HEALTH EDUCATION FRAMEWORK

FOR CALIFORNIA PUBLIC SCHOOLS

Kindergarten Through Grade Twelve

Chapter 1
Introduction

Adopted by the California State Board of Education
May 2019

Published by the California Department of Education
Sacramento, 2021

Introduction

CHAPTER 1

Health education is a vital subject for all California students—one that will influence many aspects of their lives. Good health and academic success are inextricably linked. Healthy children make better students and better students become healthy, successful adults who are productive members of their communities. Healthy students, healthy relationships, and a healthier environment are achievable goals through health education that fully addresses the *Health Education Content Standards for California Public Schools, Kindergarten Through Grade Twelve* (health education standards) (2008). In the past 20 years, health education has evolved to become a powerful, comprehensive, theory-driven, evidence-based platform from which to educate, inform, and empower youth to make well-informed health decisions that lead to positive practices that promote a lifetime of good health.

The *Health Education Framework for California Public Schools, Kindergarten Through Grade Twelve* (framework), which is guided by the health education standards, is intended to assist elementary teachers, secondary health education teachers, administrators, school nurses, school counselors, other educators, local educational agencies (LEAs), district personnel such as curriculum specialists, community partners such as school-based health center staff, and school board members in developing programs that educate, influence, and inspire California's children to learn, adopt, and maintain positive health practices throughout their lives.

An effective school health program can be one of the single most cost-effective investments a nation can make to simultaneously improve education and health

(World Health Organization 2019). Schools play a critical role in promoting the health and safety of children and adolescents by assisting them in establishing a lifetime of positive health practices. Schools have direct contact with more than 95 percent of our nation's youth aged five to seventeen years old, for approximately six hours a day, and up to 13 critical years of their social, psychological, physical, and intellectual development (Centers for Disease Control and Prevention [CDC] 2019a). Thus, health instruction is best provided by credentialed health education teachers in middle and high school, fully credentialed teachers in transitional kindergarten (TK) through sixth grade, or credentialed school nurses with a special teaching authorization in health.

As discussed in the Health Education for Every Student section of chapter two, in areas where there is a shortage of credentialed health instructors, LEAs are encouraged to explore a variety of local-level options for ensuring appropriate health education credentialing. Also, opportunities for professional learning are essential in assisting all teachers to expand their knowledge and skills to teach health education. High-risk behaviors, such as unhealthy eating; inadequate physical activity; high-risk sexual and violence-related behaviors including bullying and intimate partner violence; and usage of alcohol, tobacco, and other drugs, are often established in childhood and adolescence. Today's youth encounter greater health challenges and more complex health-related issues at a faster pace than in previous generations (Telljohann et al. 2015). Health education teachers have the unique opportunity to make a meaningful impact and positive change for the youth of today and tomorrow by teaching students positive health behaviors, skills, and practices they will remember and apply for a lifetime.

One of the primary goals of health education is health literacy for all students in California. Health-literate students can understand basic health information, directions, and services needed to make informed personal health decisions which may also contribute to healthier communities. Health-literate and health-informed students are:

- Critical thinkers and problem solvers when confronting health issues
- Self-directed learners who have the competence and skills to use basic health information and services in health-enhancing way
- Effective communicators who organize and convey beliefs, ideas, and information about health issues, translating their knowledge to applied practices

- Responsible and productive citizens who help ensure that their community is kept healthy, safe, and secure

These four essential characteristics of health-literate individuals are woven throughout the health education standards and this framework.

The Health of Our State

All students in California should have access to high-quality health education. California youth experience many real and potential health challenges that could be improved by high-quality health education. For example, consider the following statistics related to obesity: 74 percent of adolescents in California do not consume the recommended five or more servings of fruit and vegetables per day, and at least 65 percent of youth consume at least one sugary beverage or soda per day (Wolstein, Babey, and Diamant 2015, 14). Only 18 percent of California adolescents meet the recommended one hour of physical activity a day (Wolstein, Babey, and Diamant 2015, 18). Those who are less physically active and have poor nutrition are more likely to be obese. More than one million California adolescents aged twelve to seventeen are overweight (16 percent) or obese (17 percent) (Wolstein, Babey, and Diamant 2015, 3). Obesity is a well-established risk factor for diabetes and cardiovascular issues such as stroke and heart disease later in life. Issues such as food insecurity, lack of sleep, and nutrition deficiencies are also a growing concern (CDC 2019b).

Growing trends confirm some adolescents may spend more time using technology-related activities (texting and engaging with online social media on their mobile devices, playing video games, or watching television) than engaged in physical activity, placing them at an increased risk for obesity-related childhood diseases and mental health issues (American Academy of Pediatrics 2009; Rosen et al. 2014). Other students may experience barriers to participating in physical activity, such as a lack of access to a safe area to exercise or for recreation. Students may also experience transportation challenges, have limited funds to participate in exercise programs, or are unable to obtain exercise equipment (Pate et al. 2011; Rosen et al. 2014). Human-caused environmental health hazards, such as poor air quality, also affect millions of Californians, including 1.2 million children diagnosed with asthma, making it imperative students learn the importance of maintaining a healthy environment as a cornerstone to good personal and community health (Milet 2017).

The health of California youth may be improved by high-quality health education. Many children in California are eating a nutritious diet, exercising regularly and meeting the recommended amounts of physical activity; not using alcohol, tobacco, and other drugs; and are generally healthy and happy. Important legislative initiatives, such as limiting or prohibiting the sale of sweetened beverages in schools, and policies for school health education curriculum, such as the California Healthy Youth Act, have fostered more promising health outcomes. However, continued efforts are warranted to support healthy youth in adopting lifelong health-enhancing behaviors and becoming productive, healthy adults.

