STATE OF MICHIGAN
DEPARTMENT OF EDUCATION
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

THOMAS D. WATKINS, JR.
SUPERINTENDENT OF
PUBLIC INSTRUCTION

September 19, 2003

MEMORANDUM

TO: State Board of Education

FROM: Thomas D. Watkins, Jr., Chairman

SUBJECT: Approval of School Health State Board Policies: (1) Policy on Coordinated School Health Programs to Support Academic Achievement and Healthy Schools, (2) Policy to Promote Health and Prevent Disease and Pregnancy, and (3) Policy on Quality Physical Education

At the January 2003 State Board of Education meeting, the Healthy Schools Network presented information on Coordinated School Health Programs and Network activities. At the suggestion of the State Board of Education, three policies (Attachments A, B, and C) were developed to address the need raised by the Board. Each policy addresses specific health issues schools can use as a guide as they examine their own school health programs and policies.

These three new policies build on and incorporates the vision of numerous policies approved by the State Board of Education such as: Policies for Creating Effective Learning Environments (December 2000); Policies on Bullying (July 2001); Resolution on National School Lunch Week (August 2001); Resolution Supporting School-Based and School-Linked Health Centers (January 2002); and Resolution on Parenting Awareness Month (February 2003). In addition, the new policies build on the leadership of Michigan Legislature and State Board initiatives including: Act 451 of 1976, the adoption of requirements for health and physical education in every school, in 1984 established boiler plate language for the *Michigan Model for Comprehensive School Health Education*, in 1994 supported the development of the *Exemplary Physical Education Curriculum*, and in 1998 the Board approved the *Health Education Content Standards and Benchmarks* and *Physical Education Content Standards and Benchmarks.* In 2001 the Department collaborated in producing *The Role of Michigan Schools in Promoting Healthy Weight: A Consensus Paper.*

Schools must do all they can to promote students' health and well being if Michigan's ambitious academic achievement goals and the goals of the federal *No Child Left Behind Act of 2001* are to

608 WEST ALLEGAN STREET • P.O. BOX 30008 • LANSING, MICHIGAN 48909
www.michigan.gov/mde • (517) 373-3324

be realistically attained. Schools cannot achieve their primary mission of education if students and staff are not physically, mentally, and socially healthy. Coordinated School Health Programs can positively impact student academic achievement and empower students with the knowledge, skills, and judgment essential to help them make healthy and responsible choices in life. The Board, therefore, encourages each Michigan school district/building to adopt its own vision for student health and to plan, adopt, implement, evaluate, and periodically re-examine the effectiveness of the Coordinated School Health Programs organizational model.

Well-planned and implemented comprehensive school health education has been shown to positively influence students' health-related knowledge, skills, and behaviors and contributes to their academic achievement. Schools, in concert with families and communities, have a duty to implement effective sexuality education programs that will help students make responsible decisions during their school years and into their adult lives. The Board recommends that local school boards support their school administrators and faculty to select, adopt, and implement comprehensive sexuality education programs that are based on sound science and proven principles of instruction.

A child's intellectual growth cannot take place without having met his or her basic physical needs. Every child's school experience should include the opportunity to participate in quality physical education programs and other health enhancing physical activity. The Board encourages all public schools to offer physical education opportunities that include the components of a quality physical education program and daily opportunities for unstructured physical activity/recess for all students through sixth grade.

It is recommended that the State Board of Education approve the School Health State Board Policies: (1) Policy on Coordinated School Health Programs to Support Academic Achievement and Healthy Schools, (2) Policy to Promote Health and Prevent Disease and Pregnancy, and (3) Policy on Quality Physical Education as attached to the Superintendent's memorandum dated September 19, 2003.

Attachments

Michigan State Board of Education

Policy on Coordinated School Health Programs to Support Academic Achievement and Healthy Schools

The Michigan State Board of Education has long believed that the education system, in partnership with families and communities, shares a duty to help prevent unnecessary injury, disease, and chronic health conditions that are costly burdens on families and the entire State of Michigan. The Board further believes that schools must do all they can to promote student health and well-being if Michigan's ambitious academic achievement goals and the goals of the federal *No Child Left Behind Act of 2001* are to be realistically attained. Schools cannot achieve their primary mission of education if students and staff are not physically, mentally, and socially healthy.

