisexual or transgender or gender non-conforming students. Many curricula assume heterosexuality and do not address disease prevention among same sex partners. Any kind of bias is in direct conflict with the mandate of schools to provide educational equality for all students.

INSTRUCTIONAL MINUTES

The Joint Committee on National Health Education Standards recommends that students in grades Pre-K-2 receive a minimum of 40 hours and students in grades 3-12 receive 80 hours of health instruction per academic year.⁴⁸

According to the School Health Policies and Programs Study, a national survey conducted by the Centers for Disease Control and Prevention’s Division of Adolescent and School Health to assess school health policies and practices across the U.S., a median total of 20, 30 and 40 hours of health education is provided for elementary, middle and high school students respectively.⁴⁹ Within these totals, only 3.1 hours in elementary, 6 hours in middle, and 8.1 hours in high school of instruction is devoted to HIV, pregnancy and STD prevention topics.⁵⁰

Some states have required number of instructional minutes for certain classes but most do not. For example, New Jersey requires 150 minutes per week of health and physical education⁵¹ but this still does not assure that sexuality and HIV-prevention education topics are addressed.

Finally, schools can consider whether to mandate health education as a graduation requirement thereby ensuring time to teach. Most states have health and/or physical education as a graduation requirement but many do not require a specific allocation of time to health (e.g., 1 unit of health and physical education) or do not specify topics to be covered in health unit.

- For a summary of health and physical education requirements, see [Education Commission of the States](#). (Note that this summary has not been updated since 2007 and some laws have changed, most notably Texas which no longer requires health education as a graduation requirement.)
- [National Association of State Boards of Education State School Health Policy Database](#) provide additional information about state graduation requirements and links to relevant statutes.
- Examples of districts that require health education include [New York City Department of Education](#) and [San Francisco Unified School District](#).

SINGLE SEX CLASSROOM INSTRUCTION

Under Title IX, schools receiving federal funding are generally prohibited from discriminating on the basis of biological sex. However, there are two exceptions in which classes/programs can be segregated on the basis of sex: physical education classes that involve bodily contact (e.g., wrestling) and human sexuality education.⁵² Mississippi is the only state that requires single-sex instruction for human sexuality education.⁵³ South Carolina requires instruction on pregnancy prevention to be presented separately to male and female students.⁵⁴ At the K-8 level, Arizona also requires gender-segregated instruction.⁵⁵

There have been no studies that establish the effectiveness of single-sex classroom education in regard to sex education. Schools may consider establishing single-sex instruction for the purposes of classroom management or increased teacher and student comfort; however, it is important that both classes are taught the same content and students who are transgender or gender non-conforming can select which class to attend.

PROFESSIONAL DEVELOPMENT

Given the unique nature of sexuality education, ongoing professional development is critical. Some states have professional development requirements specifically related to sexuality education and/or HIV/AIDS prevention education (e.g., California, Maryland, [Michigan](#)) but most states do not. Others require a minimum number of professional development hours (e.g., Colorado, Indiana, Georgia, New Jersey) for license renewal or professional re-certification but do not specify topic areas. In recent years, however, these requirements have been eliminated or suspended due to budget cuts in some states.

- Maryland [state policy](#) requires teachers of family life and human sexuality as well as HIV/AIDS to have additional professional development. ([National Association of State Boards of Education State School Health Policy Database](#) can provide detailed information about your state's laws pertaining to ongoing professional development.)
- Because of the limited pre-service and available ongoing professional development related to sexuality education, a policy addressing professional development for teachers delivering sexual health education might address knowledge about:
 - state and district policies pertaining to provision of sexuality education and access to services for older students
 - basic human development and its social, biological and cognitive domains
 - state health education standards, curricula frameworks and scope and sequence within the district
 - content pertaining to the delivery of sexuality education topics including contraceptives, HIV and STDs
 - legal and ethical responsibilities pertaining to sexual abuse, consent and other applicable state laws.
 - Some school districts have instituted their own professional development programs to address the needs of educators.
- [Chicago Public Schools'](#) policy mandates training before teaching family life or comprehensive sexual health education

A comprehensive professional development policy might address administrators, counselors, nurses, and other school staff as well as classroom teachers so all staff understand the basic state laws and policies as well as district policies pertaining to confidentiality, mandatory reporting requirements, and other pertinent laws.