The California Healthy Kids Survey provides insightful student data on health behaviors (WestEd 2018):

- 40 percent of high school students do not eat breakfast
- Close to 13 percent of seventh-graders, 32 percent of ninth-graders, and 48 percent of eleventh-graders have used alcohol or drugs at some time with 32 percent having used electronic smoking devices (ESDs).
- 7 percent of seventh-graders, 19 percent of ninth graders, and 29 percent of eleventh graders reported currently using alcohol and other drugs
- Approximately 30 percent of seventh-grade students reported being harassed or bullied

High levels of depression are occurring among adolescents, with 25 percent of seventh-graders and 32 percent of eleventh-graders reporting chronic sadness

The CDC confirmed 32 percent of high school (grade levels nine through eleven) students in the United States felt sad or hopeless almost every day for two or more consecutive weeks prompting them to discontinue their usual activities, and 16 percent of California high school students reported seriously contemplating suicide (2018, 48; WestEd 2018, 37). Regarding sexual behavior, 32 percent of California students in grade levels nine through twelve reported ever having sexual intercourse, approximately 10 percent lower than the national average (CDC n.d.).

Educating students about environmental health, from both a personal and community health perspective, is a strand in the standards that continues from kindergarten through high school where students are expected to learn, among other issues, about the impacts of air and water pollution on health. These topics

tie directly to California's Environmental Principles and Concepts (EP&Cs), adopted by the State Board of Education in 2004. The EP&Cs are an important piece of the curricular expectations for all California students that teachers can incorporate through their many connections with the health education standards, specifically by focusing instruction on the personal and community effects of environmental issues.

California's Environmental Principles and Concepts

Principle I—The continuation and health of individual human lives and of human communities and societies depend on the health of the natural systems that provide essential goods and ecosystem services.

Principle II—The long-term functioning and health of terrestrial, freshwater, coastal and marine ecosystems are influenced by their relationships with human society.

Principle III—Natural systems proceed through cycles that humans depend upon, benefit from, and can alter.

Principle IV—The exchange of matter between natural systems and human societies affects the long-term functioning of both.

Principle V—Decisions affecting resources and natural systems are based on a wide range of considerations and decision-making processes.

Source: *California Education and the Environment Initiative (2019). A complete listing of the EP&Cs, including their detailed descriptions, is provided on the California Education and the Environment Initiative website. This initiative is run through the CalRecycle program and the document is available on the CalRecycle website.*

Concerns about achieving environmental justice are a critical social dimension of health education because of the potential broad-ranging community effects of environmental issues such as air pollution, water pollution, and toxic chemicals released by industrial and other activities. The California Environmental Protection Agency states that the "principles of environmental justice call for fairness, regardless of race, color, national origin or income, in the development of laws and regulations that affect every community's natural surroundings, and the places people live, work, play and learn" (CalEPA 2020). Other definitions speak to the equitable distribution of environmental risks and benefits; fair and meaningful participation in environmental decision-making; recognition of community

ways of life, local knowledge, and cultural differences; and the capability of communities and individuals to function and flourish in society.

Rigorous standards-based instructional methods and strategies can support students in achieving more positive health-behavior outcomes and addressing the complex community and global health issues that impact the natural world and their personal health.

Health Defined

The World Health Organization defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (1946). This definition of health is still the most recognized guiding definition in public health today. Beyond this comprehensive definition, the US Department of Health and Human Services' Healthy People 2020 and the CDC are resources that examine public health through a variety of lenses, including health disparities and health equity. Health disparities and health equity are greatly influenced by the social determinants of health—the conditions in which people are born, grow, live, work, and age (World Health Organization 2017). Researchers and public health professionals recognize the following five categories as determinants of health (CDC 2014b):

- Biology and genetics (e.g., sex assigned at birth, age, family history of a chronic disease)
- Individual behavior (e.g., eating unhealthy foods, not engaging in physical activity, trying alcohol for the first time)
- Social environment (e.g., discrimination, socioeconomic status, and other factors that influence environmental justice in local communities and the state as a whole)
- Physical environment (e.g., housing, recreational areas, air and water quality)
- Health services (e.g., a child having access to quality health care and having or not having health insurance)

Health Education: An Essential Component of Comprehensive School Health

The American School Health Association definition of school health is comprehensive and includes the following components (2014b):

- A healthful environment
- Nursing and other health services students need to stay in school
- Nutritious and appealing school meals
- Opportunities for physical activity that include physical education
- Health education that covers a range of developmentally appropriate topics taught by knowledgeable teachers
- Programs that promote the health of school faculty and staff
- Counseling, psychological, and social services that promote healthy social and emotional development and remove barriers to students' learning

In accordance with the mission of the American School Health Association, the school health sector envisions "healthy students who learn and achieve in safe and healthy environments nurtured by caring adults functioning within coordinated school and community support systems" (2014a).

Health education begins in the earliest years of schooling and continues through graduation from high school. It is best provided by credentialed teachers or credentialed school nurses with a special teaching authorization in health during a designated time in elementary grades and by credentialed health education teachers in a health education class in middle and high school. Establishing healthy behaviors, practices, and skills during childhood is the work of all professional educators and more effective than trying to change well-established behaviors during adulthood.

Schools play a critical role in not only promoting the health and safety of children but also in teaching young people the skills, applied practices, and behaviors for a lifetime of good health. The health education standards are the foundation for instruction that provides opportunities for students to practice

essential skills to maintain healthy lifestyles and emotional well-being. Social and emotional learning can help students develop the understanding, strategies, and skills that support a positive sense of self, promote respectful relationships, and build student capacity to recognize and manage their own emotions and make responsible decisions. Social and emotional learning provides a foundation for safe and positive learning, and enhances students' ability to succeed in school, careers, and life.

Research confirms that age-appropriate and medically accurate health education in schools reduces the prevalence of high-risk health behaviors among youth and can positively impact academic performance outcomes, including retention and graduation (Basch 2010; CDC 2014a). Children who are physically, socially, and mentally healthy are ready to learn and be productive in school. Establishing positive personal and public health practices among young people can lead to improved individual health outcomes. Healthy students attend school regularly, achieve academically, and live healthier lives (Michael et al. 2015; CDC 2014a).

Research in education also confirms instructional strategies that address cognitive, affective, and skill domains are most effective (Telljohann et al. 2015). As medical research and health information develops quickly, and changes at an even more rapid pace, effective health education instruction must also incorporate the most current, medically accurate, evidence-based, and theory-driven content from reliable resources. Health education instruction and resources must be accessible for all student groups, inclusive, culturally relevant, and age appropriate and must incorporate technology, when available, in support of the twenty-first century learner. The health education standards and this framework provide recommendations for health education teachers, other credentialed teachers, school counselors, school nurses, administrators, and curriculum development specialists to plan, implement, and evaluate effective health education from TK through twelfth grade. This framework also serves as a resource for health educators and community-based organizations working with school districts.

