Offices of Research and Education Accountability

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Comptroller of the Treasury
JOHN G. MORGAN

FAMILY LIFE EDUCATION IN TENNESSEE

April 2007

STATE OF TENNESSEE

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Comptroller

COMPTROLLER OF THE TREASURY

STATE CAPITOL

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April 3, 2007

The Honorable Ron Ramsey
Speaker of the Senate
The Honorable Jimmy Naifeh
Speaker of the House of Representatives
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Public Chapter 682 (2006) requires the Office of Education Accountability to review Tennessee's Family Life Curriculum programs as established by Title 49, Chapter 6, Part 13. For the purposes of this report, OEA reviewed literature and state policies on family life education and surveyed school districts to determine content, extent of participation, comparison to other state's programs, and impact reported in relevant studies. This report identifies the legislated roles for state-level and local-level government entities pertaining to family life education, highlights current practices, and suggests recommendations for improvement. The report provides information that may be useful to policymakers in considering ways to improve Family Life Education in Tennessee.

Sincerely,

John G. Morgan
Comptroller of the Treasury

Family Life Education in Tennessee

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EXECUTIVE SUMMARY

Directive and Scope

Public Chapter 682 (2006) directs the Comptroller's Office of Education Accountability (OEA) to review Tennessee's Family Life Curriculum programs (see Appendix 1). This report provides an overview of family life programs in Tennessee and elsewhere, of curriculum content, the extent of participation in various school districts, comparison to other states' programs, and reported impact in relevant studies. To collect this information, OEA administered an online family life education survey to all school districts, with a 63 percent response rate. The office also reviewed state statutes, policies, and curricula standards; interviewed relevant Department of Education, Department of Health, and State Board of Education personnel, as well as abstinence education and comprehensive sexuality education providers; reviewed other states' laws and practices; and analyzed data and research from federal agencies and other organizations.

Summary

Fewer teens are having sex and those who are having sex are using methods of birth control. Both of these trends have led to a nationwide decline in teen pregnancy rates, yet teens are still engaging in risky behaviors:

- Sixty-nine percent of Tennessee high school seniors have had sex.
- In 2005, Tennessee ranked 8th worst in chlamydia rates, 13th worst in gonorrhea rates, and had the 12th highest AIDS rate in the nation.
- The highest teen pregnancy rates are still in the South. One study estimated that the costs to Tennessee of teen childbearing were $181 million in 2004 alone. Teen pregnancy also has effects on both parents and their children in terms of employment, educational attainment, health, and poverty.

Tennessee Public Chapter 565 (1989) requires LEAs in counties with a pregnancy rate of at least 19.5 pregnancies per 1,000 females aged 15-17 to create and implement a family life education program. It also directed the State Board of Education to create a program that could be used by any LEA that did not choose to create its own program. *T.C.A.* 49-1-205 instructed the Department of Education to develop a family life education technical support program for LEAs that requested assistance.

However, in Tennessee, LEAs are primarily responsible for the implementation and development of their family life education programs and receive only minimal support from state-level resources and agencies:

- *There is no clear definition of Family Life Education in Tennessee.* (page 9) While the intent of the law seems to indicate a concern with teen sexual activity, the code does not speak clearly to the issue. Therefore, LEAs have formed their own goals for family life education: most districts focus on reducing teen pregnancy and STDs, and promoting sexual abstinence until marriage.
- *Although the state directs LEAs to create policies and procedures for the implementation of Family Life Education through Coordinated School Health, a state-level Family Life Education plan does not exist.* (page 9)
- *Lifetime Wellness and Healthful Living curriculum standards offer a framework for teaching family life education, yet the state provides no additional guidance for putting the standards into practice in the classroom.* (page 11) Seventy-five percent of districts surveyed use the state health and wellness curriculum standards to conduct their family life education. The state standards offer a framework, but do not suggest how teachers can help students achieve the learning objectives. This can cause difficulties for teachers without health education training.
- *The state has not created a plan of technical assistance in Family Life Education for LEAs, although the Department of Education provides some elements of assistance.* (page 12) *T.C.A.* 49-1-205 instructed the Department to provide technical assistance that would include: methods for maintaining a high level of parental and community support; training opportunities for family life instructors; assistance in selecting family life textbooks and resource materials; and mechanisms for monitoring and evaluating implementation of family life courses.

Family Life Education in Tennessee differs from district to district. (page 14) LEAs cover a range of topics, and use a variety of materials, instructors, and methods of communicating with parents. However, most LEAs cannot determine whether their family life instruction affects their students' behavior, because they do not evaluate their programs. In addition, only 33 percent of districts responding to the survey provide professional development opportunities for their family life instructors, although many schools wanted to receive training.

Recommendations for the General Assembly:
The General Assembly, in cooperation with the Department of Education and the State Board, may wish to define more clearly the goals of Family Life Education.

The General Assembly may also wish to:

- Align law with districts' current practices.
- Require that LEAs use materials and impart knowledge that is medically or scientifically accurate.
- Consider supplemental funding to either the Department of Education or the Department of Health to augment educator training programs.

State Level Administrative Recommendations:
The State should provide assistance to LEAs that teach family life education, including:

- State Board of Education policies and procedures to guide LEAs in evaluation, supervision and implementation of family life components of health education, pursuant to *T.C.A.* 49-6-1302(a)(2).
- Department of Education technical assistance, pursuant to *T.C.A.* 49-1-205.

Local Level Administrative Recommendations:
LEAs should provide assistance to family life instructors, including:

- Additional guidance for teachers to put health and wellness curriculum standards into practice in the classroom.
- Professional development training for family life instructors.

LEAs should evaluate the effectiveness of their family life instruction, pursuant to *T.C.A.* 49-6-1301(d).

Districts should ensure that outside instructors bringing supplemental materials into class meet criteria for "qualified instructors" as defined by the local board of education and that their materials are reviewed before they are presented to a class.

Local school boards should be aware of Tennessee law regarding family life education and ensure that their school districts are fulfilling necessary requirements. They should also be aware that they can request technical assistance from the Department of Education if necessary.

See pages 17-19 for a full discussion of the report's recommendations.

See Appendices 8 and 9 for response letters from the Tennessee Department of Education and the State Board of Education, respectively.

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BACKGROUND

Trend: *Teen pregnancy is on the decline nationally, but the highest rates are still in the South.*

Between 1999 and 2004, teen pregnancies[1] in Tennessee dropped 24 percent,[2] a trend that mirrors that of the nation as a whole. The nationwide drop in teen pregnancy can be attributed to two factors:

- Fewer teens are having sex. The percentage of high school students who have had sex dropped 13.3 percent between 1991 and 2005.[3]
- Those who are having sex are using condoms or other methods of birth control. Nationally, 63 percent of teens used a condom and 18 percent used birth control pills during their last sexual intercourse.[4]

The large drop in teen pregnancies reflects progress in reducing the behaviors that result in pregnancy. Even with that reduction, however, the United States still has one of the highest teen pregnancy rates of all industrialized nations, and the Southern region has higher rates than the rest of the nation. (See Exhibit 1.)

While trends show that fewer teens are having sex, teens still exhibit high-risk behaviors that can lead to pregnancy and sexually transmitted diseases (STDs).

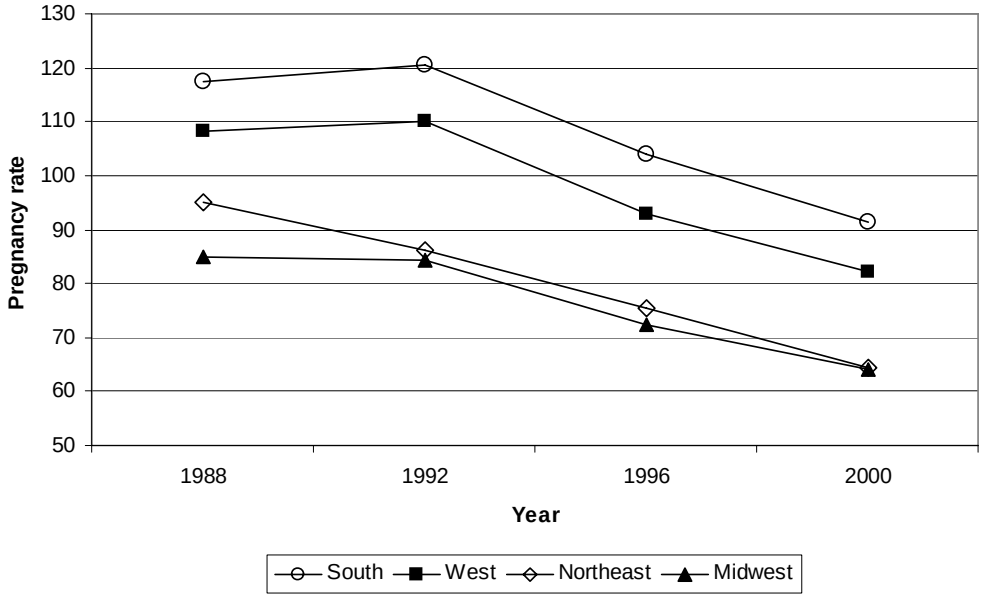
In Tennessee in 2004, babies born to mothers under the age of 20 comprised 13 percent of all births in the state. The majority of these births (80 percent) were to unmarried mothers,[7] which follows the national trend.

A Class of Tennessee 12th graders……

In an average class of 30 Tennessee high school ***seniors***, 21 (69 percent) have had sex[5] and nine have had four or more partners. Of the 16 who are currently sexually active,[6] seven used a condom the last time they had sex.

Of these 30 Tennessee high school seniors, four have been physically forced to have sex when they didn't want to.

Exhibit 1: Pregnancy Rates per 1000 women aged 15-19, by census region, 1988-2000



Source: Guttmacher Institute, "U.S. Teenage Pregnancy Statistics: National and State Trends and Trends by Race and Ethnicity," September 2006.

Trend: *Gonorrhea and chlamydia rates are high in the South, as are AIDS rates.*

Pregnancy is not the only possible outcome of teen sexual activity. Adolescents are more likely to contract STDs and have higher rates of chlamydia and gonorrhea than any other age group.[8] Young teen girls are more susceptible to STDs than older adults because they are physically immature, are more likely to have multiple sex partners, and may not have access to prevention services.

In 2005, Tennessee ranked 8th worst in chlamydia rates and 13th worst in gonorrhea rates in the nation. While the gonorrhea rate in the South declined 18 percent between 2001 and 2005, the region still had the highest gonorrhea rate among the four regions of the country, and Tennessee's rate was higher than the Southern average. Historically, rates of gonorrhea and chlamydia in the Southern region have been higher than in any other region of the country.[9]

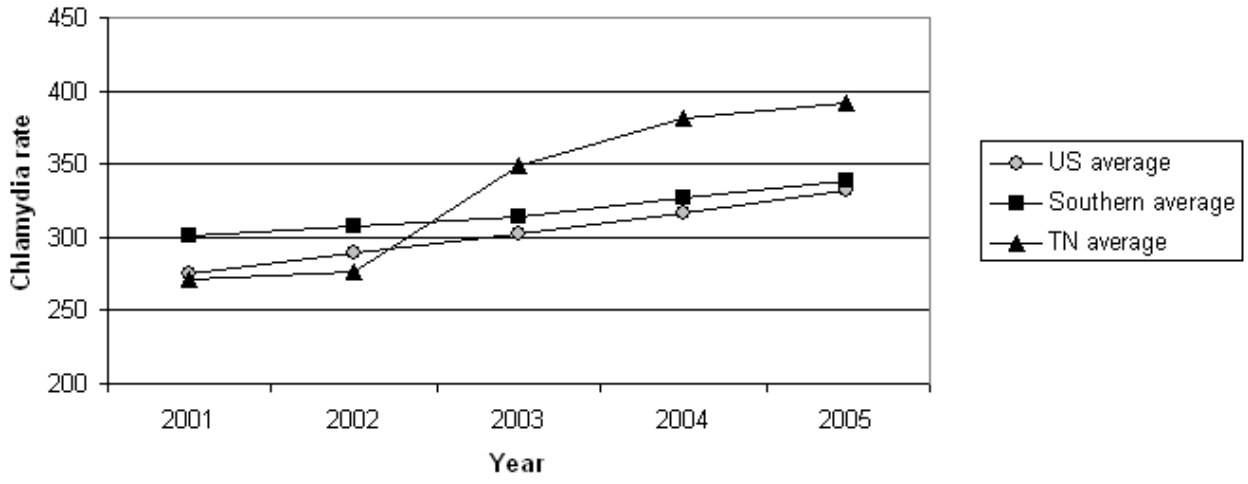
Exhibit 2 illustrates the increased chlamydia cases in the United States and especially in the South. The number of Tennessee's reported cases jumped between 2002 and 2003 in part because of improved diagnostic techniques, revealing that Tennessee's rates appear higher than the Southern average, although not all Southern states are using the new diagnostic techniques.