EXTERNAL ORGANIZATIONS AND AGENCIES

Community-based organizations provide essential services to students and support to teachers and other staff. Relative to sexuality education, it is common for some community-based organizations or health departments to teach the some or all of the classes devoted to sex education and/or provide professional development and technical assistance. It is important to screen organizations and individual staff who are coming into a classroom for a variety of reasons including security, quality control (i.e., medical accuracy and alignment to standards) and professionalism.

Given this, some districts have elected to adopt policies outlining the standards, expectations

and/or requirements for outside consultants who deliver sexual health education in the classroom. Policies may require outside consultants to present a sample lesson and/or be approved by a curriculum review committee or school health advisory council, for example. Some of the expectations for outside consultants may include:

- alignment of their materials to adopted health education standards
- knowledge, background and skill in presenting sexuality education content that is developmentally appropriate and medically accurate
- appropriate level of security clearances to work with students (i.e., background check)
- Teachers who invite external organizations into their classrooms to deliver sexuality education content may have the following responsibilities:
 - be present in the classroom while instruction is being delivered
 - assign grades and conduct any testing or assessment, if relevant
 - ensure compliance with relevant laws and district policies that govern the delivery of sexual health education
 - ensure that all required content is covered
 - review and assure that all materials, handouts, videos are medically-accurate, bias free and age-appropriate

Some schools specifically prohibit teachers from bringing in outside presenters to cover more than 50 percent of the total amount of instructional time. Other districts, given the sensitive nature of sexual health education, allow only guest presenters to speak on specific topics for a limited amount of time. In this case, teachers are required to ensure that the guest presenter has the requisite knowledge, background and skill to present on a specific topic.

Sample policies pertaining to external organizations and agencies include:

- [Chicago Public Schools](#)
- Michigan Department of Education [guest presenter policy](#)
- California Department of Education [checklist for guest presenters](#)
- [Beaverton School District, Oregon](#)

Policy Overview: Sexual and Reproductive Health Services

Teens report many barriers to accessing sexual and reproductive health services (e.g., STD/HIV testing, Pap tests and pelvic exams, pregnancy testing) including accessibility (i.e., inconvenient clinic hours), transportation, confidentiality and cost.^{56 57} In an effort to reduce barriers to health services for teens, schools can play a pivotal role in connecting adolescents to sexual and reproductive health services directly through school-based health centers or the provision of services such as testing and counseling on school grounds or through a linkage and referral system to community-based providers.

PARENTAL RIGHTS AND MINOR CONSENT

Generally, states have recognized the rights of parents to make health care decisions on behalf of their children. However, in the area of reproductive and sexual health, states have moved to allow minors to consent to testing, treatment and care recognizing that if parental consent were required, some minors would not get the care they need.⁵⁸ Today, twenty-six states and the District of Columbia allow minors to consent to contraceptive services and all states allow minors to consent to STD services.⁵⁹

- [State Policies in Brief, An Overview of Minors' Consent Law](#) details what services a minor can access without parental consent including contraceptive services, STD/HIV testing and treatment, adoption and abortion.
- Within school-based settings, regardless of minor consent laws, parents are typically asked to sign a consent form at the beginning of each school year to allow students to access available health services, including sexual and reproductive health services. Here are some samples:
- Multnomah County Health Department School-Based Health Center Program, providing services to students in Portland Public Schools, consent to treat. In addition, their [Confidentiality/Parent/Guardian Involvement](#) Policy sets forth procedures for obtaining consent from minors.
- Baltimore City Health Department [School-Based Health Center Registration](#)

PROVISION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Very few states require districts to provide sexual and reproductive health services on campus including but not limited to STD/HIV testing,

pregnancy testing, pap and pelvic examinations, and contraceptives. (Only four states – Alabama, Mississippi, New Mexico and Wisconsin – require districts or schools to provide identification and treatment STDs when needed. Mississippi also requires districts or schools to provide HIV counseling, testing and referral.⁶⁰)

However, there are various models that schools have employed to connect adolescents with health services many of which rely heavily on external partners to manage clinical aspects of service delivery. School administrative support and coordination are critical in launching and sustaining access to sexual and reproductive health services.⁶¹

- See [Best Practices for Youth Friendly Sexual and Reproductive Health Services in Schools](#) published by Advocates for Youth for an overview of ways schools can provide services to meet the special needs of older students.

SCHOOL-BASED HEALTH CENTERS

School-based health centers began more than 25 years ago primarily in high schools because of high rates of teen pregnancy and sexually transmitted disease (STDs).⁶² According to the [National Assembly on School-Based Health Care's](#) (NASBHC) National Census in 2007-2008, there are about 2,000 school based health clinics (SBHCs) nationwide. SBHCs are typically located on school property or through a mobile unit typically operated by another entity like a community health center, hospital or health department. SBHCs generally provide both primary care and mental health services to students.