The Board is convinced that Coordinated School Health Programs (CSHP) can positively impact student academic achievement and empower students with the knowledge, skills, and judgment essential to help them make healthy and responsible choices in life.[1] The Board, therefore, encourages each Michigan school district/building to adopt its own vision for student health and to plan, adopt, implement, evaluate, and periodically re-examine the effectiveness of this model.

This policy builds on and incorporates numerous earlier policies. In Act 451 of 1976, the Michigan Legislature adopted requirements for health and physical education in every school. Since 1984, the *Michigan Model for Comprehensive School Health Education* has been implemented in over 90 percent of Michigan's public schools. Since 1994, the Governor's Council on Physical Fitness, Health & Sports has implemented the Exemplary Physical Education Curriculum (EPEC) in almost 70 percent of Michigan school districts. In recent years, the Board has adopted several other policies and resolutions related to school health programs.[2]

The Board makes the following recommendations:

I. The Board recommends that each school district develop, adopt, and implement, to the extent that resources permit, a comprehensive plan for a Coordinated School Health Program that:

- **Responds to the needs, preferences, and values of families and the community;**
- **Emphasizes a positive youth development approach;**
- **Is based on models that demonstrate evidence of effectiveness; and**
- **Makes efficient use of school and community resources.**

The Coordinated School Health Program model suggested by the Centers for Disease Control and Prevention (CDC) includes the following eight components: Health Education; Physical Education; Health Services; Family and Community Involvement; Counseling, Psychological,

---

[1] See the accompanying document, *Background and Research*, in Appendix A.

[2] Policies on Safe Schools (May 2000); Policies for Creating Effective Learning Environments (December 2000); Policies on Bullying (July 2001); Resolution on National School Lunch Week (August 2001); Resolution Supporting School-Based and School-Linked Health Centers (January 2002); Policies on Integrating Communities and Schools (August 2002); Resolution on Michigan Safe Schools Week (October 2002); Resolution on Parenting Awareness Month (February 2003).

and Social Services; Nutrition Services; Healthy School Environment, and Health Promotion for Staff. See Appendix A for history regarding the CSHP model and a discussion of each of these components. The eight-component model is based on the premise that the health of school-age youth is dependent upon a systems approach that addresses program, policy, services, and environment issues.

II. The Board recommends that: a) each school district establishes a School Health Council and b) each school building establishes a School Health Team. Each Council/Team should include a diverse representation of school staff, families, students, and members of the community to oversee and evaluate the Coordinated School Health Program and make recommendations to the school board.

The School Health Council (SHC) focuses on district-level policies and programs and should work in conjunction with district-level school health committees that may already be in place, such as the Sex Education Advisory Committee, Safe and Drug Free Schools Councils, and Emergency Management Planning Teams. To enhance program efficiency and accomplishments, committee members should be kept up-to-date regarding the progress of other committees. Professional development for SHC members is strongly encouraged and opportunities can be shared on line at www.michigan.gov/mde

SHC can support the efforts of the State Board of Education Strategic Initiatives, Education YES! Indicators of Engagement and the federal *No Child Left Behind Act of 2001* legislation. SHC provide a sensible process to integrate decision-making and collaboration of educational leadership to support healthy children and youth, foster cooperation by building consensus and trust between teachers, staff, family, and community members in an innovative way, and link the school improvement and academic achievement efforts that result in improved student health and healthy schools. The School Health Team focuses on building-level implementation and collaboration process to integrate decision-making.

III. The Board recommends that each school building and district designate a School Health Program Coordinator to assist with implementing and evaluating the Coordinated School Health Program.

Practical experience confirms CDC's recommendation that School Health Program Coordinators are best designated at the building and district levels to efficiently plan, implement, coordinate, and evaluate the Coordinated School Health Program components.

IV. The Board recommends that the Michigan Department of Education provide all possible assistance to school districts and schools to implement effective Coordinated School Health Programs.

The Michigan Department of Education can provide support for local implementation of CSHP by:

Modeling collaboration with other agencies and organizations;

- Developing program guidelines, sample policies and position descriptions, resource lists, state and local student health data, and other information useful for program planning and improvement;
- Providing professional development opportunities for School Health Council members, School Health Program Coordinators, and School Health Team members; and
- Providing direct technical assistance in implementing CSHP.