In addition, in 2005 the South had a higher AIDS case rate than any other region. Tennessee had the 12th highest AIDS rate in the nation.[10]

Trends indicate that:

- *Compared to the national average (47percent), more Tennessee children (55 percent) are engaging in sexual activity.*[11]
- *Tennessee children are having sex at younger ages*. Twelve percent of 9th graders had sex for the first time before the age of 13 compared to eight percent of 12th graders.[12]
- *Nineteen percent of high school senior girls in Tennessee have been physically forced to have sex when they didn't want to.*[13]
- *Younger girls are having sex with much older partners.* Nationally, 34 percent of girls who were under 16 years old when they had sex for the first time had partners that were at least four years older.[14]
- *A lower percentage of sexually-active Tennessee children (58 percent) used a condom the last time they had sex than the national average (63 percent),*[15] *although 9th graders are using them more than 12th graders (71 percent versus 47 percent).* Male latex condoms are 84 to 98 percent effective in preventing pregnancy[16] and consistent condom use can decrease the risk of HIV/AIDS transmission by 85 percent.[17]

Exhibit 2: Reported chlamydia cases 2001-2005, Southern average compared to US average



Source: Centers for Disease Control, STD Surveillance 2005.

Taxpayers, teen parents, and their children shoulder the costs and consequences of teen pregnancy.

In 1996, the New York-based Robin Hood Foundation, which focuses on poverty issues, conducted a comprehensive study of adolescent childbearing costs, focusing on teens that have their first baby at age 17 or younger and comparing their outcomes to women who become first-time mothers at age 20 or 21.[18] The study found that teen pregnancy costs U.S. taxpayers about $6.9 billion each year in public assistance benefits, medical care expenses, prison costs, foster care, and lost tax revenue. In an analysis in 2006, the National Campaign to Prevent Teen Pregnancy estimated the U.S. public costs of teen childbearing at $9.1 billion. That study estimated Tennessee costs to be $181 million in 2004 alone.[19] Other social and health costs also result that may not be easily measured in taxpayer dollars.

Less than a third of teenage mothers earn a high school diploma, which affects their ability to get a well-paying job and increases their dependency on welfare. They also have more kids over a lifetime, increasing their income needs and the likelihood that they will live in poverty.[20] Teen fathers earn 10 to 15 percent less than men who do not have children during their teen years,[21] and are also less likely to obtain a high school diploma. Nearly 80 percent of teen fathers do not marry their babies' mothers before or shortly after the birth.[22]

Children of teen moms are often less healthy, yet receive only half the level of medical care and treatment of children born to non-teens. They are also less likely to grow up in homes with fathers, and more likely to be physically abused, abandoned, or neglected. These children typically score lower on cognitive development and standardized tests, are less successful in school, and hence are less likely to earn their high school diplomas than the comparison group.[23] The daughters of adolescent mothers are more likely to become adolescent mothers themselves, and teenage sons of adolescent mothers are almost three times more likely to end up in prison.[24]

States that greatly reduced their teen pregnancy rates in the 1990s had coordinated statewide efforts that include education, healthcare, health access, and community collaboration to make teen pregnancy reduction a priority.

While teen pregnancy rates have fallen nationwide, several states stand out as having greater than average rate reductions. Between 1988 and 2000, Tennessee's teen pregnancy rate for 15 to 19 year olds dropped 19 percent. In that same time period, California's rate dropped 38 percent, Vermont's by 46 percent, Michigan's by 32 percent, and Georgia's by 22 percent.[25] While each of these states had varied strategies for approaching the problem both at the state and local levels, their programs had similar basic characteristics. Beginning in the early 1990s, the governors and/or legislatures of California, Vermont, Michigan, and Georgia prioritized the reduction of teen pregnancy with the inception of programs and statewide awareness campaigns. These four states incorporated the following into teen pregnancy prevention efforts:[26]

- *Coordination* among state agencies, such as Education, Health, Human Services, Family and Children Services, and with community-based groups
- *Sex education*, both abstinence-only and abstinence-based
- *Family planning services*, including counseling on sexual health issues, pregnancy and STD testing, and dispensing contraception in school-based and community clinics and through private physicians
- *Male responsibility programs* that encouraged young men to take a stronger role in preventing teen pregnancy
- *Teen subsequent pregnancy prevention* to keep pregnant and parenting teens from becoming pregnant again
- *Youth development* that focused on reducing risky behaviors in general and provided tutoring, mentoring, career counseling, sex education, and skill-building
- *Public awareness* through television, radio, and print ads

Interagency coordination and cooperation was key in all of these programs, as was state and federal funding. These states also targeted services at areas with the highest teen pregnancy rates.

Influences on Teen Sexual Decision-Making: *Why do teens choose to abstain from or engage in sexual activity?*

Teens make decisions based on a multitude of factors. They are influenced not only by peers, family, and their communities, but also by their socioeconomic status and life experiences. Other important elements that influence teen decision-making are biological factors and adolescent brain development.

A study done for the National Campaign to Prevent Teen Pregnancy[27] reviewed 400 research studies and grouped factors into four "themes":

- Individual biological factors (and brain development)
- Disadvantage, disorganization, and dysfunction in the lives of teens and their environments
- Sexual values, attitudes, and modeled behavior
- Connection to adults and organizations that discourage sex, unprotected sex, or early childbearing

The study also noted that some factors were easier to influence than others. For example, teen pregnancy prevention programs could have an impact on communication between parents and children about premarital sex and contraception. However, these programs could not influence family structure or environmental factors, like income or education level. While educators and communities accept that family life education programs in schools have a positive effect on teen sexual decisions and behavior, they must also realize that other powerful factors may come into play that cannot be addressed in the classroom. (See Exhibit 3.)

Exhibit 3: Influences on Teen Sexual Activity[28]

The Teen:

Males are more likely than females to have sex at a younger age. Teens that are 14 or younger when they start having sex are more likely to have multiple partners, and are at greater risk for a pregnancy or an STD.

Teens who go through early puberty and who are more physically developed at a younger age are more likely to become sexually experienced.

The area of the brain that controls impulses and enables planning, decision-making, and priority-setting is "under construction" during the teen years, and may not be fully mature until the mid-twenties.[29]

Adolescents who have aspirations for the future and are academically successful are more likely to delay sex or to use contraception. Young teen moms tend to have lower GPAs, more school absences, and more difficulty with school even before they become pregnant. [30]

The Teen's Family and Environment:

Teens whose families have higher education and income levels are more likely to postpone having sex than teens whose families have lower educational attainment and live in high-poverty neighborhoods.[31]

Children of teen mothers are more likely to start having sex at an early age and to become teen parents themselves.

Parent-teen communication about sex, birth control, and disapproval of sexual activity, as well as consistent parental supervision, positively influence teen decision-making about sex. Parents' involvement with their teen's schooling also decreases the likelihood that their teen will engage in risky behavior.

The Teen's Peers and Romantic Partners:

Teens that have friends who are high achievers and who avoid risk-taking behaviors are less likely to have sex at an early age.

Teens with sexually active friends—or friends they *perceive* to be so—are more likely to have sex themselves. Teens who believe their peers don't use condoms are also less likely to use them. Teens who believe sexual experience will increase others' respect for them are more likely to have sex.

Teens in romantic relationships—especially with older partners—are more likely to have sex. Furthermore, sexual relationships between girls younger than 15 and males three or more years older are more likely to be involuntary, less likely to involve contraception and more likely to result in a pregnancy. [32]

The Teen's Values:

Religion can affect attitudes and beliefs about contraception and sexual activities, and can have an effect on friendship choices and dating patterns.[33] Teens who frequently attend religious services are less likely to have permissive attitudes about sexual intercourse. Research suggests while religious teen boys are more likely to use contraception, religious teen girls are less likely than their non-religious peers to use contraception when they begin sexual activity.[34]

Controversy and the Importance of Program Evaluation: Abstinence Education versus Comprehensive Sexuality Education

Sexuality education, or family life education, can vary based on focus or topics covered. For example, some programs focus solely on abstinence until marriage ("abstinence education") and others may also include information on contraception ("comprehensive sexuality education"). The "debate" on which focus is more effective or more appropriate has become a controversial issue nationally.

While it is important for family life education programs to perform comprehensive, accurate, scientific evaluations of their effectiveness, it can be difficult for them to do so.

The importance of comprehensive scientific evaluation cannot be understated for programs that deal with sensitive topics such as adolescent sexuality, the choices teens make with regard to sexuality, and their reproductive health. The issue of how schools teach "family life education" (or "sex education" or "abstinence education") is both emotionally and politically charged. Well-designed

What is "abstinence education"? What is "comprehensive sexuality education"?

The National Governor's Association[35] explains the difference in the following ways:

Abstinence Education: *"Abstinence programs focus on the importance of remaining abstinent until marriage and on the benefits of a monogamous marital relationship. There are two types of abstinence education: 1) abstinence-only teaches that abstinence is the only way to prevent unwanted pregnancy; 2) abstinence-based teaches that abstinence is the best way to prevent pregnancy and sexually transmitted diseases, but also includes information on contraception."*

Comprehensive Sexuality Education: *"Sexuality education programs promote and encourage abstinence. However, the main focus of these programs is to equip teens with knowledge about sex, sexually transmitted diseases (STD), and contraception as a means to protect against unwanted pregnancy and STD. Sexuality education is generally part of an overall health curriculum that also addresses a wide range of sexuality-related issues such as gender differences, dating and marriage and families."*

The Debate: Supporters of teaching "authentic abstinence" feel that teaching abstinence along with information about contraception is a contradiction. They also assert that comprehensive sexuality educators who also teach abstinence do not spend as much time on abstinence as they do on contraception. Robert Rector, a researcher with The Heritage Foundation and supporter of abstinence education, is the author of the federal abstinence education grant guidelines. He has argued that comprehensive sexuality education materials implicitly promote teen sex.[36] The Tennessee Department of Health's federally-funded Abstinence Education program does not promote that claim.[37]

Comprehensive sexuality educators support promoting abstinence, but also feel that young people need information about contraception. They assert that "abstinence-only" programs are unrealistic and do not provide enough information for adolescents to protect themselves from STDs and pregnancy. Recently, proponents of comprehensive sexuality education have claimed that some abstinence materials are inaccurate and misleading.[38]

The Reality: Most sexuality education programs, whether focused primarily on abstinence or on education about contraception, are much more than *sexuality* education programs. Many abstinence education programs in Tennessee have youth development components: federally-funded projects must provide at least one activity that enhances life skills, such as voluntary service or vocational education. Many comprehensive sexuality education programs also have youth development components. Moreover, a 2000 Kaiser Family Foundation survey found that, "regardless of the main message of ['abstinence-only' or 'comprehensive'] sex education, courses almost certainly will include certain fundamentals or 'core elements' that include HIV/AIDS, other STDs, the basics of reproduction, and abstinence.[39] It is also important to keep in mind other factors, besides in-school sexuality education, that influence a teen's decision to have sex or abstain.

evaluations can cut through the rhetoric to discover "what works"—what programs delay the onset of sexual activity, and have an effect on rates of teen pregnancy and STDs. Unfortunately, few evaluations exist that can accurately draw cause-effect connections between family life education programs and student behavior outcomes.