Additionally, according to NASBHC's 2007-08 Census, about sixty percent of SBHCs provide gynecological exams and PAP tests.⁶³ Approximately 65 percent provide STD testing and treatment and some form of HIV testing.⁶⁴ Eighty percent offer pregnancy testing, but about 60 percent preclude the provision of contraceptives most often because of a local school district policy⁶⁵ although some states specifically preclude the provision of contraceptives.⁶⁶ Texas further precludes SBHC's from providing any other reproductive health services, counseling or referrals.⁶⁷

- [The National Assembly of School-Based Health Care](#) provides a summary of applicable federal and state policies pertaining to school-based health centers.

SCHOOL-LINKED HEALTH CENTERS AND OTHER PARTNERSHIPS

In order to meet the needs of their students, schools that are among the thousands without a SBHC or whose SBHCs do not provide sexual and reproductive health services may consider establishing school-linked health centers. School-linked health centers are located off school property, often provide hours of operation before or after school and can typically provide more comprehensive sexual and reproductive health care services than school-based health centers. According to the School Health Policies and Programs Study, thirty-four percent of schools had arrangements with agencies, organizations or health care providers not located on school property to provide health services to students when needed.⁶⁸

- The [Corner Health Center](#) in Ypsilanti, Michigan is an example of a school-linked health center providing a wide range of services, including sexual and reproductive health services.

To address the high rates of STD and HIV infection among adolescents, some school districts around the country have partnered with state or county departments of health to promote STD testing.

- The District of Columbia Public Schools and the DC Department of Health launched a [school-based STD screening program](#) in all DC public high schools to test and treat STDs. For more about the DC program and other partnerships to support implementation of STD and other reproductive health services in schools, the National Coalition of STD Directors produced a series of four webinars, which can be viewed [here](#).
- Similarly, Philadelphia School District, in partnership with the City of Philadelphia's [Department of Public Health](#), offers STD education and free, confidential testing in all the city's high schools.
- The Michigan Department of Community Health, Division of Health, Wellness and Disease Control, STD Section developed a [Guide to Implementing a Sexually Transmitted Disease School Wide Screening](#) to support communities in planning and implementing a screening and treatment program.

THE ROLE OF SCHOOL NURSES AND OTHER PERSONNEL

The role of school nurses has expanded considerably over the last 100 years and now encompasses the provision of direct and indirect health services, counseling and health education, coordination of school health initiatives and student care. They also serve as a critical connection point between the medical and educational communities establishing a direct linkage between academic achievement and student health by ensuring students get the care they need to stay in school.⁶⁹

School nurses, as well as other school personnel, are cited as critical sources of information by students⁷⁰ and routinely manage confidential student health information.⁷¹

Relative to sexual health services, school nurses, in compliance with board policy may:

- Provide medically accurate information and resources to students and staff;
- Provide referrals and counseling relative to pregnancy, STD and HIV testing;
- Dispense condoms and contraceptives; and
- Provide counseling to pregnant teens, or teens who think they might be pregnant.

Advanced practice nurses may also conduct pregnancy testing, provide prenatal care and prescribe medications depending on state law. In some instances, school nurses are employed by an outside organization, for example a health department or local hospital, which can often expand the scope of services provided to students.

Counselors, teachers, administrators and other staff can also be sources of referrals to appropriate, reputable youth-friendly community resources – or at the very least know another professional (i.e., school nurse) in the school in which to connect a student to get an appropriate referral. A vetted list of agencies to which students can be referred can facilitate teachers and staff in providing appropriate referrals.

- Created by the Adolescent Health Working Group, the [San Francisco Youth Health Services & Referrals](#) is an example of a resource list for students and staff.

CONDOM AVAILABILITY POLICY

To help mitigate the spread of sexually transmitted diseases, including HIV, and to prevent unintended pregnancy, a school district may develop and implement a condom availability program. Most condom availability programs are offered only in high schools and are prevalent in larger urban school districts like Los Angeles, New York, Philadelphia, Seattle, Baltimore, Houston and Chicago.

Key questions to consider in the development of a condom availability policy include: What information will be given to students and how? Who will be authorized to provide condoms and related information? What training will be required of authorized school personnel? Where and when will condoms be made available? What is the process for informing parents and obtaining consent?