Coordinated School Health Programs ~ Background & Research

Primary and secondary school education has undergone a transformation during the past two decades. States and school districts nation wide have struggled to develop initiatives to improve student achievement. While we as a nation have spent a great deal of time and effort to raise expectations and develop standards for student achievement, health is another critical issue that requires more immediate attention by educators, nation wide.

Good health is **necessary** for **academic success**. Like adults at work, students at school have difficulty being successful if they are depressed, tired, bullied, stressed, sick, using alcohol or other drugs, hungry, or abused. Coordinated School Health Programs (CSHP) are a solution. Fully implemented CSHP can help students succeed academically while improving their short- and long-term health status. Both research and intuition tells us that when students are fit, healthy, and ready to learn, they achieve more success in all areas of their lives.

Effective CSHP do not add more work to school buildings and districts. They help staff do business differently, more collaboratively, by involving parents, teachers/staff, students, and communities to help identify and resolve health concerns. This collaborative approach is designed to promote student success by helping students establish and maintain healthy, personal and social behaviors to improve student knowledge about health and develop personal and social skills that assist them in making smart choices in school and in life.

According to the Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health, "Schools by themselves cannot, and should not be expected to, address the nation's most serious health and social problems. Families, health care workers, the media, religious organizations, community organizations that serve youth, and young people themselves also must be systematically involved. However, schools could provide a critical facility in which many agencies might work together to maintain the well-being of young people...."

The History of Coordinated School Health Programs

In 1987, the CDC first proposed the concept of a coordinated school health program. True coordinated school health programs consist of eight separate but interconnected components. Many of these components exist in every school, but they are often not formally linked in a coordinated way. Active family and community involvement is critical to the success of any coordinated school health program. The following is a list of the eight components and their role in student health:

1 **Health Education** provides critical health information to students.

2. **Physical Education** instructs students on how to be physically active for life.
3. **Health Services** provide essential health care, enabling students to stay healthy, prevent injuries, and improve academic achievement.
4. **Family/Community Involvement** enables students to be supported by the larger community.
5. **School Counselors, Psychologists, and Social Workers** attend to students' mental health needs.
6. **Nutrition Services** provide a healthy nutrition environment, including good breakfast and lunch programs.
7. **Healthy School Environment** provides a building that is safe and conducive to learning and a school climate that ensures all feel safe, supported, and free from harassment or surroundings that may be detrimental to health.
8. **Health Promotion for Staff** improves staff personal health behaviors and provides positive personal examples that reinforce positive student health behaviors.

To be effective, CSHP must be directed toward the needs of students and staff, responsive to the needs of families, and reflective of community values. All eight components must be linked to and supportive of one another. Often, schools with effective coordinated school health programs develop a committee of representatives from each component area. The committee meets to develop school health priorities and programs to address student needs. Many school districts employ a coordinator who works to optimize the connections between the eight separate component areas to prevent duplication of services and to seek additional resources.

As the school reform movement has taken shape over the past two decades, the components of coordinated school health programs have been shown to have an impact on student success in school. The following is a list of each of the eight component areas and the research that illustrates how they contribute to healthy behaviors and improved academic achievement. A short definition of the component precedes the research of each area.

1. **Health Education:** Comprehensive school health education is age-appropriate curriculum and instruction designed to address all aspects of health, including the physical, mental, emotional, and social dimensions, and is designed to increase students' knowledge and their ability to use that knowledge to make healthy decisions. Students who receive comprehensive school health education increase their health knowledge and improve their health-related skills and behaviors. Curricula that have research indicating effectiveness have been proven to assist students in establishing and maintaining healthy behaviors.[1 2 3] For example, a study of third and fourth grade students that included a control group of students who did not receive comprehensive school health education and an experimental group that did showed that students who received comprehensive school health education scored higher than the control group on assessments in reading and mathematics.[4]

---

[1] Connell, D., Turner, R., and Mason, E. (1985). Summary of findings of the school health education evaluation: Health promotion effectiveness, implementation, and costs. Journal of School Health, 55(8), 316-321.
[2] Botvin, G.J., Griffin, K.W., Diaz, T., Ifill-Williams, M. (2001) Preventing binge drinking during early adolescence: one-and two-year follow-up of a school-based preventive intervention. Psychology of Addictive Behaviors, 15(4),360-365.
[3] Dent, C., Sussman, S., Stacy, A., Craig, S., Burton, D. Flay, B. (1995). Two year behavior outcomes of project towards no tobacco use. Journal of Consulting and Clinical Psychology, 63(4),676-677.
[4] Schoener, J., Guerrero, F., and Whitney, B. (1988). The effects of the Growing Healthy program upon children's academic performance and attendance in New York City. Report from the Office of Research, Evaluation and Assessment to the New York City Board of Education.