Evaluations that use experimental design are more likely to measure program effects accurately. The key to an evaluation that uses "experimental design" is that it compares changes among youth that participated in a program to youth that have the same characteristics but were not in the program. More credible evaluations:[40]

- Randomly assign participants to the program being evaluated or to a control group (or have an "experimental design");
- Track a large number of program participants;
- Measure behavioral outcomes, not simply attitudes and beliefs;
- Conduct a follow-up study after time has passed to measure lasting effects;
- Perform statistical analyses;
- Use independent evaluators.

Often, states or local programs that wish to evaluate effectiveness do not have the expertise or capacity to do such evaluations themselves, nor the funding to contract with an outside evaluator, as these evaluations tend to be expensive. They may conduct surveys or pre-/post-tests to assess attitudes and expectations, as well as ask whether the student is sexually active, but often do not have baseline data or control groups to measure impacts specific to their programs. Also, when looking at family life education programs, evaluators often must deal with privacy issues, permission to survey students, and self-reported behavior, which may or may not be truthful. Therefore, most non-experimental evaluations present evidence that *suggests* connections between a program and behavioral outcomes, but does not directly tie a program to behavioral changes in a cause-effect relationship.

Nationally, few programs have been evaluated using rigorous experimental research design, and therefore it is difficult to draw conclusions about their effectiveness.

Staff Note: *To the extent possible, staff has reviewed evaluations of states' and national programs, as well as some local programs in other states promoted by comprehensive sexuality educators and abstinence educators. Staff also wishes to note that it was very difficult to isolate evaluations performed by "neutral" parties that did not formally support either one "side" or the other. Where it is known, staff identifies whether an author or publication supports a particular agenda.*

While federally-funded experimentally-evaluated Title V abstinence education programs have shown some positive changes in attitudes and beliefs, their effect on behaviors is inconclusive.

In 1996, as part of welfare reform, the federal government provided an additional $50 million in earmarked funding to the Title V Maternal and Child Health Block Grant for abstinence education;[41] Congress has reauthorized these funds several times. States apply for this grant funding when they submit their annual Title V application. Awardees (states) then distribute the money among local level applicants that provide abstinence education to students. Tennessee's total award amount for FY 2006 is $993,367, which helps fund 16 programs throughout the state.[42] Federally-funded abstinence education programs must adhere to eight guidelines for content and purpose; they may discuss methods of contraception only in terms of failure rates.

Many grant applicants come from faith-based organizations. While churches and faith congregations have a long history of offering social services in their communities, historically they have done so without public funding. Within the past decade, government support and funding of faith-based initiatives has increased faith-based groups' activity in service provision; in this case providing in-school and after-school sexuality—often abstinence—education programs.

Keeping in mind the importance of experimentally-designed evaluations, the Office of Education Accountability reviewed several independent and state-initiated evaluations that were non-experimental,[43] but for this report focused on the only Congress-authorized, federally-funded study[44] that met the criteria to be considered experimental

and therefore potentially more accurate. In this study, the authors recognized that,

> [e]mpirical evidence on the effectiveness of abstinence education is limited. Moreover, most studies of abstinence education programs have methodological flaws that prevent them from generating reliable estimates of program impacts. Even the features of abstinence programs implemented, the curricula used, and the experiences of program staff and program participants are not well documented in a readily accessible way.[45]

Therefore, Congress intended for this federal evaluation to strengthen the knowledge about strategies for promoting sexual abstinence through extensive analyses. In reviewing programs in four states, evaluators concluded in 2005 that:[46]

Positive findings:

- Program participants reported being more supportive of abstinence and less supportive of teen sex than the control group.
- The program significantly affected perceptions of the potential adverse consequences of teen and nonmarital sex.

Neutral findings:

- There is limited evidence that the programs raised expectations to abstain from sex.
- There is no evidence that any of the four programs led youth to develop views more supportive of marriage than their control group counterparts.
- There is limited evidence that the programs had impacts on peer influences and relations.
- Youth in both the program and control groups displayed no difference in their self-concept, refusal skills, or communication with parents.

The federally-contracted evaluation team expects to release information on behavioral outcomes, such as teen sexual activity and other risk-taking behaviors, in the near future. Until then, however, they cannot draw conclusions on the behavioral effects of these programs.

Some comprehensive sexuality education programs have shown effects on teen sexual behavior, while others have not.

The National Campaign to Prevent Teen Pregnancy released reports[47] for their "Putting What Works to Work" project that included reviews of 29 sexuality education programs—including comprehensive sexuality education, abstinence education, youth development, and HIV/AIDS education programs. All program evaluations reviewed had the following characteristics:

- Were completed in 1980 or later;
- Were conducted in the United States or Canada;
- Were targeted at teens under age 18;
- Used an experimental or quasi-experimental design;
- Had a sample size of at least 100 or more program and control group participants;
- Measured effects of the timing of first sexual intercourse or the impact on sexual behavior.

Of the 29 sexuality education programs reviewed, 12 used an *experimental* evaluation design and were found to be effective in changing behaviors.[48] Of those, seven delayed sexual initiation for certain populations, eight improved contraceptive use, and three programs reduced teen pregnancy. The National Campaign also urges the reader to "[k]eep in mind that there may very well be a number of creative programs that are effective in helping young people avoid risky sexual behavior that simply have not yet been evaluated."[49]

In sum, *some* programs work in *some* places with *some* populations. A program that works in one community may not work in another, and sometimes a program may not work at all.

Effective abstinence and comprehensive sexuality education programs have some common characteristics.

In May 2001, the National Campaign to Prevent Teen Pregnancy released research on effective sex education and HIV education programs. The author, Douglas Kirby,[50] presented some common characteristics of effective curricula, shown in Exhibit 4.

Some programs work better with certain populations than with others. According to Kirby's research, more promising sex education programs are modeled after programs that are already in place, that work with similar populations, and that have demonstrated effectiveness. If that is not possible, Kirby advises, programs should be designed to incorporate the characteristics listed in Exhibit 4.

Exhibit 4: Ten Characteristics of Effective Sex and HIV Education Programs[51]

Effective programs:

1. Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.
2. Are based on theoretical approaches that have been effective in influencing other risky health-related behavior and identify specific important sexual antecedents to be targeted.
3. Deliver and consistently reinforce a clear message about abstaining from sexual activity and/or using condoms or other forms of contraception. Kirby stated that this was one of the most important characteristics that distinguishes effective from ineffective programs.
4. Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or use methods of protection against pregnancy and STDs.
5. Address social pressures that influence sexual behavior.
6. Provide examples of and practice with communication, negotiation, and refusal skills.
7. Include interactive teaching methods and have them personalize the information.
8. Incorporate behavior goals, teaching methods and materials that are appropriate to the age, sexual experience, and culture of the students.
9. Last longer than a few hours.
10. Select teachers or peer leaders who believe in the program and then provide them with adequate training.

CONCLUSION 1: In Tennessee, LEAs are primarily responsible for the implementation and development of their family life education programs and receive minimal support from state-level resources and agencies.

Historically, Tennessee school districts have closely guarded local control for education, especially around such sensitive topics as sex education or family life instruction. Currently, state-level guidance is minimal for family life education. The state could provide more direction without taking ultimate control away from local education agencies. The result could be a more streamlined, consistent approach, as well as programs that LEAs could more easily monitor.

There is no clear definition of Family Life Education in Tennessee.

In 1989, the Tennessee General Assembly wrote into statute a program for family life education (Public Chapter 565). While a section in the Code[52] already existed outlining the content of "sex education" (including "teaching facts concerning human reproduction, hygiene and health concerns" and "presentations encouraging abstinence from sexual intercourse during the teen and pre-teen years") the new law set out guidelines to require LEAs to provide "family life education." LEAs in counties that had a pregnancy rate of at least 19.5 pregnancies per 1,000 females aged 15 through 17 would be required to create and implement a program over the following four years that would emphasize

> abstinence from sexual relations outside of marriage, the right and responsibility of a person to engage in such relations, basic moral values, as well as the obligations and consequences which arise from intimacy. The program shall also include a component which specifically addresses the nature and prevention of AIDS and other sexually transmitted diseases. (*T.C.A* 49-6-1301(b))

As of 2005, 79 counties fit this criterion (see Appendix 2).

What is the difference between Sex Education and Family Life Education?
While the *T.C.A.* cross-references the two sections regarding "sex education" and "family life education," the law does not define family life education as sex education, although what mandates an LEA to develop a family life curriculum is a high teen pregnancy rate. So, while the intent of the law seems to indicate a concern with teen sexual activity, the code does not speak clearly to the issue. "Family life education" may be used interchangeably with "sex education," yet the presence of the two separate statutes that refer to the same topic, but not to each other, may cause confusion about the goals of family life education. One school district may assume that it deals with teaching "basic moral values," while another may assume it deals with adolescent reproductive health or teenage pregnancy prevention.

In October 2006, the Office of Education Accountability conducted an online family life education survey, inviting all LEAs to participate; 85 of the 136 districts responded (see Appendix 3 for a list of respondents and Appendix 4 for the Survey Questions). The table in Exhibit 5 (page 10) shows possible goals for family life education and the percentage of district survey respondents that consider each a main goal.

Some districts have developed policies for family life education that outline goals and general content. Most districts focus on reducing teen pregnancy and STDs, and promoting sexual abstinence until marriage through family life education. Both the survey results and review of some districts' policies suggest that LEAs have formed their own goals for family life education.

Although the state directs LEAs to create policies and procedures for the implementation of Family Life Education through the Coordinated School Health program, a state-level Family Life Education plan does not exist.

Tennessee law mandates that any LEA in a county with a pregnancy rate of at least 19.5 per 1,000 females aged 15 to 17 must provide family life education. Also, State Board of Education Guidelines for Coordinated School Health require all LEAs that accept funding for that program must

teach family life education (see Appendix 5 for a description of Coordinated School Health). LEAs that qualify either based on pregnancy rate or by condition of being part of the Coordinated School Health program have the option of either (1) creating their own family life education program, or (2) adopting the state's program which, according to *T.C.A* 49-6-1302, would be created by the State Board of Education.

According to Tennessee law, the State Board was to have developed a "complete plan of family life instruction suitable for implementation by any LEA which fails to devise, adopt and implement a local program of family life instruction" starting in the 1991-1992 school year. This program was to have included an AIDS and STD component, policies and procedures for administering, evaluating, implementing, and supervising family life education, as well as prescribing policies for LEAs to utilize the services of outside parties, namely health care professionals and social workers. Those that qualify but do not implement either their own or the state's program can lose state funding. However, the Department has not enforced this penalty, and no group or individual is directed to check on compliance.