What Information: Typically, students who request condoms are required to participate in counseling in which abstinence from sexual activity is stressed and basic information about condoms and how to use them is provided. Some schools allow condom demonstrations and others do not.

Who Provides Information: School nurses, health teachers, other teachers, administrators or school counselors may provide condoms and information to students. Some districts have a training and certification process that staff must attend to ensure consistency. Some require that both male and female staff are available to increase student comfort. A few schools use peer educators to provide condoms to students.

Where and When are Condoms Available: Some school districts have special resource rooms where students can drop in for condoms. Others are made available through school-based clinics. Some limit the hours of condom availability to after school or only during certain periods of the school day.

How are Parents are Notified and How do Parents Consent: Most districts have an opt-out policy that allows parents and guardians to decline the right of their child to receive condoms.

- Los Angeles Unified School District implemented a condom distribution policy in 1992. A [summary its policy and parental notification letter](#) provides an example of an opt-out policy.
- New York City also has a condom availability program. A summary of the program requirements, parent and student letters and additional resources can be found [here](#).

PRIVACY AND CONFIDENTIALITY

A considerable amount of personal data is collected by school districts including student test scores, attendance records, grades and other personal information regarding gender, age, address and phone as well as health information. Three federal laws govern the use of this information:

Family Education Rights and Privacy Act (FERPA) protects the confidentiality of student records and provides access to parents.

Health Insurance Portability and Accountability Act (HIPAA), among other things, protects the privacy and confidentiality of personal medical information.

- The U.S. Departments of Health and Human Services and Education issued a [joint guidance document](#) to help clarify the relationship between FERPA and HIPAA.
- **Protection of Pupil Rights Amendment (PPRA)** provides parents of minor children certain rights as it pertains to the collection of personal information through surveys.
- The American Academy of Pediatrics and National Association of School Nurses, in addition to 30 national organizations, parents and other supporters, developed [Health, Mental Health and Safety Guidelines for Schools](#) which provides additional guidance regarding the [confidentiality of health records](#) in accordance

with FERPA and HIPAA. See also the National Association of School Nurses [FERPA and HIPAA resources](#) for more.

- The American School Health Association's [Protecting and Disclosing Student Health Information: How to Develop School District Policies and Procedures](#) provides guidance in navigating the various legal considerations in managing student health information.

Meeting the Needs of Every Student

EQUITY AND NON-DISCRIMINATION

The U.S. Department of Education is responsible for enforcing several laws that pertain to non-discrimination and equity in education. Taken together, these laws prohibit discrimination on the basis of race, color or national origin; sex; and disability.

Some state laws applicable to public schools go beyond these federal protections to include non-discrimination on the basis of religion, sexual orientation, gender identity and gender expression. In the absence of enabling legislation at the state level, school districts are encouraged to support at a minimum a safe, respectful learning environment for all students.

- Developed by the American Civil Liberties Union, this [model anti-discrimination policy](#) was developed to assist schools in affirming equal opportunity for all students and staff.
- Recently enacted in New York State, the [Dignity for All Students Act](#) enumerates further protections for students to ensure a safe, supportive learning environment.

Ensuring equity for gay, lesbian and bisexual students is of particular concern and extends beyond policies pertaining bullying and/or harassment. Equity applies to curriculum decisions (i.e., non-biased) as well as extra-curricular activities, including Gay Straight Alliances (GSAs). The federal Equal Access Act passed in 1984 provides that federally funded secondary schools ensure equal access to extracurricular clubs, meeting space and opportunities to promote the club. There are over 4,000 GSAs nationwide.⁷²

- U.S. Department of Education, [GSA/Equal Access Act Letter and Legal Guidelines](#). Issued in June 2011, this letter and associated guidelines from Secretary of Education Arne Duncan provides additional guidance to schools relative to the Equal Access Act and Gay Straight Alliances.

PREGNANT AND/OR PARENTING TEENS

Teen mothers are less likely to graduate from high school than their non-parenting peers.⁷³ A recent report published by the National Women's Law and Center entitled *A Pregnancy Test for Schools: The Impact of Education Laws on Pregnant and Parenting Students* identifies a number of structural barriers that impede young mothers from returning to school and graduating despite the Title IX prohibition of sex discrimination that also protects pregnant and parenting students.⁷⁴

To help pregnant and parenting teens stay in school, [some states](#) have policies in place to ensure that school districts provide means to enable pregnant or parenting students ability to complete homework assignments associated with absences related to prenatal care, delivery and postpartum and/or obtaining health care for their child. North Carolina has one the most comprehensive policies providing:

“...pregnant and parenting students receive the same educational instruction as other students. It instructs local districts to adopt policies ensuring that pregnant or parenting students are not discriminated against or excluded from any program, class or extracurricular activity. The policy also must allow for excused absences for pregnancy and related conditions and illness of a custodial child. In addition, the local policy must address homework, make up work and the availability of a homebound teacher to minimize falling behind from absences.”⁷⁵

- Charlotte-Mecklenberg Schools in North Carolina [policy on pregnant and parenting teens](#) reflects the above state policy.
- The National Partnership for Women and Families' [Education for Pregnant and Parenting Minors in CA: Educators Companion Guide](#) to the [California Pregnant and Parenting Youth Guide](#) can assist in answering legal questions pertaining to the provision of public education to pregnant and parenting students and is applicable to other jurisdictions.
- The National Women's Law and Center report [A Pregnancy Test for Schools: The Impact of Education Laws on Pregnant and Parenting Students](#) ranks state laws and recommendations for states and local school districts.
- The U.S. Department of Education's Office for Civil Rights published a pamphlet on [Supporting the Academic Success of Pregnant and Parenting Students](#) with information and resources on the requirements of schools under Title IX to meet the needs of pregnant and parenting students.

TRANSGENDER AND GENDER NON-CONFORMING STUDENTS

Promoting a safe, inclusive school environment for all students is a key task within public education.⁷⁶ In recent years, there has been growing awareness of the unique needs of transgender and gender non-conforming students to not only

ensure their safety but also to ensure their academic success.^{77 78} School districts can consider implementing policies related to school culture (i.e., training teachers and staff to address bullying and harassment [hyperlink to below]) that create a safe, inclusive school environment for all students as well as practical considerations related to gender-segregated activities and areas like restrooms or locker rooms.

- The Gay Lesbian Straight Education Network (GLSEN) and the National Center for Transgender Equality (NCTE) have developed [Model District Policy on Transgender and Gender Nonconforming Students: Model Language, Commentary and Resources](#).
- Seattle Public Schools has recently developed a [Superintendent Procedure](#) regarding Transgender and Gender Non-Conforming Students which outlines suggested approaches to circumstances that may affect transgender and gender non-conforming student's safety and protection.

BULLYING AND HARASSMENT

Bullying and harassment are of growing concern in schools. Technology has complicated schools' ability to identify and promptly address bullying, harassment and relationship violence. However, there is a growing movement within schools to proactively create safe, supportive school environments.⁷⁹

In response, many states require school districts to adopt a policy pertaining to bullying and harassment. Some provide a model policy for adoption which defines terms, sets out reporting requirements and penalties for non-compliance.

- The U.S. Department of Education, Anti-Bullying [Letter and Guidance](#), issued in October 2010 with corresponding guidance in December 2010, outline the legal responsibilities of school districts in address bullying and harassment and ensuring a safe learning environment for all.
- U.S. Department of Education Anti-Bullying [Background, Summary and Fast Facts](#) is a companion piece to the Anti-Bullying Letter of October 2010.
- Developed by the American Civil Liberties Union, this [model anti-harassment policy](#) was developed to assist schools in creating safe school environments for all students.
- [Ready, Set, Respect! The Gay, Lesbian, Straight Education Network's Elementary School Toolkit](#) provides schools with a set of resources to help teach about respect to students at the elementary level. It was developed in partnership with the National Association of Elementary School Principals and National Association for the Education of Young Children.
- For a summary of your state's anti-bullying laws and policy, see [stopbullying.gov](#), a federal resource developed by the U.S. Department of Health and Human Services.

LEGAL CONSENT, AGE OF MAJORITY AND MANDATORY REPORTING

The laws related to minors vary from state to state and it is very important for district legal counsel, administrators, teachers, counselors and school nurses to familiarize themselves with their state's legal requirements concerning:

Age of consent - refers to the age in which a minor can legally consent to sexual intercourse, usually between ages 16 and 18. Statutory rape is related to age of consent

Age of Majority - occurs when a minor turns a certain age and is legally considered an adult. [Each state determines when a person is legally an adult](#) and in a majority of states, eight is considered the legal age of majority.

Mandatory reporting - require school staff to report suspected child abuse or neglect and in some states bullying and harassment as well. These obligations vary from state.

- The U.S. Department of Health and Human Services Administration on Children and Families provides [a fact sheet defining child abuse and neglect](#) and delineates [who is required to report abuse and neglect in each state](#).