2. **Physical Education:** Some schools are reducing time for recess and physical education in response to demands to improve students' academic performance. Ironically, this shift in school time allocation may be having the opposite effect on academic achievement. Research shows that school-based physical activity programs can help students increase concentration, reduce disruptive behaviors, and improve scores in mathematics, reading, and writing. In two separate controlled studies, class time for academics was reduced by about 250 minutes per week in the experimental groups to increase exposure to physical education. In both studies, academic test scores were either improved or unchanged when compared to control groups that did not have increased time for physical activity. Research also suggests a critical relationship among movement/attention, spatial perception, and learning/memory in youth and adults, including those with special needs. Beyond the academic benefits, physical activity and physical education contribute to the maintenance of positive interpersonal relationships and reduce the incidence of depression, anxiety, and fatigue. Vigorous physical activity can help reduce anxiety, tension, depression, and reaction to stressors.[5]
3. **Health Services:** When most people think of school health services, they think of physical health and the school nurse. Local district employed school nurses are still the most effective method of delivering health services to students in school. More schools are entering into partnerships with a community health provider, such as a hospital or health department, and contracting with them for nursing services. Schools are also partnering to deliver student health services through an on-site health center. This is especially true where access to primary health care is very limited for the school-age population. School health service programs provide emergency/urgent care, medication administration, case management for students with chronic health conditions, and a host of preventative services, including immunizations and health education. These programs can make a major impact on the students' health and their ability to succeed in school. This impact is reflected in better attendance, decreased dropouts and suspensions, and higher graduation rates.[6] [7]
4. **Family/Community Involvement:** As most educators know, when supportive parents are involved in their children's education, they are more likely to get better grades, score better on standardized tests, show up for school regularly and on time, and complete their assigned homework. When teachers and parents work in partnership, they can provide the support required and accountability necessary for student success.[8] [9] Student participation in community activities can support classroom learning in significant ways. In two separate studies, community activities were shown to positively impact academic achievement, reduce school suspension rates, and improve school-related behaviors. The increased interest in co-curricular, extracurricular, and after-school programs that are supported by community initiatives, recognizes the positive impact on student involvement. Coordinated school health programs can provide the necessary linkages to ensure that these programs support, rather than compete with, the school's objectives for student achievement.[10] [11]

---

[5] Michigan Department of Education. (2001). The Role of Michigan Schools in Promoting Healthy Weight: A Consensus Paper. Available online at: http://www.michigan.gov/mde or http://www.emc.cmich.edu.
[6] McCord, M., Klein, J., Foy, J., & Fothergill, K. (1993). School-based clinic use and school performance. Journal of Adolescent Health, 14(2),91-98.
[7] A comparison of absentee/attendance rates in high schools with and without school based health clinics. Thesis submitted to Michigan State University.
[8] National Committee for Citizens in Education. (1987). The Evidence Continues to Grow: Parental Involvement Improves Student Achievement. Ed. Anne Henderson. National Committee for Citizens in Education: Columbia, MD.
[9] Shaver, A.V. and Walls, R.T. (1998). Effect of Title I Parent Involvement on Student Reading and Mathematics Achievement. Journal of Research and Development in Education, 31(2),90-97.
[10] Community involvement and disadvantaged students: A review. Review of Educational Research, 61(3),379-406.