The World Health Organization conducted a comprehensive evaluation of school health education programs and found the most effective programs share the following qualities (2003):

- Youth are more successful in establishing healthy behaviors when health education develops learners' skills, increases students' knowledge, and influences their attitudes.

- Healthy behavioral outcomes are more likely to occur when skill development and practice are tied to specific health content, decisions, or behaviors.
- The most effective method of skill development is learning by doing—ensuring students are active, not passive, learners.

For more information on skills-based health education reference the World Health Organization's Information Series on School Health, Skills for Health (2003).

The Whole School, Whole Community, Whole Child Approach

The CDC and Association for Supervision and Curriculum Development (ASCD) provide a collaborative and comprehensive approach to school health with the Whole School, Whole Community, and Whole Child (WSCC) model (CDC 2019d; see the CDC and ASCD's Whole School, Whole Community, and Whole Child Model image below). The whole-child approach is an effort to transition from a focus on narrowly defined academic achievement to one that promotes the long-term development and success of all children. Health education is often implemented in a certain class or specific awareness campaign, but may not be truly integrated into the entire school district's master curriculum plan in the same manner as other content areas. The WSCC model includes the eight components of a coordinated school health program, extending to integrate a whole child approach to education. The WSCC approach seeks to improve a child's cognitive, physical, social, and emotional development as it pertains to health education. This approach includes individual health, community involvement, family engagement, physical environment, advocacy, and public policy.

This standards-based health education framework addresses the majority of the constructs of the WSCC, including:

- Health education
- Physical activity
- Nutrition
- Health services
- Counseling and social services
- Social and emotional climate
- Physical environment
- Family engagement

It also addresses community involvement in support of improving learning and health outcomes for a healthy, safe, challenged, engaged, and supported child through coordinated policy, processes, and practice (CDC 2019d). The wheel could also be expanded to demonstrate the importance of community, cultural norms, climate, agencies, parents/caretakers/guardians, stakeholders, health practitioners, and educators that ideally work in concert to support students. Additionally, many school districts have found this model to provide guidance as they revise their district's school wellness policies and regulations to implement wellness throughout school environments and instructional programs for students as well as other programs for students and employees.

The CDC and ASCD's Whole School, Whole Community, and Whole Child Model

Long description of the CDC and ASCD's Whole School, Whole Community, and Whole Child Model is available at https://www.cde.ca.gov/ci/he/cf/ch1longdescriptions.asp#ch1link1.

Source: *CDC (2019d).*

Promoting a Safe, Supportive, and Inclusive Learning Environment

California schools are made up of diverse populations that vary in terms of primary language, culture, ethnicity, gender, gender identity, sexual orientation, religion, health conditions, immigration status, and types of abilities and disabilities. The "Access and Equity" chapter addresses the instructional needs of students who may face academic and other challenges, such as English learners, students living in poverty, youth in foster care, advanced learners, and students with different cognitive and physical abilities. All students benefit from a learning environment in which these challenges are understood and addressed. Creating a safe, supportive, inclusive, and nonjudgmental environment is crucial in promoting healthy development for all students.

To promote inclusion, teachers are encouraged to use names that reflect the diversity of California's students and people-first language when designing instruction and activities and developing examples. For example, if a student has a disability, the student is referred to as a student with a disability versus a disabled student. A safe and inclusive linguistic environment in the health education context is one where students are supported to express their ideas using their primary or secondary language. Teachers create an inclusive classroom environment by adopting an asset orientation toward cultural and linguistic diversity and respecting multiple viewpoints and backgrounds, especially when addressing topics where values and expectations are likely to differ across cultural groups, such as sexuality and drug use.

Educators must keep issues of motivation, engagement, and cultural and linguistic responsiveness at the forefront of their work in supporting students to achieve the health education standards. To ensure students are engaged and motivated to learn, the following tips are recommended:

- Create an information-rich environment
    - Provide meaningful, health-related text on classroom walls and well-stocked, inviting, and comfortable libraries that contain a range of health-related texts (e.g., nutrition and physical activity, social and emotional learning), including texts in students' home languages.

- Promote inquiry and autonomy
  - Allow students to generate their own questions and to choose health-related activities, texts, and even locations in the room in which to engage with health-related books, manipulatives, and tasks independently.
- Make it relevant
  - Ensure that health education experiences are relevant and responsive to students' interests, everyday life, or important current events.
- Emphasize collaboration
  - Structure frequent opportunities for students to collaborate with their peers in health-related group learning tasks, to read and discuss texts, and in creating artifacts that demonstrate their learning.

To ensure access and equity for culturally and linguistically diverse learners, educators must also adopt an asset-orientation toward students. This includes the school community's open recognition that students' ethnicities, religious backgrounds, home cultures and experiences, primary languages and home dialects of English (e.g., African American English or Chicanx American English), family composition, gender expression, and other aspects of students' identities are resources, valuable in their own right and useful for deep learning. To ensure cultural and linguistic responsiveness, the following tips are recommended:

- Create a culturally sustaining environment
  - Design a positive and welcoming classroom environment that exudes respect—and promotes sustainment—for cultural, linguistic, and all types of diversity.
- Know students well
  - Spend some time understanding the layers of students' identities, particularly if their backgrounds differ from your own, including their cultural and linguistic assets and how individual students interact with their primary languages and home cultures.

- Honor students' languages while ensuring that integrated English language development standards and instruction are implemented to help all English learners access the health education content
    - Use students' primary languages or home dialects of English, as appropriate, to acknowledge them as valuable assets and to support all learners to engage meaningfully with the curriculum.
- Prioritize culturally relevant texts and topics
    - Use texts that accurately reflect a wide range of students' ethnic, cultural, linguistic, and familial backgrounds, as well as other variables that contribute to their identities, such as sexual orientation and gender expression, so that students see themselves as belonging and valued in the school curriculum.

See the "Access and Equity" chapter for additional information.