State Board staff indicate that Family Life Education has been incorporated into the Coordinated School Health Guidelines. Indeed, as of March 2007 any existing policies and procedures that refer to the administration of Family Life Education are found in the Board's Coordinated School Health Guidelines (Board Policy 4.204, Guidelines for School Health Programs). These guidelines call on participating LEAs to develop and maintain local school system policies (pertaining to, but not limited to, family life curriculum); to develop a staff training system; and to develop an assessment of, among other things, school health programs. In addition, school systems must verify that they comply with certain items, including engaging the services of qualified and licensed individuals in any aspect of Coordinated School Health. The Department of Education also provides sexual behavior and pregnancy data to the school systems so that they may plan health programs appropriate to their local needs.[53]

However, while the State Board's Coordinated School Health guidelines direct LEAs in the implementation of school health programs (and by association, family life education), the State Board of Education has not developed state-level procedures for assessment, supervision, and evaluation specific to family life education. In addition, Coordinated School Health was only recently expanded in 2006 from the 10 pilot sites created in 2000 to a statewide initiative, of which 31 of 136 LEAs now participate.[54] Therefore, any state policies pertaining to Family Life Education implementation did not exist until 2000, and then with limited LEA scope.

Exhibit 5: District Goals for Family Life Education

Goal	Percent of respondents that chose this item as one of its three main goals:
Reducing teen pregnancy rates	61%
Reducing STD and HIV infection rates	52%
Promoting sexual abstinence until marriage	44%
Instilling basic moral values in students	37%
Teaching the basics of human reproduction	30%
Teaching communication, refusal, and negotiation skills	30%
Delaying the onset of teen sexual activity	24%
Informing students of the emotional consequences of sex	14%
Reducing teen dating violence	6%

Source: OEA survey, Sept. 2006.

Lifetime Wellness and Healthful Living curriculum standards offer a framework for teaching family life education, yet the state provides no additional guidance for putting the standards into practice in the classroom.

As in many other states, Tennessee's Family Life Education is not a stand-alone program. It is embedded in the Healthful Living and Lifetime Wellness curriculum standards. Components of family life education are introduced in several other ways as well, including vocational and elective classes such as Family and Consumer Sciences, Adult Living, Teen Living, and Family and Parenting Education. However, 75 percent[55] of LEAs use the state health and wellness curriculum standards to conduct their family life instruction. Lifetime Wellness and Healthful Living classes—the state's required health education—include "Disease Prevention and Control" and "Sexuality and Family Life" domains that cover aspects of family life education. (See Exhibit 6.)

These curriculum *standards* are accompanied by recommended—not required—objectives for what a student should learn at each level and performance indicators (see Appendix 6 for Family Life and Disease Prevention learning objectives at different grade levels). They offer a framework but are not specific curriculum guidelines—they do not suggest how teachers can help students achieve the learning objectives. This can cause difficulties for teachers, particularly those without health education training. A 2004 evaluation of Tennessee's Coordinated School Health pilot sites noted that certified health educators were not the norm in those districts; instead, health teachers were often faculty members with primary academic preparation in other areas.[56] Some districts provide clear guidance for teachers by specifically outlining what students should be taught at each level and methods and training for teaching it. However, nearly half of all districts that use the state standards for family life instruction provide no additional assistance to teachers on how to put them into action in the classroom.[57] A Department official stated that they have recently begun discussing the possibility of developing an ancillary document that would provide more specific guidance for family life education that LEAs could use if they chose.

Forty percent of Tennessee LEAs supplement the state's curriculum standards with over 30 different commercial curricula. Some districts outline how supplemental materials are to be chosen, by what criteria and procedures and who is responsible; however, many do not. Although most states do not mandate a specific curriculum for family life, STD/HIV, or teen pregnancy prevention education, several states have documents to give guidance or curriculum suggestions or methods to ensure that quality curricula are chosen.[58]

Exhibit 6: Examples of Tennessee's Family Life Education-Related Curriculum Standards

Grade Level	Domain	Standard
K – 2 3 – 5 6 – 8	Family Life	The student will understand the contributions of family relationships to healthful living
		The student will understand the stages of human growth and development
		The student will understand the need and process of setting personal goals and standards for healthful living
	Disease Prevention and Control	The student will understand attitudes and behaviors for preventing and controlling disease
9 – 12	Disease Prevention and Control	The student will recognize behavioral factors leading to communicable and non-communicable disease and have the knowledge to obtain proper care
	Sexuality and Family Life	The student will examine behaviors, responsibilities, and attitudes of human sexuality and recognize the influence of social and family structures on decision-making

Source: Tennessee Department of Education, *TN's K-8 Healthful Living Standards* and *Lifetime Wellness, Grades 9-12, Course Description*

- California's "Health Framework for California Schools" provides curriculum suggestions; "Putting it All Together: Program Guidelines and Resources for State-Mandated HIV/AIDS Prevention Education in California Middle and High Schools" gives direction and support in meeting mandates and explaining legislative requirements.
- Georgia's "Quality Core Curriculum Standards and Resources" recommends resources and curricula for teaching about HIV/AIDS.
- Indiana law requires the Department of Education, in consultation with the Department of Health, to develop AIDS educational materials.
- Michigan's Department of Education has a website with guidance and resource materials and is urged to distribute medically accurate materials.
- New Hampshire's "Health Education Curriculum Guidelines" suggests instruction in Family Life and Human Sexuality topics.
- Vermont offers a "Sample Comprehensive HIV Policy for Schools: Pre-K – 12" containing suggestions for HIV/AIDS education.
- Washington's Department of Health must approve all materials for medical accuracy.

States also differ in requiring certain topics be taught. For example, some states require that in addition to the core topics of human reproduction, HIV/AIDS/STD prevention, and abstinence, students learn about adoption, avoiding sexual assault, legal consequences of parenthood, adequate prenatal care, and healthy dating.

The state has not created a plan of technical assistance in Family Life Education for LEAs, although the Department of Education provides some elements of assistance.

T.C.A. 49-1-205 instructs the Department of Education to develop a technical support and assistance program for LEAs providing family life education, if the LEA requests it or if the LEA chooses to use the state program as opposed to developing its own. Technical assistance would include:

suggested methods for maintaining a high level of parental and community support for family life education; workshops, seminars or other training opportunities for family life instructors; assistance in selecting family life textbooks and resource materials most suitable for the special needs of the community which the LEA serves; recommended mechanisms for effectively monitoring and evaluating implementation of family life courses; and other similar services to assist the LEA.

The Department does not have designated staff with the responsibility of assisting LEAs to implement curriculum standards, provide technical assistance or have oversight duties of family life education.

Available Technical Assistance

The Department of Education has not developed such a program, although it does provide some, but not all, elements of technical assistance to LEAs when requested.

- *Methods for maintaining a high level of parental and community support*. The Department does not provide guidance in this area.
- *Workshops, seminars or other training opportunities for family life instructors*. A 1996 State Performance Audit of the Family Life Curriculum found that there was "no mandated training, certification, or endorsement for family life instructors."[59] The Department responded that "while the family life law does not mandate that instructors be required to receive training, our goal will be to make it available to every LEA requesting the Department's assistance." The situation has not changed. Currently, the Department does not provide training opportunities for family life instructors. Instructors receive training if their district offers it and requires they take it. Only one-third[60] of districts that offer family life education provide professional development opportunities for their family life instructors. However, the Department has been providing training for AIDS educators in the school systems through a $250,000 CDC grant since 1988. This program—called the HIV/AIDS Prevention Teacher Training Center (TTC) and housed at UT-Chattanooga—focuses on training HIV/AIDS educators in high-risk populations and in high-risk areas of the state, at

the request of a school system, through three regional HIV prevention education institutes and a cadre of 10 trainers.[61] LEAs can take advantage of this resource; the TTC reports that the Department sends a letter to each school system each year, indicating that they provide this training at no cost. However, in 2005 only 10 school districts responded to this offer because the TTC was going through a restructuring process.[62] The Department has recently hired a new HIV Prevention Education Director and will focus on expanding the training to include some family life educators in 2007. However, to expand such training to more—or even all—districts that provide family life education would likely require supplemental funding from the state.

Although not provided by the Department of Education, the state-funded Tennessee Adolescent Pregnancy Prevention Program (TAPPP)—housed in the state Department of Health—can train teachers free-of-charge if a school or district requests it, usually during teacher in-service days. This training provides teachers with science-based, developmentally- and age-appropriate materials, as well as discussions intended to increase teachers' comfort and confidence in teaching pregnancy prevention. Although TAPPP does not use a particular curriculum (and therefore can be adapted to different districts' needs) the educators are available for technical assistance and consultation in choosing a curriculum, if needed.[63] They can also provide networking opportunities, community education, awareness and health fairs, media presentations, and loans of audio-visual and print materials.

With the recent hiring of the HIV Prevention Education Director, the Department of Education and the Department of Health report that they are attempting closer collaboration in the areas of HIV prevention and adolescent pregnancy prevention.

- *Assistance in selecting family life textbooks and resource materials*. The Department of Education does not help districts select course materials for family life education. As with textbooks in any subject area, the State Textbook Commission, advised by the Textbook Review Committee, recommends a list of health and wellness textbooks for approval by the State Board of Education. Local boards of education then select texts off of the approved list, yet do not receive guidance on which textbooks to select. However, teachers may use any supplemental materials they choose in the classroom—some school principals require prior approval of supplemental materials while others do not. Tennessee does not have a law mandating that textbooks and supplemental materials used in classes that address family life, HIV/AIDS/STD prevention, or sex education must be medically accurate, although several other states do.[64]
- *Mechanisms for effectively monitoring and evaluating implementation of family life courses.* The aforementioned 1996 State Audit also found that the Department itself had done very little monitoring and had failed to provide LEAs with guidelines for monitoring and evaluating their programs. The responsibility for program evaluation lies with the LEAs, not with the state. However, the state *is* required to provide monitoring and evaluation mechanisms for LEAs through its technical assistance program, but to date has not done so. State-level leadership in this area could promote more local-level evaluation of the effectiveness of family life education.

CONCLUSION 2: Family Life Education in Tennessee differs from district to district. LEAs cover a range of topics, and use a variety of materials, instructors, and methods of communicating with parents. However, most LEAs cannot determine whether their family life instruction affects their students' behavior.

The Comptroller's Office of Education Accountability conducted a survey regarding family life education in Tennessee, including questions about grade levels in which it is taught, curriculum standards used, outside instructors, professional development, components included and primary district goals for family life education. Staff received responses from 85 of the 136 LEAs in the state, a 62.5 percent response rate (see Appendix 3 for a list of participating LEAs and Appendix 4 for the survey questionnaire). ***The information in this section was provided by those respondents and therefore the percentages noted are percentages of respondents, not of all LEAs in Tennessee****. More specific numbers are provided in the endnotes.*

While districts cover a wide range of topics in family life education, almost all of them teach a few of the same select topics.

Although only 30 percent of LEAs responding to the survey considered teaching the basics of human reproduction as a main goal, 88 percent claimed to cover the topic. In addition, 94 percent of respondents reported that they covered the issues of self-esteem and self-respect, and 85 percent say that they work with students on building skills to negotiate themselves out of uncomfortable situations and to refuse to have sex or sex without protection. (See Exhibit 7.)

To review, the main family life education goals most often cited by LEAs (see page 10) included reducing teen pregnancy rates (61 percent), reducing HIV and STD infection rates (52 percent), and promoting sexual abstinence until marriage (44 percent). While the majority of LEA respondents (88 percent) reported that they covered sexual abstinence and the nature and prevention of STDs and HIV, only 56 percent described methods of contraception and one-third covered how to access contraceptive services, indicating that Tennessee's disease and pregnancy prevention education focuses on abstinence, rather than contraception. While this is in keeping with the directive in *T.C.A* 49-6-1301(b) regarding primary emphasis on abstinence, Tennessee law "permits instruction regarding contraception."[65] Districts that cover contraception in their family life instruction are not in violation of Tennessee law.