Parental Notification - "No federal or state statute or other rule or regulation requires parental notification by school officials of pregnancy or abortion plans of minors reporting pregnancy or abortion plans to public school officials." (Arnold et al. vs. Board of Education, 1990).

References

- 1 Wright TD, and Richardson JW. School-Based Health Care: Advancing Educational Success and Public Health. Washington, DC; American Public Health Association, 2012
- 2 <http://nces.ed.gov/fastfacts/display.asp?id=84> accessed on July 11, 2013
- 3 Basch, Charles E., Healthier Students are Better Learners, Equity Matters: Research Review No. 6, March 2010, page 4
- 4 Schools and Health: Our Nation's Investment. Institute of Medicine, 1997.
- 5 Fast Facts, National Center for Education Statistics, US Department of Education. <http://nces.ed.gov/fastfacts/display.asp?id=372> accessed on August 7, 2012
- 6 Basch CE. Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap. New York, NY; The Campaign for Educational Equity, Teachers College Columbia University; 2010
- 7 Wright TD, and Richardson JW. School-Based Health Care: Advancing Educational Success and Public Health. Washington, DC; American Public Health Association, 2012
- 8 Richardson, JW. From risk to resilience: promoting school-health partnerships for children. *International Journal of Education Reform*. 2008; 17(1): 19-36
- 9 Fiscella K, Kitzman H. Disparities in academic achievement and health: the intersection of child education and health policy. *Pediatrics*. 2009; 123(3): 1073-108 <http://pediatrics.aappublications.org/content/123/3/1073> accessed on November 12, 2012
- 10 Taras, H and Potts-Datema, W. Chronic health conditions and student performance at school. *Journal of School Health*, 2005; Vol. 75(7) 255- 266.
- 11 Freudenberg, N. Ruglis J. Reframing school dropout as a public health issue. *Preventing Chronic Disease* 2007; 4 (4):A107 http://www.cdc.gov/pcd/issues/2007/oct/07_0063.htm accessed on November 12, 2012
- 12 Singh, S; Darroch, J. E. 2000. Adolescent Pregnancy and Childbearing: Levels and Trends in Developed Countries. *Family Planning Perspectives* 32(1):14-23.
- 13 Kost K and Henshaw S, U.S. Teenage Pregnancies, Births and Abortions, 2008: State Trends by Age, Race and Ethnicity, New York: Guttmacher Institute, 2013, <http://www.guttmacher.org/pubs/USTPtrends13.pdf> accessed on March 14, 2013
- 14 Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2009. Atlanta: U.S. Department of Health and Human Services; 2010. <http://www.cdc.gov/std/stats09/surv2009-Complete.pdf> accessed on March 14, 2013
- 15 Centers for Disease Control and Prevention. Vital Signs: HIV Among Youth in the U.S. Atlanta, GA: US Department of Health and Human Services, 2012. <http://www.cdc.gov/vitalsigns/HIVAmongYouth/index.html> accessed on April 3, 2013.
- 16 Perper, K., Peterson, K., & Manlove, J., Diploma Attachment Among Teen Mothers, 2010. *Child Trends, Fact Sheet: Washington, DC.* http://www.childtrends.org/Files/ChildTrends-2010_01_22_FS_DiplomaAttainment.pdf
- 17 Ibid.
- 18 Centers for Disease Control and Prevention. Youth Risk Behavioral Surveillance – United States, 2010. *MMWR* 2012; 61 (No. SS-4). <http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf> accessed on October 31, 2012.
- 19 https://www.guttmacher.org/statecenter/spibs/spib_SE.pdf accessed on August 6, 2012
- 20 Ibid.
- 21 NASBE State Health Policy Database
- 22 http://www.cdc.gov/healthyyouth/shpps/2006/factsheets/pdf/FS_Overview_SHPPS2006.pdf accessed on May 1, 2012
- 23 A CDC Review of School Laws and Policies Concern Child and Adolescent Sexual Health *Journal of School Health*, Volume 78, Number 2, February 2008.
- 24 Future of Sex Education, Public Education Primer <http://www.futureofsexed.org/publiceducationprimer.html> accessed on April 27, 2012
- 25 Informed by Centers for Disease Control and Prevention definition of health education; available at <http://www.cdc.gov/HealthyYouth/CSHP/#1>
- 26 http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf accessed on March 21, 2010
- 27 Ibid.
- 28 Ibid.
- 29 <http://www.nsba.org/Board-Leadership/SchoolHealth/Families-as-Partners.pdf> accessed on December 11, 2012
- 30 <http://www.families-schools.org/downloads/FACEHandbook.pdf> accessed on December 11, 2012
- 31 <http://www2.ed.gov/policy/elsec/leg/esea02/pg2.html#sec1118> accessed on December 11, 2012
- 32 Epstein, JL. School, family and community partnerships: Preparing educators and improving schools. Westview Press, 2001.
- 33 <http://www.advocatesforyouth.org/publications/442?task=view> accessed on December 11, 2012
- 34 <http://www.guttmacher.org/pubs/journals/3305201.html> accessed on December 14, 2012
- 35 Bleakley, A. Public Opinion on Sex Education in US Schools. *Archives of Pediatric Adolescent Medicine*. 2006; 160: 1151-1156.
- 36 Sexual Health Education Poll of Washing State Parents and Voters (Seattle, WA: Planned Parenthood Public Policy Network of Washington, 2004).
- 37 August Scripps Howard Texas Poll (Texas: Scripps Howard, August 9-26, 2004)