5. **School Counselors, Psychologists, and Social Workers:** This group works in concert with other school and community professionals to provide appropriate assistance for students and their families. Effective programs focus on prevention, address problems, facilitate positive learning and healthy behavior, and enhance healthy student development.[12] In one study, a comprehensive intervention had a significant and positive impact on student achievement over time. This intervention resulted in enhanced student commitment and attachment to school, less social misbehavior, and improved academic achievement.
6. **Nutrition Services:** School nutrition services involve much more than school lunches. An effective program integrates an appealing meal program with nutrition education and a food environment that promotes healthy eating. School nutrition is focused on lifelong benefits. Ensuring that schools offer nutritious, appealing choices whenever and wherever food and beverages are available on campus is an important policy objective of many federal and state programs. Hunger not only impacts health but also affects students' academic achievement in profound ways. In national health data, children ages six to 11 who reported not having enough food to eat were more likely to have significantly lower mathematic scores, were more likely to have repeated a grade, were more likely to have seen a psychologist, and were more likely to have had difficulty getting along with other children. In teenagers, the results were dramatic: they were more than twice as likely to have seen a psychologist, almost three times as likely to have been suspended from school, almost twice as likely to have difficulty getting along with others, and four times as likely to have no friends. The findings speak to the critical need for school nutrition programs so that students can thrive in and out of the classroom.[13]
7. **Healthy School Environment:** A positive school climate and safe school facilities are both important for student success. One study noted a link between school facilities and academic performance. The study found that the physical environment of the school could be either a support or a hurdle to student achievement. As with adults in their workplaces, students perform better in facilities that are attractive, functional, safe, and secure.[14] The social and emotional climates of the school are equally critical to students' academic success. Students must feel support from parents, administrators, teachers, and peers to achieve their full potential. The importance of connections to parents and school are the two most important factors in healthy, social development for children and youth. In several studies, students who develop a positive affiliation with school are also more likely to remain academically engaged and less likely to be involved in misconduct at school.[15] Another vitally important facet is to prevent exposure to biological or chemical agents that may be detrimental to health. For example, students and staff who have asthma or allergies may be sensitive to the presence of animals in the classrooms, dust, cleaning fluids, markers, or perfumes. The air quality in schools should be monitored for molds, dust and proper humidity.
8. **Health Promotion for Staff:** By encouraging staff to practice healthy behaviors at school, improve their personal health and practice healthy behaviors, administrators, teachers, and

---

[11] Allen, J. P., Philliber, S., Herrling, S., and Kupermine, G. P. (1997). Preventing teen pregnancy and academic failure: Experimental evaluation of a developmentally based approach. Child Development, 64(4),729-742.
[12] Hawkins, J., Catalano, R., Kosterman, R., Abbott, R., and Hill, K. (1999). Preventing adolescent health-risk behaviors by strengthening protection during childhood. Archives of Pediatric Adolescent Medicine, 153,226-234.
[13] Murphy, J., Pagano, M., Nachmani, J., Sperling, P., Kane, S., and Kleinman, R. (1998). The relationship of school breakfast to psychosocial and academic functioning. Archives of Pediatric Adolescent Medicine, 152,899-907.
[14] Building conditions, parental involvement, and student achievement in the District of Columbia public school system. Urban Education, 28(1),6-29.
[15] Simons-Morton, B., Crump, A., Haynie, D., and Saylor, K. (1999). Student-school bonding and adolescent problem behavior. Health Education Research, 14(1),99-107.

other staff members not only enhance their own well-being but also become role models for the students in their care. This type of reinforcement is critical to sustaining healthy behaviors for both adults and students. Many school-site health promotion programs focus on promoting physical activity for staff. The health benefits of regular physical activity are well documented and include stress reduction, maintenance of healthy weight, an improved sense of well-being, fewer sick days and generate less health insurance cost due to illness.[16] Students benefit from having healthy teachers because their teachers are more energetic and absent less often. This means more days with their regular teacher in the classroom rather than a substitute teacher. Healthy adults in the school also contribute to a positive and more optimistic environment.[17]

[16] Blair, S., Collingwood, T., Reynolds, R., Smith, M., Hagan, D., and Sterling, C. (1984). Health promotion for educators: Impact on health behaviors, satisfaction, and general well-being. American Journal of Public Health, 74(2),147-149.
[17] Symons, C.W., Cummings, C.D., Olds, R.S. (1994). Healthy People 2000: An agenda for school site health promotion programming. In: Allensworth, D.D., Symons, C.W., Olds, R.S. Healthy Students 2000: An Agenda for Continuous Improvement in America's Schools. Kent, OH: American School Health Association, 1994.