Students will explore and discover their identities, gender expression, and sexuality throughout their education and into and beyond their high school years. In terms of gender and sexuality, using gender-neutral language and not promoting gender stereotypes can help in creating an inclusive classroom. Gender-neutral language is not limited to using gendered pronouns or nouns to refer to an individual (e.g., he/she, him/her, his/hers). Gender-neutral pronouns include the singular form of "they/them/theirs." When referring to relationships, use the term "partner" or "significant other." Using gender-neutral language helps avoid incorrect assumptions based on personal biases, student appearance, or possible lack of awareness.

It can be helpful for a teacher to state their gender pronouns during classroom introductions and invite students to do the same if they are comfortable doing so. It is similarly important to acknowledge and affirm different sexual orientations and same-sex relationships so that all students feel their experiences and needs are reflected in their health education. Teachers can provide inclusive instruction with examples of varying gender identities and sexual orientations. Educators must be mindful and proactive in respectfully recognizing differences in gender and sexual orientation to create a welcoming and inclusive classroom for all students.

The usage of LGBTQ+ throughout this document is intended to represent an inclusive and ever-changing spectrum and understanding of identities. Historically, the acronym included lesbian, gay, bisexual, and transgender, but has continued to expand to include queer, questioning, intersex, asexual, allies, and alternative identities (LGBTQQIAA), as well as expanding concepts that may fall under this umbrella term in the future.

This safe and positive learning environment is particularly important to establish for addressing challenging topics related to healthy relationships, sexual abuse, and sex trafficking. These issues are important to discuss throughout a student's education because of the prevalence and severity of the consequences associated with childhood abuse and to increase the likelihood that students will have positive relationship, sexual, and reproductive health experiences.

Relationship Violence, Child Sexual Abuse, and Sex Trafficking

In accordance with the health education standards and the California Education Code, students learn about healthy relationships, child sexual abuse, and human trafficking, which includes sex trafficking, in age-appropriate ways (more information regarding sex trafficking can be found in the appendix). Students gain knowledge about these issues as well as related topics, such as affirmative consent, relationship violence, bullying, sexual harassment, and media influences. This learning can begin as early as TK and kindergarten as students explore protective skills such as setting boundaries, identifying emotions, and telling a trusted adult if a boundary is crossed.

Because gender stereotypes are often contributors to harassment and bullying, students can also begin challenging gender stereotypes early to set a foundation for more in-depth learning and discussion in higher grade levels. It is imperative that students begin learning about these issues as early as possible to promote their safety and health and to help create a safe and healthy school environment for all students. Learning is meant to be age- and developmentally appropriate with the intent of laying the groundwork and building a foundation of skills and knowledge that can protect students, now and in the future.

Students are impacted by bullying, sexual harassment, sexual abuse, relationship violence, and sex trafficking at alarming and unacceptable rates:

- One-third of teens experience relationship abuse (Liz Claiborne Inc. and Family Violence Prevention Fund 2009)
- 1 in 4 girls and 1 in 6 boys are sexually abused before the age of eighteen (CDC 2010)
- One-third of female rape victims, and nearly 1 in 4 male rape victims, were first raped between the ages of eleven and seventeen (CDC 2019c)
- About 13 percent of female rape victims and about 25 percent of male rape victims were first raped before the age of ten (CDC 2019c)
- Between 1 in 4 and 1 in 3 students have been bullied (Musu et al. 2019, vi)
- 70.6 percent of young people say they have seen bullying in their schools (Bradshaw, Sawyer, and O'Brennan 2007)
- The average age a child is first brought into sex trafficking is between eleven and fourteen years old (California Against Slavery Research and Education n.d.)

Students are vulnerable to abuse by both peers and adults, and it takes a community to address the problem. Prevention education and intervention efforts in schools are critical components of a multisectoral approach to protect youth from abuse and harm.

It is important for teachers, other educators, school administrators, school support staff (such as school counselors, school nurses, and school social workers), community partners (such as school-based health centers) school board members, and parents, guardians, and caretakers to be aware of these issues in order to support students' growth, learning, and emotional needs. Students learn a variety of sensitive topics that are sometimes difficult to discuss. Educators play a key role in guiding these discussions in a way that is safe and respectful. Professional development and trainings in cultural competency and bias training is recommended for the educator to understand that their own biases, filters, and perceptions can impact the safety and sensitivity for these discussions.

Some topics may be challenging for educators as well, especially if they have had personal experience with violence or abuse. In such cases, educators should seek assistance from school administrators or community resources, if needed, for instructional or personal support.

It is important to clarify that school counselors are not licensed health educators nor are they eligible to receive a supplementary authorization to teach health education; however, they are an important resource for student support services and trusted contact for students (California Commission on Teacher Credentialing 2019). Other content may be difficult to approach because of possible student disclosure, in which a student shares personal experience with the content. There is potential for this in every classroom, considering that many children are impacted by violence, abuse, and even sex trafficking.

Some educators may be uncomfortable receiving disclosures from students. It is important to remember that students often identify teachers as trusted adults and educators play a critical role in the ongoing protection of children. If a student discloses abuse or being in a dangerous situation, educators should listen and respond with empathy. Educators have a duty to report suspected abuse or neglect to Child Protective Services and/or law enforcement in accordance with mandated reporting laws and then refer to school policies for next steps. Prior to discussion and activities related to sensitive topics that may result in disclosures, teachers should explain their role as a mandated reporter. It may be helpful to share with students that most adults who have contact with minors are mandated reporters for the purpose of protecting them from abuse and harm.

Mandated Reporting

The health education standards address topics such as personal safety; the student's role in their family; peer and dating relationships; violence; and alcohol, tobacco, and other drugs. During instruction and learning on these topics, students may disclose abuse or neglect. If a teacher or any other school personnel suspects a child is experiencing abuse or neglect, they have a legal duty to report suspected abuse and neglect to the appropriate authorities. All school personnel should be aware of this responsibility, and school districts are required to provide annual training to all school personnel regarding reporting requirements.

Child Abuse and/or Child Neglect Can Be Any of the Following:

- A physical injury inflicted on a child by another person other than by accidental means.
- The sexual abuse, assault, or exploitation of a child.
- The negligent treatment or maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. This is whether the harm or threatened harm is from acts or omissions on the part of the responsible person.
- The willful harming or endangerment of the person or health of a child, any cruel or inhumane corporal punishment or any injury resulting in a traumatic condition.