- 38 Baldassare, Mark PPIC Statewide Survey California; Public Policy Institute of California, 2005.
- 39 <http://www.mshealthpolicy.com/wp-content/uploads/2012/10/HB-999-Survey-MSU-Report-Nov-2011.pdf> accessed on December 10, 2012
- 40 http://files.appcnc.gethifi.com/news-and-publications/research-and-publications/2009_Parent_Opinion_Survey.pdf accessed on July 9, 2013
- 41 Sex Education in America: General Public/Parents Survey. Washington, DC: National Public Radio, Kaiser Family Foundation, Kennedy School of Government, 2004.
- 42 Fiscal Year 2011 Indicators for School Health Programs Glossary of Terms http://www.cdc.gov/healthyYouth/evaluation/indicators/pdf/questionnaires/quest_hivsea_2011.pdf accessed on May 31, 2012
- 43 <http://www.cdc.gov/healthyouth/hecat/> accessed on July 9, 2013
- 44 Douglas Kirby, PhD, B.A. Laris, MPH, and Lori Roller, MSW, MPH; ETR Associates, May 2006
- 45 Douglas Kirby, PhD, Lori Roller, MSW, MPH, and Mary Martha Wilson, MA; ETR Associates, February 2007
- 46 Santelli, J.S., Medical Accuracy in Sexuality Education: Ideology and the Scientific Process. *American Journal of Public Health*, October 2008; 98(10): 1786-1792. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636467/?tool=pubmed> accessed on April 23, 2012.
- 47 Guttmacher Institute State Policies in Brief, as of April 1, 2013 Sex and HIV Education http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf accessed on April 12, 2013.
- 48 Joint Committee on National Health Standards. (2007). *National Health Education Standards*, 2 Ed. Atlanta, GA: American Cancer Society
- 49 Kann, L. et. al. Health Education: Results from the School Health Policies and Programs Study, *Journal of School Health*, October 2007, Vol. 77, No. 8. http://www.ashaweb.org/files/public/JOSH_1007/josh77_8_kann_p408.pdf accessed on August 6, 2012
- 50 Centers for Disease Control and Prevention, National Center for Chronic Disease and Prevention, Division of Adolescent and School Health, SHPPS Topic and Component Specific Fact Sheets. http://www.cdc.gov/healthyouth/shpps/2006/factsheets/topic_component.htm
- 51 http://www.state.nj.us/education/genfo/faq/faq_chpe.htm accessed on December 11, 2012
- 52 <http://www2.ed.gov/about/offices/list/ocr/t9-guidelines-ss.html> accessed on April 23, 2012
- 53 http://nasbe.org/healthy_schools/hs/state.php?state=Mississippi accessed on April 23, 2012
- 54 http://nasbe.org/healthy_schools/hs/state.php?state=South%20Carolina accessed on November 12, 2012
- 55 http://www.nasbe.org/healthy_schools/hs/state.php?state=Arizona accessed on April 12, 2013
- 56 Brindis, C et al. Meeting the reproductive health care needs of adolescents: California's Family Planning Access, Care and Treatment Program *Journal of Adolescent Health* Vol. 32(6) pages 79-90 June 2003
- 57 Best Practices for Youth Friendly Clinical Services. *Advocates for Youth* 2009 <http://www.advocatesforyouth.org/component/content/article/1347--best-practices-for-youth-friendly-clinical-services#references> accessed on November 12, 2012
- 58 Boonstra, H and Nash E. Minors and the Right to Consent to Healthcare. *The Guttmacher Report on Public Policy*, August 2000. <https://www.guttmacher.org/pubs/tgr/03/4/gr030404.pdf> accessed on April 12, 2013.
- 59 Guttmacher Institute State Policies in Brief, As of November 1, 2012 An Overview of Minor's Consent Law http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf accessed on November 13, 2012
- 60 Centers for Disease Control and Prevention. *State-Level School Health Policies and Practices: A State-by-State Summary from the School Health Policies and Programs Study 2006*. Atlanta: U.S. Department of Health and Human Services; 2007.
- 61 Wright TD, and Richardson JW. *School-Based Health Care: Advancing Educational Success and Public Health*. Washington, DC; American Public Health Association, 2012
- 62 *Legal Issues in School Health Services: A Resource for School Administrators, School Attorneys and School Nurses*. Editors Naide C. Schwab and Mary H.B. Gelfman, 2001, 2005
- 63 *School Based Health Centers: National Census School Year 2007-2008* <http://www.nasbhc.org/atf/cf/%7BB241D183-DA6F-443F-9588-3230D027D8DB%7D/NASBHC%202007-08%20CENSUS%20REPORT%20FINAL.PDF> accessed on May 29, 2012
- 64 Ibid.
- 65 Ibid.
- 66 http://nasbe.org/healthy_schools/hs/search.php?sel_st=wild&sel_cat=D&sel_top=wild&txt_policy=contraceptives&search=Search accessed on December 17, 2012
- 67 NASBE Health Policies Database accessed on May 29, 2012
- 68 Centers for Disease Control and Prevention. *School Health Policies and Programs Study: Health Services 2006*. Atlanta: U.S. Department of Health and Human Services; 2007.
- 69 Selekman, Linda (editor). *School Nursing: A comprehensive text*. National Association of School Nurses. 2006
- 70 Klein, JD et al. Adolescents' Access to Care Teenagers' Self-reported Use of Services and Perceived Access to Confidential Care. *Archives of Pediatric & Adolescent Medicine*. 1998;152(7):676-682
- 71 Selekman, Linda (editor). *School Nursing: A comprehensive text*. National Association of School Nurses. 2006
- 72 <http://www.justice.gov/crt/about/cor/byagency/ed4071.php> accessed on May 4, 2012