The majority of LEAs do not evaluate the effectiveness of their family life instruction, even though it is required by law.

T.C.A. 49-6-1301 (d) states that "the LEA shall prescribe procedures to provide for the periodic review and evaluation of family life instruction," yet only 19 percent[66] of district respondents have such a review and evaluation system. Some districts have a family life education policy that includes a statement requiring an annual evaluation. However,

Exhibit 7: Topics That Tennessee School Districts Report They Cover in Family Life Education

Topic	% of districts that report they cover this topic
Self-esteem, Self-respect	94%
Human reproduction	88%
Abstinence from sexual relations	88%
Nature and prevention of HIV/AIDS and other STDs	88%
Skill-building (refusal skills, negotiation skills, etc.)	85%
Basic moral values	80%
How to communicate with parents, peers, and others about sexuality, concerns, etc.	74%
Sexual/dating violence	74%
Describing methods of contraception	56%
How and where to access contraceptive services	33%

Source: OEA Survey, Sept. 2006.

the OEA survey results indicate that many districts do not adhere to that portion of the policy. An LEA may also request that the Department of Education evaluate the quality and effectiveness of family life instruction in that district and recommend ways to improve it, as well as foster community and parental support for family life instruction,[67] yet the Department reports that no LEA has ever requested such an evaluation. Because so few LEAs monitor or evaluate their Family Life Education programs, state and local education officials, parents, and teachers do not know whether their programs are effective, if the students are getting accurate information, or if the program should be redesigned to more effectively educate students.

Many LEAs do not have the staff or expertise to conduct solid, scientific evaluations of their family life education programs; other LEAs may feel that an evaluation is unnecessary. Comptroller's staff heard and read about programs that purportedly cut the teen pregnancy rate in certain counties, yet was not presented with evidence that such programs were *directly linked* to the reduction of those rates. Although teen pregnancy may decrease as the result of a particular program, over the past several years teen pregnancy rates have dropped all over the country. Guidance from the Department in the form of a standard evaluation option could help the LEAs adhere to their evaluation requirements, determine whether their programs are indeed effective, and identify elements of their programs that should be changed or remain the same. A standard evaluation option could also allow the Department to identify model programs throughout the state that other LEAs could modify to fit their own needs.

Three-quarters of districts that provide family life instruction use outside volunteers to teach a portion or all of the components in the classroom.

Coordinated School Health guidelines highlight the need to utilize the services of qualified instructors, yet many LEAs use outside volunteers to teach components of Family Life Education. The state lacks guidelines for what constitutes a "qualified" family life education instructor, as well as state-level policies and procedures for utilizing the services of outside volunteers as family life instructors. Of the districts responding to the survey, the overwhelming majority bring in volunteers from outside the schools to teach family life education. Some examples of guest speakers and instructors include:

- local physicians and nurses
- health department personnel
- people living with AIDS
- teen parents
- representatives of rape crisis centers
- clergy
- youth ministers
- faith-based organizations
- abstinence education groups
- representatives of domestic violence centers
- parents
- funeral directors

This is not to say that outside volunteers are unqualified or teaching inaccurate information; indeed, some outside instructors are trained healthcare professionals. Some school districts have board policies that require "community resources" (people that come in as invited speakers) to be approved by the principal and/or the superintendent, and other districts have no such policy. The classroom teacher often uses her or his own discretion to determine which outside instructors will teach all or portions of family life education; in some cases those at the district level may be unaware of which outside groups are teaching in the classroom.

According to the OEA survey, only 33 percent of districts that provide family life education provide professional development opportunities to their instructors. Aside from promoting community involvement in schools, the overwhelming use of outside instructors may be a result of lack of confidence or expertise, and most likely low comfort levels in teaching the material included in family life education. In fact, a 2004 CDC survey revealed that in Tennessee many schools wanted to receive staff development on topics addressed in family life education but did not receive it.[68] (See Exhibit 8.)

Exhibit 8: Percentage of schools in Tennessee in which the lead health educator wanted to receive training on family life education topics, and percentage of those that actually received it

Topic	% of schools that wanted to receive staff development in topic	% of schools that received staff development in topic
Pregnancy prevention	59.2	24.8
STD prevention	62.9	34.5
HIV prevention	65.4	48
Human sexuality	55.1	24.4

Source: CDC, *School Health Profiles: Surveillance for Characteristics of Health Education Among Secondary Schools*, 2006

Only half of LEAs that provide family life education report that they hold annual public meetings for parents to review materials, ask questions, and speak with instructors, as required by law. However, most districts provide information to parents in some manner.

State law requires LEAs that develop their own family life instruction programs to "prescribe procedures… to provide for periodic public hearings and parental conferences to ensure a high level of community and parental input and support for family life instruction."[69] LEAs that implement the family life instruction plan developed by the State Board must "periodically conduct thereafter, but not less frequently than once each September, public meetings for parents to confer with family life instructors, to review resource materials and course content, and to offer comments and suggestions."[70] However, only slightly more than half of districts hold these meetings.

Some districts that do not hold the meetings use other methods to inform parents and allow them to look at materials. Some send written communication home to parents, place notices in local newspapers, make information available through Open Houses, at Board of Education meetings or at the school for a limited time if parents want to come in and look at it. For example, Metro Nashville Public Schools sends a permission slip and a letter to parents that contains information about the topics being presented, supplemental materials that will be used, expected guest speakers, and an invitation to view materials.

Communication with parents and the community is important around what some consider such a controversial topic. Tennessee has an "opt-out" provision: any parent who wishes to remove his or her child from family life education may do so on any grounds. Parents will feel more secure about what their child is learning when they first have the opportunity to review the materials and ask questions.

RECOMMENDATIONS

Legislative Recommendations

The General Assembly, in cooperation with the Department of Education and the State Board, may wish to more clearly define the goals and content of Family Life Education. While current law instructs LEAs with a certain teen pregnancy rate to implement a program emphasizing premarital abstinence, rights and responsibilities of engaging in sexual relations, basic moral values, obligations and consequences of intimacy, and the nature and prevention of AIDS and other STDs, it provides no additional guidance for content expectations. In addition, the law mentions no goals of the program, nor does the Department of Education. Other states, such as Arizona, Alabama, California, Georgia, Louisiana, Maryland, Rhode Island, and Virginia have outlined more specific expectations in legislation, and yet still leave program development and implementation to the school districts. Formally defining the "goals" of family life education on the state-level that parallel what districts are already doing or guide them to include other important information could be instructive to school districts in developing or reviewing programs and in establishing frameworks specifically intended to address such goals.

The General Assembly may wish to align law with districts' current practices. As family life education is now embedded in the Department of Education's health and wellness curricula standards, and the majority of districts use these standards to guide their family life education, the legislature may wish to reflect that in amendments to the current law. Many districts were unaware of the requirement to develop a "program" for family life education and some districts that would be required to provide it based on their teen pregnancy rates initially stated that they did not provide family life instruction as outlined in *T.C.A.* 49-6-1301--1304. According to *T.C.A.* 49-6-1301(e), the Department of Education could withhold funding from districts that should have been, but claimed to not provide this instruction.

The General Assembly may wish to require that LEAs use materials and impart knowledge that is medically or scientifically accurate. While the Office of Education Accountability did not find any specific instances of LEAs teaching medically inaccurate information, a safeguard such as a legal requirement would help ensure that such information is free from ideology and instead focused on accurate information. Fourteen other states have such requirements. If the legislature chooses to make such a requirement, it may wish to define "accuracy" based on information and data provided by federal government or international agencies, (such as Centers for Disease Control, Food and Drug Administration, National Institutes of Health, World Health Organization, etc.), or on information from standard medical texts, peer-reviewed journals, or national medical associations.

The General Assembly may wish to consider supplemental funding to either (1) the Department of Education to augment the HIV/AIDS educator training program and to expand it to include family life educators, to the extent possible as allowed by the federal grant or (2) the Department of Health's Tennessee Adolescent Pregnancy Prevention Program for training purposes. As only 33 percent of LEA survey respondents provide training to their family life instructors, and because of the sensitivity of the subject, teacher training could have a positive influence on a school's ability to convey accurate information to students and make teachers more comfortable with the topic, and thus effective. Both of these are established programs with a history of training educators on topics associated with family life. The General Assembly may also consider joint funding for the TAPPP and HIV/AIDS educator training programs, allowing the two programs to share resources.

Administrative Recommendations—State Level

The State should provide assistance to LEAs that teach family life education.

- ***The State Board of Education, in conjunction with the Department of Education, should develop goals, policies and procedures for family life education to guide LEAs in evaluation, supervision and implementation of family life components of health education, pursuant to T.C.A. 49-6-1302(a)(2).*** While Coordinated School Health guidelines (State Board Policy 4.204) direct LEAs to create their own policies and procedures that encompass family life education, a complete state-level plan for family life education (including procedures for supervision, evaluation, and administration) does not exist. While LEAs want the ability to educate their students as they see fit, administrative standards would ensure that systems are in place to identify successful and unsuccessful methods of teaching family life education, that the information is consistent and accurate throughout districts, and that outside parties coming into schools to teach family life education are qualified.
- ***The Department of Education should develop a plan of technical assistance for LEAs for family life instruction pursuant to T.C.A. 49-1-205. Specifically:***
  - **Designate a Family Life Education Consultant, much like the Math, Social Studies, and Language Arts consultants in the Department.** This person, or persons, would be responsible for: overseeing technical assistance to the LEAs; providing examples of promising practices that the LEAs could model at the local level; providing simple evaluation techniques; ensuring that LEAs are adhering to state law by providing Family Life Education and achieving the Learning Objectives outlined in the Lifetime Wellness and Healthful Living curriculum standards.
  - **Emphasize the importance and the provision of professional development and training for family life instructors.** Only 33 percent of LEA survey respondents offer professional development activities to their family life instructors. This may affect the tendency of districts to bring in outside instructors to teach the family life portions of health education. According to the Tennessee State Board of Education Policy 5.200 on Professional Development, "it is the state's responsibility to encourage and provide resources for and information about professional development." State law suggests "workshops, seminars, or other training opportunities for family life instructors." Other states have taken pro-active approaches to the issue of training for sexuality or HIV prevention educators. California, Michigan, and Kansas require that family life instructors be trained; New York funds such training; Utah sponsors in-service training; and Maine's Department of Education provides no-cost training on evidence-based curricula.
  - **Recommend methods for effectively monitoring and evaluating the implementation of family life courses.** Program evaluation is vitally important, especially in family life education, to ensure that students are getting the best information to influence their behaviors and sexual decision-making. However, most districts do not have the capacity, resources, or experience to perform program evaluations. Optional evaluation tools made available by the state Department of Education may assist LEAs in fulfilling their legal obligation to review and evaluate the effectiveness of their family life instruction. The Department could create this tool or identify high-quality evaluation examples from LEAs that do evaluate their programs.
  - **Identify evidence-based program models and curricula that LEAs could adopt, if they choose.** In this way, the Department could fulfill its directive to provide assistance in selecting resource materials and additionally give LEAs program options that have been shown to be effective. If the Department determines that reducing pregnancy rates is a Family Life Education goal, it may want to work with other state departments in ways similar to those modeled by California, Vermont, Michigan, and Georgia (see page 3).

- **Provide an optional, ancillary document that offers LEAs more specific guidelines for the state health and wellness curriculum standards, should districts require additional guidance.** Department of Education staff indicate they are developing such a document.

Administrative Recommendations—School Districts

LEAs should provide assistance to family life instructors.