For additional information, see the CDE Child Abuse Identification and Reporting Guidelines web page and California Penal Code sections 11166.5 and 11165.7.

Source: *California Department of Education (2019).*

Guest Speakers, Food, Plants, and Pets in the Classroom

While guest speakers and video resources can be important supplemental resources for health education, the primary instruction is the responsibility of the credentialed teacher of health education or credentialed teacher of elementary grades. Guest speakers and media resources, including books and videos, should always be vetted for appropriateness, for compliance with state statutes, and to ensure the content they are providing is valid, age appropriate, and medically accurate. If a guest speaker is invited to present on topics required under the California Healthy Youth Act, they must have expertise in comprehensive sexual health and HIV prevention education.

EC Section 51936 permits school districts to contract with guest speakers to provide comprehensive sexual health education and HIV prevention education. All outside consultants and guest speakers must have expertise in comprehensive sexual health education and HIV prevention education and have knowledge of the most recent medically accurate research on the relevant topic or topics covered in the instruction. If school districts do use outside consultants, their instruction must comply with all requirements listed in *EC* sections 51930–51939. For information on determining if an outside speaker is adhering to *EC* for comprehensive sexual health education and HIV prevention education, please visit the CDE Checklist for Guest Speakers web page at https://www.cde.ca.gov/ci/he/cf/ch1.asp#link1.

Literature and media such as video content used in a school is determined by the district. California *EC* Section 240 requires that "Governing boards of school districts shall adopt instructional materials in accordance with the provisions of Section 60040" (Section 60040 relates to social content standards). *EC* Section 60002 states the following: "Each district board shall provide for substantial teacher involvement in the selection of instructional materials and shall promote the involvement of parents and other members of the community in the selection of instructional materials." The SBE has adopted a policy document, entitled "Guidelines for Piloting Textbooks and Instructional Materials" (2015) and can be accessed at https://www.cde.ca.gov/ci/he/cf/ch1.asp#link2.

EC 51938 requires school districts to notify parents of the instruction prior to implementation and to make materials available for parents to review. School

districts are required to notify parents/guardians a minimum of 14 days prior to the first day of comprehensive sexual health instruction. **To opt-out of this instruction, parents/guardians must request in writing that their child not participate in the instruction.** If the parent/guardian does not request in writing that the child be withheld, the child will attend the instruction (*EC* Section 51938[a]).

Additional guidance on the California Healthy Youth Act Notice and Parental Excuse is provided in chapter two, "Supporting Health Education," and can also be found by visiting the California Department of Education's (CDE) Comprehensive Sexual Health and HIV/AIDS Instruction web page, and the California Healthy Youth Act under the California Legislative Information web page.

Teachers should use caution when instruction includes preparing or serving food in the classroom. Some students may have nut or other food allergies or dietary restrictions. Because district and school policies differ, teachers should consult their school's policy on preparing and serving food in the classroom, nut and other food allergies, and safe storage of cooking equipment. For food allergy resources, teachers can consult their school or district credentialed school nurse, county wellness coordinator, and the California Department of Education Guidelines for Accommodating Children with Special Dietary Needs on the CDE School Nutrition web page.

Teachers should be aware of district and school policies regarding plants and pets in the classroom. Even if the local policy allows plants and pets in the classroom, teachers should check with the school nurse and parents, guardians, or caretakers for any allergies their students may have.

Overview of the Health Education Standards

The health education standards provide direction for health education instruction in California's public schools by providing school districts with clear and accessible fundamental tools for developing health education curricula. The focus of the health education standards is on teaching the skills that enable students to make healthy choices and avoid high-risk behaviors. The skills of analysis, accessing and evaluating information, communicating, goal setting, and advocacy can be applied not only to health education but also to other interdisciplinary subjects. Ideally, the health education standards are developed and integrated with the Common Core Standards in English Language Arts (ELA), English Language Development (ELD) and other content area standards when possible.

The primary goals of the state-adopted health education standards are to

- improve academic achievement and health literacy for all students in California,
- provide school districts with fundamental tools for developing health education curricula and improving student achievement in this area, and
- ensure that all students in kindergarten through high school have access to high-quality health education instruction, providing students with the knowledge, skills, and confidence to lead healthy lives.

The Eight Overarching Health Content Standards for K–12

Long description of the Eight Overarching Health Content Standards for K–12 is available at https://www.cde.ca.gov/ci/he/cf/ch1longdescriptions.asp#chapter1link2.

Source: *California Department of Education (2008, 57).*

The health education standards are organized into eight overarching health content standards and six health content areas for kindergarten through grade level twelve (see image, The Eight Overarching Health Content Standards for K–12, above and table, The Overarching Standards and Rationales, below). The eight overarching standards describe essential concepts and skills; they are taught within the context of six health content areas. Each skill is learned and practiced specific to the content area and behavior. The health education standards support the California state standards in other subjects and interdisciplinary instruction. The health education standards are linked within and across grades, relevant to the real world, and reflect the knowledge, skills, and behaviors students need to be healthy individuals. Through standards-based instruction, students achieve greater proficiency in critical thinking, analysis, communication, and literacy.

The Overarching Standards and Rationales

Standard	Rationale
Standard 1: Essential Concepts All students will comprehend essential concepts related to enhancing health.	Understanding essential concepts about the relationships between behavior and health provides the foundation for making informed decisions about health-related behaviors and for selecting appropriate health products and services.
Standard 2: Analyzing Health Influences All students will demonstrate the ability to analyze internal and external influences that affect health.	Health choices are affected by a variety of influences. The ability to recognize, analyze, and evaluate internal and external influences is essential to protecting and enhancing health.
Standard 3: Accessing Valid Information All students will demonstrate the ability to access and analyze health information, products, and services.	Students are exposed to numerous sources of information, products, and services. The ability to access and analyze health information, products, and services provides a foundation for practicing health-enhancing behaviors.