73 http://www.childtrends.org/Files/Child_Trends-2010_01_22_FS_DiplomaAttainment.pdf accessed on June 3, 2012

74 http://www.nwlc.org/sites/default/files/final_nwlc_pregnantparenting_report.pdf accessed on December 17, 2012

75 National Association of State Boards of Education Health Policy Database link to http://ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_115C/GS_115C-375.5.html accessed on June 1, 2012

76 <http://www2.ed.gov/about/overview/mission/mission.html?src=ln> accessed on December 17, 2012

77 California Safe Schools Coalition and 4-H Center for Youth Development, University of California, Davis. Consequences of Harassment Based on Actual or Perceived Sexual Orientation and Gender Non-Conformity and Steps for Making Schools Safer. 2004. <http://www.casafeschools.org/SafePlaceToLearnLow.pdf> accessed on December 17, 2012

78 The 2011 National School Climate Survey: The Experiences of lesbian, gay, bisexual and transgender youth in our nation's schools. New York, NY: Gay Lesbian Straight Education Network. 2011. http://www.glsen.org/binary-data/GLSEN_ATTACHMENTS/file/000/002/2105-1.pdf accessed on December 17, 2012

79 <http://safesupportiveschools.ed.gov/index.php?id=33> accessed on April 25, 2013

MISSION

Established in 1980 as the Center for Population Options, Advocates for Youth champions efforts to help young people make informed and responsible decisions about their reproductive and sexual health. Advocates believes it can best serve the field by boldly advocating for a more positive and realistic approach to adolescent sexual health.

OUR VISION: THE 3RS

Advocates for Youth envisions a society that views sexuality as normal and healthy and treats young people as a valuable resource.

The core values of Rights. Respect. Responsibility.® (3Rs) animate this vision:

RIGHTS: Youth have the right to accurate and complete sexual health information, confidential reproductive and sexual health services, and a secure stake in the future.

RESPECT: Youth deserve respect. Valuing young people means involving them in the design, implementation and evaluation of programs and policies that affect their health and well-being.

RESPONSIBILITY: Society has the responsibility to provide young people with the tools they need to safeguard their sexual health, and young people have the responsibility to protect themselves from too-early childbearing and sexually transmitted infections (STIs), including HIV.