Michigan State Board of Education

Policy to Promote Health and Prevent Disease and Pregnancy

The Michigan State Board of Education recognizes that human immunodeficiency virus (HIV)[1], other sexually transmitted infections (STIs)[2], and early pregnancy are serious threats to the current and future health and academic success of Michigan students. Well-planned and implemented comprehensive school health education has been shown to positively influence students' health-related knowledge, skills, and behaviors and contributes to their academic achievement. Schools therefore have a duty, in concert with families and communities, to implement effective sexuality education programs that will help students make responsible decisions during their school years and into their adult lives.

The State Board of Education recommends that local school boards support their school administrators and faculty to select, adopt, and implement comprehensive sexuality education programs that are based on sound science and proven principles of instruction. Such research-based programs will help schools accomplish the teaching and learning goals of the federal *No Child Left Behind Act of 2001* and of Michigan's *Education YES!—A Yardstick for Excellent Schools.* To safeguard their health and the health of others, all students should receive this instruction unless a parent or legal guardian has specifically requested that their child be excused from specified classes or units within the course. Minimally, local school districts' programs must be in compliance with Michigan laws regarding reproductive health education and HIV and other STI prevention programs[3]. Provisions of these laws include a functioning advisory board, curriculum content adopted by the local school board, professional development, preview of program materials, parent notification, and public hearings related to program changes.

Local board policies that support effective sexuality programs should include the following principles and recommendations:

I. Parents/guardians and families are the first and primary sexuality educators of their children. Education programs are more likely to be effective when they are consistent with what most parents want for their children. Parents, schools, and the broader community must work together to provide consistent messages regarding healthy and responsible behavior. **The State Board of Education recommends that local school districts adopt sexuality education programs that are consistent with school and community standards and support positive parent/child communication and guidance. The Board recommends that local school districts conduct parent/community surveys to assess attitudes towards sexuality education and help determine what specific topics should be taught and when they should be introduced.**

---

[1] HIV is the virus that causes Acquired Immune Deficiency Syndrome (AIDS).

[2] The term *sexuality transmitted infections* (STIs) is used as recommended by the medical profession to replace the previous term *sexuality transmitted diseases* (STDs). Common sexually transmitted infections include chlamydia, gonorrhea, syphilis, hepatitis B, herpes, and human papilloma virus (HPV).

[3] Current statutes related to HIV and sex education instruction in school include Public Act 451 of 1976 and Public Act 94 of 1979, MCL §380.1169, MCL §380.1506, MCL §380.1507, MCL §388.1766, and MCL §388.1766a.

II. Decisions regarding the specific content of sexuality education programs, as with all curriculum areas, belong primarily at the local school district level. Sound programs of instruction address human development, healthy relationships, communication skills, possible consequences of sexual risk behaviors, influence of alcohol and other drugs on decisions and sexuality within society and culture. Instruction should emphasize that students have the power to control personal behavior and should base their actions on accurate information, values, reasoning, a sense of responsibility, and respect for self and others. Education programs should address the needs of all students: those who have abstained from sexual activity, those who have engaged in sexual activity but are currently abstaining, those who are engaging in sexual activity, and those who will decide to engage in sexual activity in the future. The content should also be consistent with the Michigan Department of Education Health Education Content Standards. **The State Board of Education urges that sexuality education program content be medically accurate and include current information.[4] Abstinence from risky sexual behavior must be stressed as the only certain way to avoid HIV, other STIs, and pregnancy.[5] Given the fact that 43 percent of Michigan high school students reported they have had sexual intercourse[6], instruction also needs to address methods to reduce risks for HIV, other STIs, and unintended pregnancy.**

III. Our nation's pluralistic society requires an educational system that provides education and supports programs that address the varied needs of highly diverse student populations in nondiscriminatory ways. **The State Board of Education recommends that school districts plan and implement sexuality education programs that are age, developmentally, linguistically, and culturally appropriate. Local school districts should use multiple sources of data regarding student needs, knowledge, and behavior to plan programs that meet the prevention needs of all students, with due attention to those who might be at greater risk for HIV, other STIs, and pregnancy.[7]**

IV. Best practice evidence suggests that an effective sexuality education program is:

a. conducted within the context of a broader Coordinated School Health Program;
b. initiated early, before students reach the age when they may adopt risky behaviors, and reinforced throughout middle and high school;
c. focused on the risk behaviors that are most likely to result in HIV infection, other sexually transmitted infections, and unintended pregnancy;
d. centered on a positive, healthy definition of sexual health rather than one that focuses only on avoiding negative outcomes;

---

[4] *Medically accurate* means verified or supported by research conducted in compliance with scientific methods and published in peer-review journals, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field.