Standard	Rationale
Standard 4: Interpersonal Communication All students will demonstrate the ability to use interpersonal communication skills to enhance health.	Positive relationships support the development of healthy attitudes and behaviors. The ability to appropriately convey and receive information, beliefs, and emotions is a skill that enables students to manage risk, conflict, and differences and to promote health.
Standard 5: Decision Making All students will demonstrate the ability to use decision-making skills to enhance health.	Managing health behaviors requires critical thinking and problem solving. The ability to use decision-making skills to guide health behaviors fosters a sense of control and promotes the acceptance of personal responsibility.
Standard 6: Goal Setting All students will demonstrate the ability to use goal-setting skills to enhance health.	The desire to pursue health is an essential component of building healthy habits. The ability to use goal-setting skills enables students to translate health knowledge into personally meaningful health behaviors.
Standard 7: Practicing Health-Enhancing Behaviors All students will demonstrate the ability to practice behaviors that reduce risk and promote health.	Practicing healthy behaviors builds competence and confidence to use learned skills in real-life situations. The ability to adopt health-enhancing behaviors demonstrates students' ability to use knowledge and skills to manage health and reduce risk-taking behaviors.
Standard 8: Health Promotion All students will demonstrate the ability to promote and support personal, family, and community health.	Personal, family, and community health are interdependent and mutually supporting. The ability to promote the health of oneself and others reflects a well-rounded development and expression of health.

Source: California Department of Education (2008, vii).

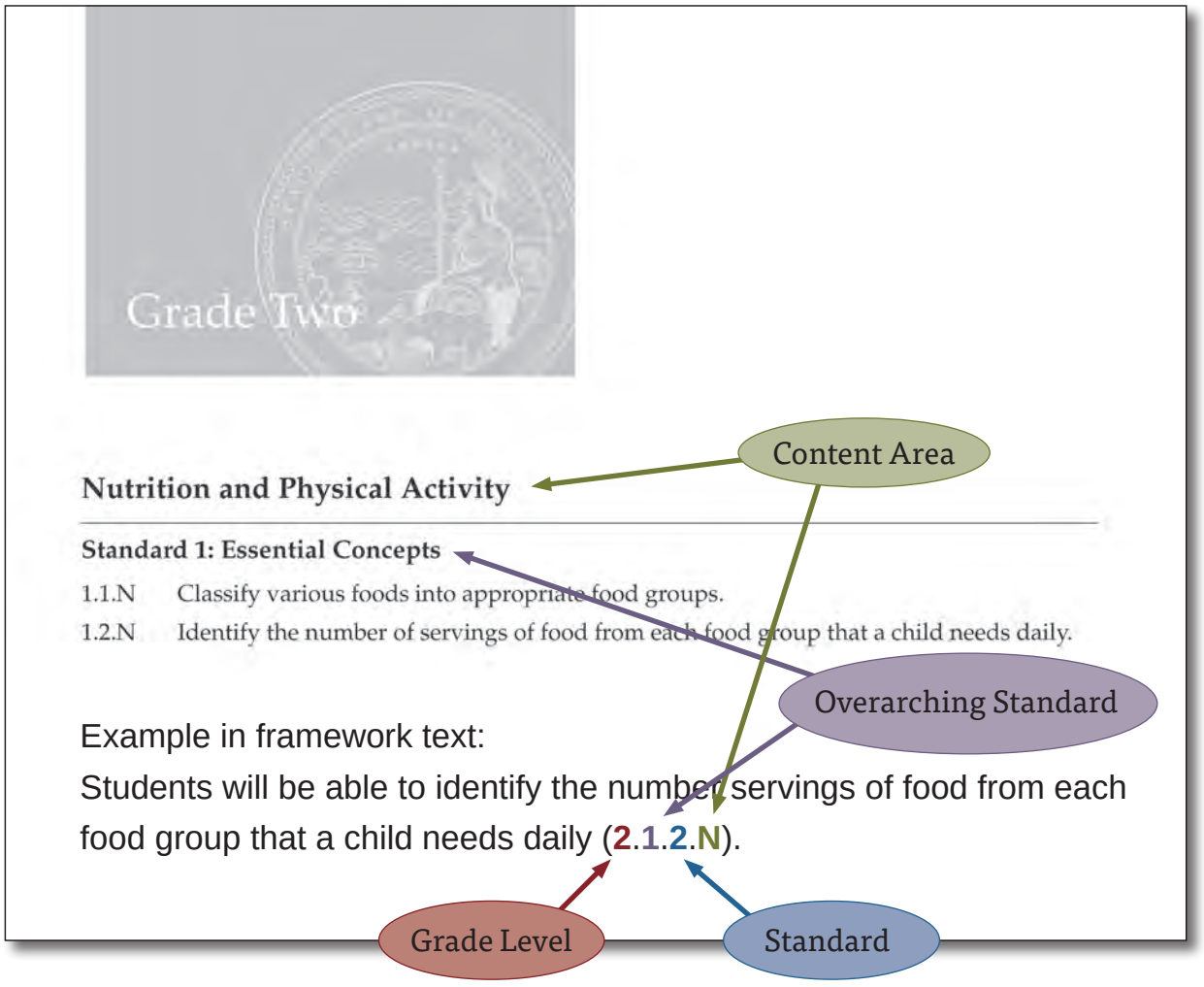
The health education standards are designed to be achieved by all students in kindergarten through grade level twelve.[1] The health education standards represent minimum requirements for comprehensive health education. To enhance the quality and depth of health instruction, some health content areas are not included for every grade level.

1 The health education standards do not define grade-specific standards for TK (formerly known as Pre-K). The TK section discusses learning progressions that bridge from the California Preschool Learning Foundations to the health education standards for kindergarten.

How to Read the Health Education Standards

The health education standards are uniquely organized by grade level, the corresponding overarching standard covered, and the content area letter abbreviation as shown below.