- ***Since the majority of school districts use the state health and wellness curriculum standards to guide family life instruction, they should provide additional guidance for teachers to put the standards into practice in the classroom.*** Seventy-five percent of districts use the state curriculum standards to guide family life instruction, yet only half of those districts provide any additional help for teachers who they require to follow them. Metro Nashville Public Schools has recently developed district guidelines for family life education within their health curriculum, based on the state standards. These guidelines outline specific topics within performance indicators. In addition, they provide guideline training to teachers.

  For both those districts that do and do not use the state standards as the basis for their family life instruction, they should have district standards and procedures in place for selecting and approving curricula (including commercial curricula) and policies for using supplemental materials, whether it be at the discretion of a school principal or whether such materials must be approved by the school board.

- ***Districts should provide professional development training for family life instructors.*** Tennessee State Board of Education Policy 5.200 on Professional Development states that school system leadership should "focus professional development to enhance educator knowledge of the subject content related to state curriculum standards," and schools themselves should "ensure that professional growth and development is continuous, ongoing, and job-embedded and includes follow-up and support for further learning." Such training could enhance the confidence and expertise for instructors teaching material included in family life education. Maryland requires local school systems to establish planned and continuous professional development programs to keep teachers up-to-date on materials and teaching methods for HIV/AIDS prevention education.

LEAs should evaluate the effectiveness of their family life instruction, pursuant to *T.C.A.* 49-6-1301(d).

Districts should ensure that outside instructors bringing supplemental materials into classrooms—including commercial curricula—meet criteria for "qualified instructors" as defined by the district or local board of education and that their materials are reviewed before they are presented to a class. If Tennessee chooses to require medical accuracy in family life materials and resources, LEAs will need to develop procedures and policies to ensure that materials presented in classes are accurate. Other states have advisory councils that make recommendations on curricula. For example, each school district in Indiana must establish an AIDS Advisory Council for the purpose of reviewing materials to make recommendations on standards for content, presentation of material and in what grades it is taught. Maryland and Michigan have similar advisory council systems. Tennessee LEAs should also have policies in place that stipulate what types of outside instructors are allowed and what their qualifications must be. Maryland requires that local school systems develop guidelines and procedures for selecting qualified teachers.

Local school boards should be aware of Tennessee law regarding family life education and ensure that their school districts are fulfilling necessary requirements, especially if the teen pregnancy rate in that county exceeds 19.5 per 1,000 15 to 17 year olds. They should also be aware that they can request technical assistance from the state Department of Education if necessary.

Endnotes

[1] Pregnancies to adolescents between the ages of 15 and 17, as reported by the Tennessee Department of Health.

[2] Tennessee Department of Health, *Tennessee Adolescent Pregnancy Summary Data 2004* and *1999*, April 2006. Accessed Aug. 28, 2006, http://www2.state.tn.us/health/statistics/PdfFiles/AdPreg04.pdf.

[3] National Campaign to Prevent Teen Pregnancy, "Teen Sexual Activity in the United States," accessed Aug. 28, 2006, http://www.teenpregnancy.org/resources/data/pdf/TeenSexActivityOnePagerJune06.pdf.

[4] Centers for Disease Control and Prevention, "Youth Risk Behavior Surveillance—United States, 2005," *Morbidity and Mortality Weekly Report*, 55(SS-5), June 9, 2006.

[5] Tennessee Department of Education, "Tennessee High School Survey Summary Table—Weighted Data" *2005 Youth Risk Behavior Survey Results*, http://www.k-12.state.tn.us/yrbs/.

[6] Had sexual intercourse with one of more partners during the previous three months.

[7] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "Demographic Characteristics of Mother, 2004," *National Vital Statistics System*.

[8] Child Trends, "Facts at a Glance," Publication #2005-02, March 2005.

[9] Centers for Disease Control and Prevention, Division of STD Prevention, *Sexually Transmitted Disease Surveillance 2005,* Nov. 2006, http://www.cdc.gov/std/stats/toc2005.htm.

[10] Based on Census Region. From the Henry J. Kaiser Family Foundation, "AIDS Case Rate per 100,000 Population, All Ages, Reported in 2005," statehealthfacts.org: 50 State Comparisons, www.statehealthfacts.org.

[11] CDC, "Youth Risk Behavior Surveillance—United States, 2005."

[12] Tennessee Department of Education, "Tennessee High School Survey Summary Table—Weighted Data."

[13] Ibid.

[14] Centers for Disease Control and Prevention, National Center for Health Statistics, "Table 39. Number of women 15-44 years of age who have had sexual intercourse and percent distribution by age difference between female and first male partner, according to age and Hispanic origin and race at first intercourse: United States, 2002," *Fertility, Family Planning and Reproductive Health of U.S. Women: Data From the 2002 National Survey of Family Growth*, Series 23, Number 25, Dec. 2005.

[15] CDC, "Youth Risk Behavior Surveillance—United States, 2005."

[16] U.S. Department of Health And Human Services, Office on Women's Health, The National Women's Health Information Center, "Birth Control Methods," http://www.4woman.gov/faq/birthcont.htm. When condoms are used correctly with every act of sexual intercourse, the effectiveness rate is 98 percent. However, when condoms are not used correctly or are not used with every act of sexual intercourse, the effectiveness rate is closer to 85 percent.

[17] U. S. Department of Health and Human Services, National Institutes of Health, National Institute of Allergy and Infectious Diseases, *Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention, June 12-13, 2000,* July 20, 2001. This document is a summary of a collaborative workshop to review the effectiveness of the male condom, which involved the National Institutes of Health, the Centers for Disease Control and Prevention, the Food and Drug Administration, and the U.S. Agency for International Development. Condoms can also reduce the risk of transmission of discharge STDs and genital ulcer diseases, yet the extent of risk reduction of these diseases is unknown; conflicting studies exist.

[18] Rebecca A. Maynard, ed., *Kids Having Kids: A Special Report on the Costs of Adolescent Childbearing*, The Robin Hood Foundation, 1996.

[19] The National Campaign to Prevent Teen Pregnancy, *By the Numbers: The Public Costs of Teen Childbearing in Tennessee*, Nov. 2006.

[20] Maynard, 1996.

[21] Nancy Berglas, Claire Brindis, and Joel Cohen, *Adolescent Pregnancy and Childbearing in California*, California Research Bureau, prepared at the request of Senator Dede Alpert, June 2003.

[22] Maynard, 1996. Another study, The Fragile Families and Child Wellbeing Study, found that 12 to 18 months after the birth of their child, only 12 percent of single parents had married their child's mother or father. See: The Center for Research on Child Well-Being, "'His' and 'Her' Marriage Expectations: Determinants and Consequences," *Fragile Families Research Brief*, Number 23, May 2004.

[23] Berglas, et al., June 2003.

[24] Maynard, 1996.

[25] Guttmacher Institute, "U.S. Teenage Pregnancy Statistics: National and State Trends and Trends by Race and Ethnicity," Sept. 2006.

[26] United States General Accounting Office, *Teen Pregnancy: State and Federal Efforts to Implement Prevention Programs and Measure Their Effectiveness*, Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate, November 1998; Cindy Costello and Henry J. Costello (eds.), *Across America: Preventing Teen Pregnancy in California, Georgia and Michigan*, National Campaign to Prevent Teen Pregnancy, 2003; Vermont Agency of Human Service, Planning Division, *What Works: Preventing Teen Pregnancy in Your Community*, December 1999; Association of Maternal and Child Health Programs, "Best Practices: Vermont Takes a Holistic Approach to Address Teen Pregnancy," *AMCHP Pulse*, June 25, 2004, and "Best Practices: Preventing Teen Pregnancy in California," *AMCHP Pulse*, July 9, 2004.

[27] Douglas Kirby, Gina Lepore, Jennifer Ryan, *Sexual Risk and Protective Factors: Factors Affecting Teen Sexual Behavior, Pregnancy, Childbearing, and Sexually Transmitted Disease: Which are Important? Which Can You Change?*, Executive Summary, Putting What Works to Work: A Project of the National Campaign to Prevent Teen Pregnancy, Sept. 2005.

[28] Taken from the following two studies, unless otherwise noted: Jennifer Manlove, Elizabeth Terry-Humen, Angela Romano Papillo, Kerry Franzetta, Stephanie Williams and Suzanne Ryan, "Preventing Teenage Pregnancy, Childbearing and Sexually Transmitted Diseases: What the Research Shows," Child Trends Research Brief, May 2002, and Elizabeth Terry-Humen, et al., *Summary: 14 and*

Younger: The Sexual Behavior of Young Adolescents, The National Campaign to Prevent Teen Pregnancy, 2003.

[29] Daniel R. Weinberger, Brita Elvevag, Jay N. Giedd, *The Adolescent Brain: A Work in Progress*, The National Campaign to Prevent Teen Pregnancy, June 2005.

[30] Berglas, et al., June 2003.

[31] Jennifer Manlove, Angela Romano Papillio, and Erum Ikramullah, *Not Yet: Programs to Delay First Sex Among Teens*, The National Campaign to Prevent Teen Pregnancy, Sept. 2004, www.teenpregnancy.org/works/pdf/NotYet.pdf.

[32] Barbara VanOss Marin, Douglas B. Kirby, Esther S. Hudes, Karin K Coyle, and Cynthia A. Gomez, "Boyfriends, Girlfriends and Teenagers' Risk of Sexual Involvement," *Perspectives on Sexual and Reproductive Health*, 38(2): 76-83, 2006, accessed June 20, 2006, http://www.guttmacher.org/pubs/journals/3807606.pdf.

[33] Mark D.Regnerus. "Talking About Sex: Religion and Patterns of Parent-Child Communication about Sex and Contraception," *The Sociological Quarterly,* 46: 79-105, 2005.

[34] Barbara Dafoe Whitehead, Brian L. Wilcox, Sharon Scales Rotosky, *Keeping the Faith: The Role of Religion and Faith Communities in Preventing Teen Pregnancy*, Overview, The National Campaign to Prevent Teen Pregnancy, September 2001.

[35] National Governor's Association, January 11, 2000.

[36] Robert E. Rector, "The Effectiveness of Abstinence Education Programs in Reducing Sexual Activity Among Youth," Backgrounder #1533, The Heritage Foundation, April 8, 2002, accessed Sept. 19, 2006, http://www.heritage,org/Research/Family/bg1533.cfm.

[37] Yvette Mack, Program Director, Tennessee Abstinence Education Program, Tennessee Department of Health, "Re: question," E-mail to the author, Nov. 27, 2006.

[38] The most well-known analysis is "The Content of Federally Funded Abstinence-Only Education Programs," commissioned by U.S. Congressman Henry A. Waxman in 2004, and thus dubbed "the Waxman Report." The report concluded that the abstinence-only curricula reviewed contained scientific errors, false information about the effectiveness of contraceptives and the risks of abortion, as well as blurred religion and science and treated stereotypes about girls and boys as scientific fact. The Heritage Foundation strongly refuted the report's conclusions, stating that it "is riddled with errors and inaccuracies about theeffectiveness of abstinence education and the risks associated with early sexual activity" and is "yet another attempt by aggressive proponents of comprehensive sex education to discredit and undermine the message of authentic abstinence education." While not a proponent nor a detractor of either approach, the GAO recently (Oct. 2006) released a statement, "Abstinence Education: Applicability of Section 317P of the Public Health Service Act" finding that the Department of Health and Human Services did not consider a section of federal law requiring medical accuracy on information about condom effectiveness applicable to abstinence education grantees. The GAO recommended that HHS "reexamine its position and adopt measures to ensure that, where applicable, abstinence education materials comply with this requirement."