[5] Use of drugs and alcohol can cloud judgment and increase the likelihood of risky sexual behaviors. HIV can also be transmitted through blood-to-blood contact that may occur with sharing of injection needles. Therefore, a strong abstinence message from both sexual activity and alcohol and other drugs is necessary.

[6] Results are from the 2003 Michigan Youth Risk Behavior Survey.

[7] Researchers have identified certain populations of students who may be at greater risk for these outcomes due to situational or behavioral factors, such as students in special education or alternative education programs, students in high prevalence communities, students who have been sexually abused, and students who identify as gay, lesbian, bisexual, transgender, or who are questioning their sexual orientation.

e. based on proven theories of behavior change, with an emphasis on instructional methods that foster functional knowledge and develop prevention skills within environments that reinforce the knowledge and skills taught;
f. of sufficient duration for students to acquire the knowledge and skills needed to adopt healthy behaviors[8];
g. implemented with consistency as approved; and
h. delivered by trained staff who are comfortable with the subject matter and supportive of the program.

The State Board of Education recommends that school districts plan, adopt, and implement sexuality education programs that are research based and consistent with principles of effective instruction.

V. Successful sexuality instruction is best provided by well-trained and supported school staff members who demonstrate:

a. sound knowledge of content and the ability to access and evaluate reliable sources for obtaining additional information;
b. skill in using a variety of teaching strategies, engaging educational methods, and performance-based student assessment;
c. the ability to communicate with and involve parents and guardians;
d. the ability to utilize trained community agency staff to enhance, but not replace, the instructional program;
e. the ability to work with appropriate school staff to link students to adolescent health services as necessary[9];
f. skill in planning and evaluating curricula; and
g. skill in working effectively with others within the school and community.

The State Board of Education recommends that school districts support on-going professional development for designated school staff in effective sexuality instruction.[10]

VI. Adoption of sexuality education materials and methods should be well documented. The program should be revised regularly based on evaluation results, changes in research, and feedback from students, parents/guardians, and teachers. Evaluation information should indicate what students have learned and were able to apply, whether the program was workable for the teachers, and how the program could be improved. **The State Board of Education recommends that the local advisory board[11] meet at least semi-annually to review program progress and make any necessary recommendations to the local school board.**

---

[8] Effective instruction is seldom a single event such as a video, an assembly or a special event. In isolation these strategies have not proven to change behavior. Dr. Doug Kirby in *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy* (2001) identified the most effective school-based programs as those that lasted fourteen or more hours.

[9] Such services may include but are not limited to school-based health services, and HIV and STI counseling, testing and referral services.

[10] Professional development for sexuality education is provided through local or intermediate school district workshops, as well as state and national conferences. MCL §380.1169 already requires training for those who teach K-12 pupils about HIV and AIDS, with an exception for licensed health care professionals who have received training on HIV and AIDS.

[11] The local advisory board is the body designated in MCL §380.1507 to review materials and make recommendations to the local school board regarding sex education programs. Minimally, it must include parents of students in the district, students, educators, local clergy, and community health professionals.

Michigan State Board of Education

Policy to Promote Health and Prevent Disease and Pregnancy

Resources

1. Details regarding the *No Child Left Behind Act of 2001* and *Education YES!* can be accessed at www.nochildleftbehind.gov and on the accountability page of the Michigan Department of Education website www.michigan.gov/mde/0,1607,7-140-22709---,00.html

2. Numerous studies support the links between comprehensive school health education, knowledge, skills, behaviors, and student achievement.
   - Connell, D., Turner, R., & Mason, E. (1985). Summary of findings of the school health education evaluation: Health promotion effectiveness, implementation, and costs. *Journal of School Health, 55*(8), 316-321.
   - Dent, C., Sussman, S., Stacy, A., Craig, S., Burton, D. & Flay, B. (1995). Two-year behavior outcomes of project towards no tobacco use. *Journal of Consulting and Clinical Psychology, 63*(4), 676-677.
   - Elias, M., Gara, M., Schuyler, T., Branden-Muller, L., & Sayette, M. (1991). The promotion of social competence: Longitudinal study of a preventive school-based program. *American Journal of Orthopsychiatry, 61*(3), 409-417.
   - Schoener, J., Guerrero, F., & Whitney, B. (1988). The effects of the Growing Healthy program upon children's academic performance and attendance in New York City. Report from the Office of Research, Evaluation and Assessment to the New York City Board of Education.