How to Read Health Education Standards

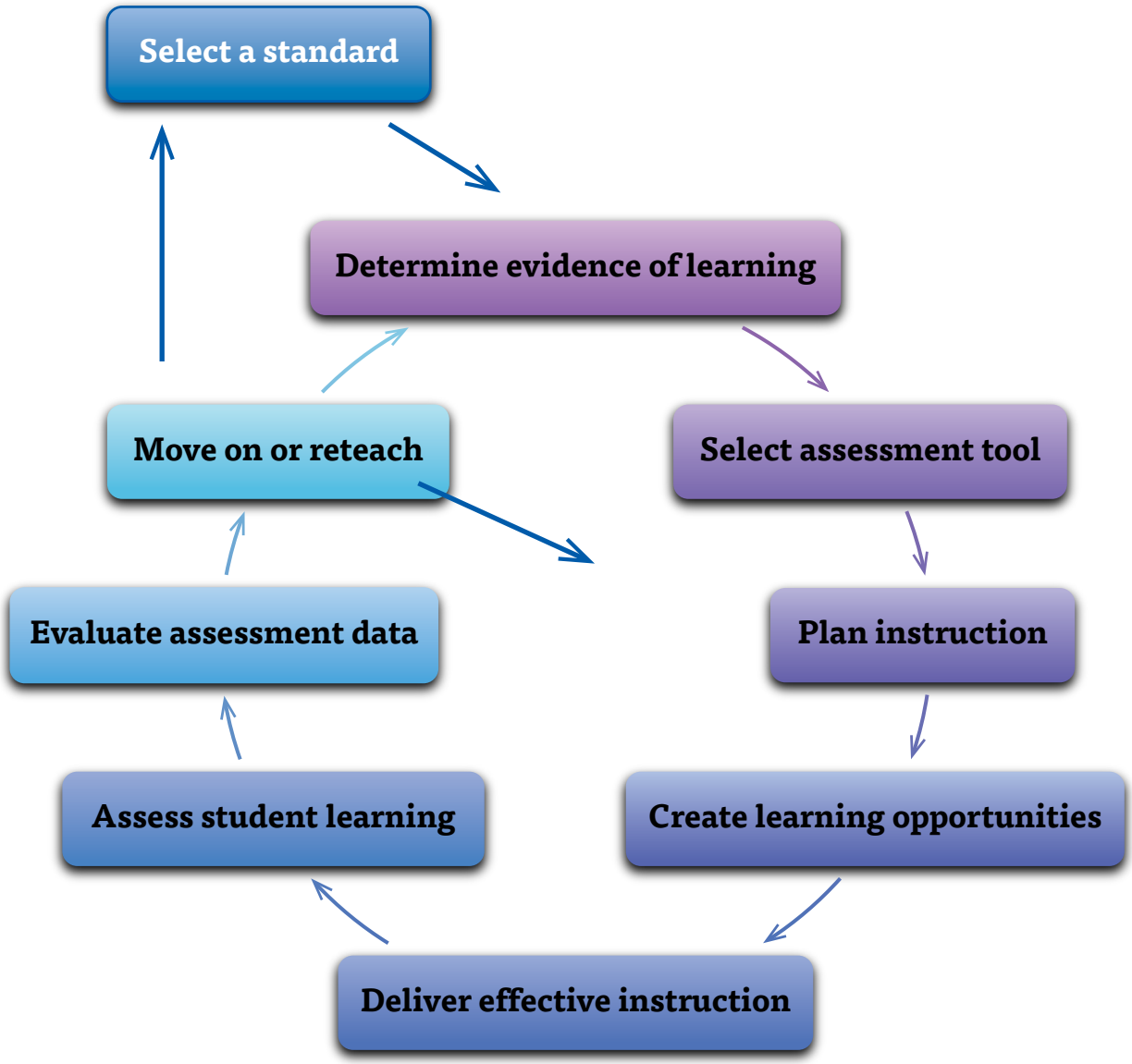


Long description of How to Read Health Education Standards is available at https://www.cde.ca.gov/ci/he/cf/ch1longdescriptions.asp#chapter1link3.

A Model for Designing Standards-Based Instruction

Health education should be taught using a standards-based approach. Standards ensure greater accountability of the content that is implemented in the classroom, help assure quality instruction, and guide teachers in the process of assessment. Standards-based instruction helps guide the planning, implementation, and assessment of student learning. Standards-based instructional design is based on practices and decisions that focus on student learning and includes each of the essential steps noted in below. The model below is one model of standards-based instructional design; it is not the only way to design instruction. The model is intended to help educators design instruction that integrates the content knowledge of the essential concepts with the skill-based standards and assesses what students have learned.

Standards-Based Instructional Design Process



Long description of Standards-Based Instructional Design Process is available at https://www.cde.ca.gov/ci/he/cf/ch1longdescriptions.asp#chapter1link4.

With high-quality instruction and sustained effort, every student should be able to achieve the health education standards; however, some students with diverse needs may require appropriate accommodations, adaptations, modifications, or differentiations to meet the health education standards. Decisions about how students achieve mastery of the health education standards and which standards-based instruction model is used are best left to individual teachers, schools, and local educational agencies.

Purposes of the Framework

The primary purpose of this framework is to provide instructional guidance and support to California teachers, administrators, curriculum specialists, other educators, and school boards for implementation of the health education standards.

This framework is based on the health education standards adopted in 2008 and reflects current research on effective health education instruction, evidence- and theory-based instructional strategies, and state statutes related to health education. An additional purpose of this framework is to serve as a resource for effective instruction and curricular planning for those teaching in transitional kindergarten through twelfth grade. It also provides guidance to developers of curriculum and instructional materials. Educators are encouraged to seek professional learning opportunities to acquire knowledge and skill development in health topics that may be particularly challenging such as comprehensive sexual health; relationship violence; alcohol, tobacco, and other drugs; and mental health.

This framework is not a curriculum, nor is it a mandate. The classroom examples and learning activities are only examples and not intended to specify that this is the only way to teach health education content or skills. Educators are encouraged to adapt and implement what works best for their students, classroom culture, and learning environment. Additionally, the framework is not inclusive of every topic that could or should be taught in health education. There are many critical health topics to choose from, as well as some topics that are required by state statutes and other health issues that will emerge over time.

Organization and Structure of the Health Education Framework

The framework is organized into general information chapters, grade-span chapters, and an appendix on sex trafficking. The general information chapters offer support to teachers, administrators, other educators, school counselors, and school board members. Chapter two, "Supporting Health Education," offers guidance to administrators and school board members on the resources

necessary to implement effective health education. Chapter seven, "Access and Equity," details ways to support and provide instruction to California's diverse learners and create an inclusive learning environment. Chapter eight, "Assessment," provides tools and resources for assessing health education including examples of assessment tools. Chapter nine, "Instructional Materials for Health Education," contains the evaluation criteria for the state adoption of health education instructional materials in kindergarten through eighth grade, and is of particular importance to producers of instructional materials because it includes information about local adoptions of instructional materials.