[39] Tina Hoff, Liberty Green, Mary McIntosh, Nicole Rawlings, and Jean D'Amico, *Sex Education in America: A Series of National Surveys of Students, Parents, Teachers and Principals*, The Henry J. Kaiser Family Foundation, September 2000.

[40] This list is a combination of methods from both Mathematica, Inc.'s federally-funded abstinence education evaluation, *First-Year Impacts of Four Title V, Section 510 Abstinence Education Programs*, June 2005, and program evaluations reviewed in Douglas Kirby's *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, The National Campaign to Prevent Teen Pregnancy, May 2001.

[41] Nicole Kendell and Sheri Steisel, "Abstinence Education," *Legisbrief*, National Conference of State Legislatures, 7(19), April/May 1999.

[42] While the Tennessee Department of Health requires quarterly reports from the awardees, it has not performed a state evaluation of abstinence education programs. Yvette Mack, Program Director, Tennessee Abstinence Education Program, Tennessee Department of Health, "Re: question," E-mail to the author, Nov. 20, 2006, and interview with Yvette Mack, July 7, 2006.

[43] Evaluations reviewed included: Edward Smith, Jacinda Dariotis, Susan Potter, *Evaluation of the Pennsylvania Abstinence Education and Related Services Initiative: 1998-2002*, prepared by the Prevention Research Center for the Promotion of Human Development, Pennsylvania State University, Jan. 2003; Arizona Department of Health Services, *Final Report: Abstinence Only Education Program 1998 – 2003*, prepared by LeCroy & Milligan Associates, Inc., June 2003; Minnesota Department of Health, *Minnesota Education Now and Babies Later (MN ENABL) Evaluation Report 1998-2002,* prepared by Professional Data Analysts, Inc. and Professional Evaluation Services; and Edward J. Saunders, Miriam J. Landsman, Nancy M. Graf, Brad Richardson, *Evaluation of Abstinence Only Education in Iowa—Year Five Report*, National Resource Center for Family Centered Practice, University of Iowa School of Social Work, Oct. 2003.
In addition, the Office of Education Accountability reviewed the 10 studies of abstinence education programs cited by Robert Rector of the Heritage Foundation. While all of the 10 program evaluations were conducted in the U.S. after 1980 and all had a sample size of at least 75, two of the 10 evaluations were determined to be experimental and two others may have been experimental but that could not be confirmed with available information. The two experimental evaluations ("Teen Aid and Sex Respect" and "Project Taking Charge") showed that these two programs reduced the onset of sexual activity among certain populations, yet evaluators mentioned that the evaluation of "Project Taking Charge" was based on a small sample size. Therefore, OEA focused on the large-scale Congress-authorized abstinence education evaluation.

[44] Rebecca A. Maynard, et al., *First-Year Impacts of Four Title V, Section 510 Abstinence Education Programs, June 2005*, prepared by Mathematica Policy Research, Inc. Submitted to U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

[45] Barbara Devaney, Amy Johnson, Rebecca Maynard, and Chris Trenholm, *The Evaluation of Abstinence Education Programs Funded Under Title V Section 510: Interim Report*, April 2002, p. 1, submitted by Mathematica Policy Research, Inc. to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[46] Maynard, et al., June 2005.

[47] Manlove, Papillio, and Ikramullah, Sept. 2004; "What Works: Curriculum-Based Programs that Prevent Teen Pregnancy," Putting What Works to Work: A Project of the National Campaign to Prevent teen Pregnancy; and Jennifer Manlove, Kerry Franzetta, Krystal McKinney, Angela Romano Papillo and Elizabeth Terry-Humen, *A Good Time: After-School Programs to Reduce Teen Pregnancy*, Putting What Works to Work: A Project of the National Campaign to Prevent Teen Pregnancy, Jan. 2004.

[48] These included youth development, comprehensive sexuality, and service learning programs. The experimentally designed abstinence education program reviewed was not found to be effective in changing behaviors.

[49] The National Campaign to Prevent Teen Pregnancy, "What Works: Curriculum-Based Programs that Prevent Teen Pregnancy," *Putting What Works to Work*, p. 5.

[50] Kirby is employed by ETR Associates, a research group that supports comprehensive sexuality education. However, the referenced report was initially reviewed and developed by a task force that included both supporters of abstinence education and comprehensive sexuality education.

[51] Douglas Kirby, *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*, National Campaign to Prevent Teen Pregnancy, 2001.

[52] *T.C.A.* 49-6-1005.

[53] Connie Givens, Director, Coordinated School Health, Department of Education, Email to the author, March 2, 2007.

[54] Phone interview with Connie Givens, Director, Coordinated School Health, Department of Education, Feb. 26, 2007.

[55] 61 of 81 respondents that offer family life education.

[56] Tennessee Department of Education, Office of School Health Programs, *Tennessee Coordinated School Health Condensed Evaluation Report 2004.*

[57] Of the 61 respondents that use the state standards for family life education, 33 provide additional assistance to teachers.

[58] National Association of State Boards of Education, "State-by-State HIV, STD, and Pregnancy Prevention Education," *Healthy Schools: State Level School Health Policies*, http://www.nasbe.org/HealthySchools/States/State_Topics.asp.

[59] State of Tennessee Comptroller of the Treasury, Department of Audit, Division of State Audit, *Special Report: Family Life Curriculum*, May 1996.

[60] 27 of the 81 respondents that offer family life education also offer professional development opportunities for the instructors.

[61] Jerry Swaim, Director, Comprehensive School Health Education and Director of the Office of School Health Programs, Department of Education, "Re: a couple of questions," Email to the author, Nov. 27, 2006, and interview with Jerry Swaim, July 13, 2006.

[62] Gene Ezell, HIV/AIDS Prevention Teacher Training Center Director, "Re: question regarding training of HIV/AIDS educators, Emails to author Jan. 18, 2007, and Jan. 24, 2007.

[63] Martha Keys, Tennessee Adolescent Pregnancy Prevention Program, "Re: questions regarding accuracy of statement," Email to author, Nov. 27, 2006; and interview with Martha Keys, Aug. 10, 2006.

[64] Alabama (*Alabama Code* Section 16-40A-2); Arizona (*A.R.S.* s 15-716), California (*West's Annotated California Education Code* s 51931, 51933, 51934), Louisiana (*R.S.* 17-281), Maryland (Code 13A.04.18.04), Michigan (*M.C.L.A.* 380.1169), Minnesota (*M.S.A*. s 121A.23), Missouri (*V.A.M.S.* 170.015 and 191.668), New York (*Commissioner's Regulations* Subchapter G, Part 135, Health, Physical Education and Recreation), Oklahoma (*Okl.St.Ann.* s 70-11-103.3) , Rhode Island (*Gen.Laws* 16-22-17), Texas (*V.T.C.A.,* Health & Safety Code s 85.004), Washington (*West's RCWA* 28A.230.070 and 70.24.240), Wisconsin (*W.S.A*. 118.019(1)). Information provided by Carla Curran, Program Principal, The Forum for State Health Policy Leadership, National Conference of State Legislatures, Email to the author, "Medical accuracy in sex ed,"Oct. 6, 2006; and the National Association of State Boards of Education.

[65] Office of the Attorney General of the State of Tennessee, Opinion, 1992 Tenn AG Lexis 18, 92-17, Feb. 26, 1992.

[66] 15 of 81 respondents that offer family life education have a system of review and evaluation.

[67] *T.C.A.* 49-6-1302 (b).

[68] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, School Health Profiles: Surveillance for Characteristics of Health Education Among Secondary School (Profiles 2004), 2006, accessed June 26, 2006, http://www.cdc.gov/healthyyouth/profiles/2004/tables.pdf.

[69] *T.C.A.* 49-6-1301 (d).

[70] *T.C.A* .49-6-1302 (b).

APPENDIX 1: PUBLIC CHAPTER NO. 682

CHAPTER NO. 682

HOUSE BILL NO. 3819

By Representative John DeBerry

Substituted for: Senate Bill No. 3472

By Senators Herron, Burks

AN ACT to amend Tennessee Code Annotated, Title 49, Chapter 6, Part 13, relative to family life curricula and sex education.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 49, Chapter 6, Part 13, is amended by adding the following language as a new, appropriately designated section:

§49-6-13__. The comptroller's office of education accountability is directed to review Tennessee's Family Life Curriculum programs as established by Title 49, Chapter 6, Part 13. Not later than February 1, 2007, the office of education accountability shall prepare a written report of its findings and recommendations and shall submit such report to the education committees of the senate and the house of representatives as well as the education oversight committee. The report should provide an overview of Family Life programs in Tennessee and elsewhere, including curriculum content, the extent of participation in various school districts, comparison to other states' programs, and impact reported in relevant studies. In developing such finding and recommendations, the office is directed to rely upon scientific evidence and social science research and to consult with diverse interested groups, including churches and other faith-based organizations.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

PASSED: May 4, 2006

JIMMY NAIFEH, SPEAKER
HOUSE OF REPRESENTATIVES

JOHN S. WILDER
SPEAKER OF THE SENATE

APPROVED this 15th day of May 2006

PHIL BREDESEN, GOVERNOR

APPENDIX 2: Adolescent Pregnancy Rate (the number of pregnancies to females aged 15-17 per 1000 females aged 15-17), Resident Data, Tennessee, 2005

***Counties in bold are required by Tennessee law to provide Family Life Education*

County	Pregnancy Rate	Rank	County	Pregnancy Rate	Rank
Anderson	33.5	34 (tie)	**Lauderdale**	42.0	12
Bedford	38.8	18 (tie)	**Lawrence**	20.1	78
Benton	38.3	20	**Lewis**	23.4	68
Bledsoe	21.2	74	**Lincoln**	20.2	76 (tie)
Blount	22.3	72	**Loudon**	31.0	43
Bradley	37.1	23	**McMinn**	24.4	64
Campbell	38.1	21	**McNairy**	45.1	7
Cannon	24.6	63	**Macon**	33.0	36
Carroll	32.2	40	**Madison**	41.9	13
Carter	33.5	34 (tie)	**Marion**	30.8	44
Cheatham	17.5	84	**Marshall**	36.6	25
Chester	27.5	55	**Maury**	26.5	59 (tie)
Claiborne	17.6	83	Meigs	12.0	90
Clay	41.2	14	**Monroe**	30.4	45
Cocke	22.9	70	**Montgomery**	32.7	39
Coffee	34.7	28	Moore	16.0	88
Crockett	27.3	56 (tie)	**Morgan**	21.1	75
Cumberland	31.8	41	**Obion**	29.9	47
Davidson	44.7	8	Overton	18.6	81 (tie)
Decatur	19.0	80	Perry	11.4	91
DeKalb	8.0	93	Pickett	*	*
Dickson	30.2	46	**Polk**	40.1	16
Dyer	45.8	5	**Putnam**	33.9	30
Fayette	39.5	17	**Rhea**	51.3	2 (tie)
Fentress	33.6	32 (tie)	**Roane**	23.7	66 (tie)
Franklin	28.1	53	**Robertson**	29.4	48
Gibson	34.6	29	**Rutherford**	28.8	50 (tie)
Giles	35.5	26	**Scott**	28.3	52
Grainger	51.3	2 (tie)	**Sequatchie**	26.3	61
Greene	27.3	56 (tie)	**Sevier**	24.2	65
Grundy	23.7	66 (tie)	**Shelby**	50.0	4
Hamblen	40.5	15	Smith	17.3	85
Hamilton	37.0	24	**Stewart**	28.8	50 (tie)
Hancock	58.1	1	**Sullivan**	26.5	59 (tie)
Hardeman	16.2	87	**Sumner**	20.2	76 (tie)
Hardin	33.7	31	**Tipton**	25.4	62
Hawkins	27.1	58	**Trousdale**	44.1	9
Haywood	42.6	11	Unicoi	13.2	89
Henderson	33.6	32 (tie)	**Union**	37.2	22
Henry	38.8	18 (tie)	Van Buren	*	*
Hickman	43.4	10	**Warren**	27.9	54
Houston	16.8	86	**Washington**	19.8	79
Humphreys	21.8	73	**Wayne**	34.9	27
Jackson	45.5	6	Weakley	18.6	81 (tie)
Jefferson	31.4	42	**White**	32.9	37
Johnson	22.5	71	Williamson	10.2	92
Knox	29.0	49	**Wilson**	23.3	69
Lake	32.8	38	*TENNESSEE*	*33.8*	

**not calculated (less than 100 incidences)*

Source: Tennessee Department of Health, *Tennessee Adolescent Pregnancy Summary Data 2004,* April 2006

APPENDIX 3: Tennessee School Districts that Participated in the Comptroller's Survey of Family Life Education

While all school districts had an opportunity to fill out the survey, the following districts participated. Those in **bold** answered that they did *not* provide family life education to their students. However, all districts are required to provide Healthful Living and Lifetime Wellness to their students. Therefore it is possible that these districts provide components of family life education that are addressed in the Healthful Living and Lifetime Wellness curriculum standards.