3. Information regarding HIV and Sex Education in Michigan schools can be accessed at www.emc.cmich.edu. The site includes information on topics including the law, communicable disease policies and guidelines, implementing school based programs, and parent involvement and resources.

4. Michigan laws including those affecting schools can be accessed through the Michigan Legislature website at www.michiganlegislature.org. A compilation of Michigan laws regarding sex education, HIV education, health education, and physical education as of September 2003 can be found at www.emc.cmich.edu/hiv/schoolcode.htm.

5. A sample Parent/Community Sex Education survey developed by the Michigan Department of Education can be accessed at http://www.emc.cmich.edu/hiv/Guide/images/AppendixA.pdf

6. Michigan's Health Education Content Standards include core concepts and the skills of accessing information, self-management, analyzing internal and external influences, decision-making and goal-setting, interpersonal communication, and advocacy and can be accessed on the web at http://www.michigan.gov/documents/Health_Standards_15052_7.pdf.

7. Michigan Youth Risk Behavior Survey data can be accessed at http://www.emc.cmich.edu/YRBS.

8. State Collaborative on Assessment and Student Standards-Health Education Project materials are available from school health staff within the Michigan Department of Education, Office of School Excellence.

Michigan State Board of Education

Policy on Quality Physical Education

A child's intellectual growth cannot take place without having met his or her basic physical needs. The curriculum for every child's preschool through high school experience should include the opportunity to participate in quality physical education programs and other health-enhancing physical activity.

I. The State Board of Education recommends that all public schools offer physical education opportunities that include the components of a quality physical education program. Quality physical education programs positively impact students' physical, social, and mental health. It is the unique role of quality physical education programs to provide opportunities for children to understand the importance of physical activity and to acquire skills to combat a sedentary lifestyle.[1, 2]

A quality physical education program addresses three critical issues: curriculum, instruction and assessment, in conjunction with an opportunity to learn and should include the following:

Curriculum:

- Has a curriculum aligned with the Michigan K-12 *Physical Education Content Standards and Benchmarks*.
- Equips students with the knowledge, skills, and attitudes necessary for lifelong physical activity.
- Influences personal and social skill development.

Instruction and Assessment:

- Is taught by a certified physical education teacher trained in best practice physical education methods.
- Aligns curriculum, instruction, and assessment.
- Engages students in curriculum choices that prepare them for a wide variety of lifetime activities.
- Keeps all students involved in purposeful activity for a majority of the class period.
- Builds students' confidence and competence in physical abilities.
- Includes students of all abilities.

Opportunity to Learn:

- Offers instructional periods totaling 150 minutes per week (elementary) and 225 minutes per week (middle and high school).
- Has a teacher to student ratio consistent with those of other subject areas and/or classrooms.
- Provides facilities to implement the curriculum for the number of students served.
- Has enough functional equipment for each student to actively participate.
- Builds students' confidence and competence in physical abilities.
- Includes students of all abilities.

---

[1] National Association for Sport & Physical Education. "What Constitutes a Quality Physical Education Program?"

[2] Michigan's Exemplary Physical Education Curriculum Project. (2001). *EPEC Lessons – Grades K, 1, 2, 3, 4, 5, User's Manual and Teaching/Learning Progressions.*

II. The State Board of Education that all public schools offer daily opportunities for unstructured physical activity, commonly referred to as recess, for all students pre-K through grade six. Recess should be in addition to physical education class time and not be a substitute for physical education. Each school shall provide proper equipment and a safe area designated for supervised recess in the elementary setting. School staff should not withhold participation in recess from students or cancel recess to make up for missed instructional time. Schools should provide opportunities for some type of physical activity for students in grades seven through twelve apart from physical education class and organized sports.