Chapters three through six are grade-span chapters. In each chapter, a brief introduction and overview of data from research surrounding the content areas are provided, followed by suggested instructional methods and teaching strategies that incorporate the standards. The health education content areas are addressed in each grade level or grade span as reflected in the content standards. Chapters three and four, for TK through third grade and grade levels four through six, are organized by grade level, reflecting the organization of the health education standards. However, chapters five and six, for grade levels seven and eight and nine through twelve, are not grade-level specific, which also reflects the organization of the standards and allows flexibility for teachers and schools to design health education courses and curriculum. Classroom examples are special sections that illustrate how a standard or multiple standards may be approached in the classroom. Learning activities present easily adaptable instructional examples. All of the grade-span chapters provide suggestions for standards-based activities to partner with school, community, and family.

References

American Academy of Pediatrics. 2009. How Teens Can Stay Fit. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link3.

American School Health Association. 2014a. About [the American School Health Association]. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link4.

American School Health Association. 2014b. What is School Health? https://www.cde.ca.gov/ci/he/cf/ch1.asp#link5.

Basch, Charles E. 2010. "Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap." *Equity Matters:* Research Review No. 6. New York: Columbia University. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link6.

Bradshaw, Catherine P., Anne L. Sawyer, and Lindsey M. O'Brennan. 2007. "Bullying and Peer Victimization at School: Perceptual Differences Between Students and School Staff." *School Psychology Review*, 36 (3): 361–382.

California Against Slavery Research and Education. n.d. Foster Care and Human Trafficking. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link7.

California Commission on Teacher Credentialing. 2019. https://www.cde.ca.gov/ci/he/cf/ch1.asp#8.

California Department of Education. 2008. *Health Education Content Standards for California Public Schools: Kindergarten Through Grade Twelve*. https://www.cde.ca.gov/ci/he/cf/ch1.asp#9.

California Department of Education. 2019. Child Abuse Identification and Reporting Guidelines. https://www.cde.ca.gov/ci/he/cf/ch1.asp#10.

California Education and the Environment Initiative. 2019. California's Environmental Principles and Concepts. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link11.

California Environmental Protection Agency. 2020. Environmental Justice Program. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link12.

Centers for Disease Control and Prevention (CDC). 2014a. *Health and Academic Achievement*. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link13.

Centers for Disease Control and Prevention (CDC). 2014b. NCHHSTP Social Determinants of Health. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link14.

Centers for Disease Control and Prevention (CDC). 2018. *Youth Risk Behavior Survey: Data Summary and Trends Report 2007–2017*. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link15.

Centers for Disease Control and Prevention (CDC). 2019a. About CDC Healthy Schools. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link16.

Centers for Disease Control and Prevention (CDC). 2019b. How You Can Prevent Chronic Diseases. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link17.

Centers for Disease Control and Prevention (CDC). 2019c. Violence Prevention: Preventing Sexual Violence. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link18.

Centers for Disease Control and Prevention (CDC). 2019d. Whole School, Whole Community, Whole Child (WSCC). https://www.cde.ca.gov/ci/he/cf/ch1.asp#link19.

Centers for Disease Control and Prevention (CDC). n.d. High School YRBS: California 2015 and United States 2015 Results. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link20.

Liz Claiborne Inc. and Family Violence Prevention Fund. 2009. *Teen Dating Abuse 2009 Key Topline Findings*. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link21.

Michael, Shannon L., Caitlin L. Merlo, Charles E. Basch, Kathryn R. Wentzel, and Howell Wechsler. 2015. "Critical Connections: Health and Academics." *Journal of School Health*, 85 (11): 740–758.

Milet, Meredith. 2017. *Asthma Prevalence in California: A Surveillance Report*. Richmond, CA: California Department of Public Health, Environmental Health Investigations Branch. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link22.

Musu, Lauren, Anlan Zhang, Ke Wang, Jizhi Zhang, and Barbara A. Oudekerk. 2019. *Indicators of School Crime and Safety: 2018* (NCES 2019-047/NCJ 252571). Washington, DC: National Center for Education Statistics, US Department of Education, and Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

National Sexual Violence Resource Center (NSVRC). 2015. Media Packet: Statistics about Sexual Violence. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link23.

Pate, Russell R., Ruth P. Saunders, Jennifer R. O'Neill, and Marsha Dowda. 2011. "Overcoming Barriers to Physical Activity: Helping Youth Be More Active." *American College of Sports Medicine, Health & Fitness*, 15, 1; 7-12. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link24.

Rosen, L. D., A. F. Lim, J. Felt, L. M. Carrier, N. A. Cheever, J. M. Lara-Ruiz, J. S. Mendoza, and J. Rokkum. 2014. "Media and Technology Use Predicts Ill-being Among Children, Preteens and Teenagers Independent of the Negative Health Impacts of Exercise and Eating Habits." *Computers in Human Behavior*, 35: 364–375. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link25.

Telljohann, Susan K., Cynthia W. Symons, Beth Pateman, and Denise M. Seabert. 2015. *Health Education: Elementary and Middle School Applications*. 8th ed. Columbus, OH: McGraw-Hill Higher Education.

Townsend, Catherine and Alyssa A. Rheingold. 2013. *Estimating a Child Sexual Abuse Prevalence Rate for Practitioners: A Review of Child Sexual Abuse Prevalence Studies*. Charleston, SC: Darkness to Light. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link26.

WestEd. 2018. *School Climate, Substance Use, and Student Well-being in California, 2015–17: Results of the Sixteenth Biennial Statewide Student Survey, Grades 7, 9, and 11*. San Francisco, CA: WestEd. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link27.

Wolstein, Joelle, Susan H. Babey, and Allison L. Diamant. 2015. *Obesity in California*. Los Angeles, CA: UCLA Center for Health Policy Research. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link28.

World Health Organization. 1946. *Constitution of the World Health Organization*. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link29.

World Health Organization. 2003. *Skills for Health*. Information Series on School Health. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link30.

World Health Organization. 2017. Social Determinants of Health. https://www.cde.ca.gov/ci/he/cf/ch1.asp#link31.

World Health Organization. 2019. What is a Health Promoting School? https://www.cde.ca.gov/ci/he/cf/ch1.asp#link32.