Alcoa City Schools
Alamo City Schools
Alvin C. York Institute
Anderson County
Benton County
Blount County
Bristol City Schools
Campbell County
Carroll County
Chester County
Claiborne County
Cleveland City Schools
Clinton City Schools
Crockett County
DeKalb County
Department of Children's Services
Dickson County
Dyer County
Dyersburg City Schools
Etowah City Schools
Fayette County
Fentress County
Franklin Special School District
Giles County
Greene County
Greeneville City Schools
Hamblen County
Hardin County
Hawkins County
Haywood County
Henry County
Hickman County Schools
Hollow Rock-Bruceton Special School District
Houston County
Humphreys County
Jackson County
Jackson-Madison County
Kingsport City Schools
Knox County
Lenoir City
Lewis County
Lincoln County
Manchester City Schools
Marshall County School System
Maryville City Schools
Maury County Schools
McKenzie Special School District
Memphis City School
Metropolitan Nashville Public Schools
Milan Special School District
Monroe County
Moore County
Murfreesboro City Schools
Oak Ridge Schools
Obion County
Oneida Special School District
Perry County
Pickett County
Putnam County
Rhea County
Roane County
Robertson County
Rogersville City Schools
Sequatchie County
Sevier County
Shelby County
Smith County
Stewart County
Sweetwater City Schools
Tennessee Infant Parent Services School
Tennessee School For The Blind
Tipton County
Tullahoma City Schools
Unicoi County
Union City Schools
Union County
Van Buren County
Warren County
Washington County
Wayne County
Weakley County
West Carroll Special School District
White County
Williamson County
Wilson County

APPENDIX 4: LEA Family Life Education Survey Questions

The following questionnaire was available to all LEAs to fill out online, or in hardcopy form. All questions relate to topics in Family Life Education. Some questions are similar to those included in a 1992Department of Education Family Life Education survey.

Name of School System:_____
Contact person or name of person filling out survey_____
Title_____
Phone number or email address:_____

1. Does your school district currently provide family life education (either as part of another class or as a stand-alone class) to students? **Y or N**

   If you answered NO to Question #1, please continue to Question #2. After completing Question #2, you have completed the questionnaire. Thank you.

   If you answered YES to Question #1, please continue on to Question #3.

2. Has your school district ever provided family life education? **Y or N** If **Yes**, when? **DATES**

   Why was the program discontinued?

3. In what grades is it taught?
4. In which class(es) is it taught?

5. Please indicate what curriculum standards your district uses for family life education: **a, b, or c**
   a. The state curriculum standards for comprehensive health education (Lifetime Wellness and Healthful Living)
   b. Locally developed curriculum
   c. Other (commercial curriculum, combination, etc.)

   If **(a),** does your district formally provide additional guidance (either in written form, with training, etc.) for teachers on how to put the state standards into action in the classroom? **Y or N**

   If **(b),** please describe.

   If **(c),** please identify/describe

6. Does your district use any commercial curricula (i.e., “Why Know?”, “Becoming a Responsible Teen,” etc.) in conjunction with or in place of state-approved health textbooks? **Y or N** If **Yes**, please list them.

7. Does your district hold public meetings for parents to confer with family life instructors, to review resource materials and course content and to offer comments and suggestions? **Y or N** If **Yes**, with what frequency? If **No**, what methods does your district use to communicate with parents and offer them the opportunity to review materials, offer suggestions and/or ask questions?

8. Does your district use outside resources, such as health care professionals, faith-based organizations or other volunteers, to assist in family life instruction? **Y or N** If **Yes**, please list/describe.

9. Are any teachers in your district certified family life educators or certified sexuality educators? **Y or N**

10. Does your district provide professional development activities (specific to family life education) for family life instructors? **Y or N**

11. In the last two years, has your district requested assistance from the State Department of Education regarding any aspect family life education? **Y or N**

12. Does your district currently have a system of review and evaluation for your family life education program? **Y or N**
    a. If **No**, do you have plans to develop one or have you ever performed an evaluation of family life curricula in your district?
    b. If **Yes,** please email a copy of your review and evaluation program, or a past evaluation, to Jessica.Gibson@state.tn.us

13. Please indicate **all** components your district includes as part of family life education:
    a. Human reproduction
    b. Abstinence from sexual relations
    c. Describing methods of contraception
    d. How and where to access contraceptive services
    e. Basic moral values
    f. Nature and prevention of HIV/AIDS and other sexually transmitted diseases
    g. Sexual/dating violence
    h. Self-esteem, self-respect
    i. Skill-building (refusal skills, negotiation skills, etc)
    j. How to communicate with parents, peers, and others about sexuality, concerns, etc.
    k. Other:

14. Please select **up to three (3)** main goals of your district's family life education program from the list below.
    a. Reducing teen pregnancy rates
    b. Reducing STD and HIV infection rates
    c. Instilling basic moral values in students
    d. Reducing teen dating violence
    e. Delaying the onset of teen sexual activity
    f. Promoting sexual abstinence until marriage
    g. Teaching the basics of human reproduction
    h. Informing students of the emotional consequences of sex
    i. Teaching communication, refusal and negotiation skills
    j. Other:

15. What, if any, topics are "off-limits" in the discussion of family life, sexuality, etc. in your district?

APPENDIX 5: Coordinated School Health

Public Chapter 554 (2000) established 10 pilot programs for the Coordinated School Health approach based on the federal Centers for Disease Control's model for the implementation of Coordinated School Health. The CDC model includes eight interactive components:

- Health Education to address the physical, mental, emotional and social dimensions taught by trained, qualified teachers;
- Physical Education/Physical Activity;
- Health Services provided by physicians, nurses, dentists, health educators and other allied health professionals;
- Nutrition Services provided by child nutrition specialists;
- Health Promotion for Staff, such as health assessments, health education and health-related fitness activities;
- Counseling and Psychological Services for students, including individual and group assessments, interventions and referrals;
- Healthy School Environment including the school building, any detrimental chemical or biological agents physical conditions such as temperature, noise and lighting; and
- Parent/Community Involvement, such as school health advisory councils and coalitions.

Public Chapter 1001 (2006) expanded the program to all LEAs in Tennessee. The legislation also created School Health Coordinator and Specialist in Physical Education positions. Currently, 31 LEAs are on board with 60 to 70 more expected to apply for the program in 2007.

APPENDIX 6: Learning Objectives for Family Life and Disease Control and Prevention Components of Lifetime Wellness and Healthful Living Curricula Standards

Learning Objectives are what the student is expected to learn at certain grade levels. The Objectives are recommended, not required. No review mechanism exists to see that the objectives are met, although students take tests on the material that their instructor teaches.

Grade Level	Learning Objectives for Family Life *The student will*:	Learning Objectives for Disease Prevention and Control *The student will*:
K-2	• Describe various types of family structures • Explain that family structures vary and can change • Identify common goals and values found in family structures • Identify ways children can contribute to health family life • Identify human growth and development stages throughout the life cycle • Describe the important differences in the stages of human growth and development • Identify personal goals and standards • Describe the importance of personal decision making to healthful living	• Identify how germs are spread • Identify habits that will promote disease prevention • Identify chronic health problems
3-5	• Identify all families as unique • Demonstrate respect for the responsibilities of each person within the family • Identify how to improve family relationships • Describe how family structures change • Identify changes in the body that occur throughout the life cycle • Demonstrate respect for others as physical changes occur at varying rates • Identify effective decision making techniques • Determine influences on setting personal goals and standards • Apply the decision-making process in developing personal goals and standards that affect family life	• Compare and contrast communicable and non-communicable diseases • Identify universal precautions
6-8	• Identify family influences in the development of personal values and beliefs and how they will affect future decisions • Analyze changing roles and responsibilities throughout the life cycle as members of families • Evaluate the influence of attitudes and behaviors on health family relationships • Describe and demonstrate understanding of developmental characteristics of adolescence including physical and emotional changes • Exhibit respect for others as physical changes occur during adolescence • Identify abstinence from sexual activity as the responsible and preferred choice for adolescents • Analyze the effectiveness of personal decision-making as it relates to future health and wellness outcomes • Describe individual goals and aspirations for healthful living • Determine how setting healthful living goals can promote lifetime wellness	• Describe signs, symptoms, and risk factors related to communicable and non-communicable diseases • Evaluate how heredity, environment and lifestyle impact both the wellness and disease process

Grade Level	Learning Objectives for Family Life *The student will*:	Learning Objectives for Disease Prevention and Control *The student will*:
9-12	• Recognize abstinence from sexual activity as a positive choice • Identify positive aspects of a relations • Identify ways of resisting persuasive tactics regarding sexual involvement • Define sexual harassment, promiscuity, and date rape and the effects of each • Discuss the influence of families, traditions, economic factors, and cultural activities on one's sexuality • Explain human reproduction • Explore alternatives to consequences of teenage pregnancy including adoption, single parenting, teenage marriage and abortion • Compare various contraceptive methods • Describe gender difference, expectation, and biases • Examine the lifelong responsibilities and requirements of being a parent	• Differentiate between communicable and non-communicable diseases • Determine heredity, environmental, and lifestyle factors which place the students at risk for disease • Describe different types of pathogens and how they affect health • Explain transmission, prevention, warning signs, and treatment of communicable diseases • Identify prevention, causes, warning signs, and treatment for non-communicable diseases • Identify appropriate community agencies providing resources for disease information and support

APPENDIX 7: Persons Contacted

Sally Armstrong, Director of Curriculum and Instruction, Clarksville-Montgomery County School System

Dr. Tina Bozeman, Coordinator, Lifetime Wellness, Physical Education, JROTC and School Health Services, Metro Nashville Public Schools

Carla Curran, Program Principal, The Forum for State Health Policy Leadership, National Conference of State Legislatures

Kelly Drummond, Boys and Girls Club of Greater Knoxville

Dr. Gene Ezell, Professor, Health and Human Performance, UT-Chattanooga, and Director, HIV/AIDS Prevention Teacher Training Center

Connie Givens, Director of Coordinated School Health, Office of School Health Programs, Tennessee Department of Education

Sandra Hodges, Blount Nurses for Health Education, Alcoa, Tennessee

Mark Huffman, Vice President of Education and Training, Planned Parenthood of Middle and East Tennessee

Scott Hughes, Hope Resource Center, Knoxville, TN

Martha Keys, Tennessee Adolescent Pregnancy Prevention Program, Tennessee Department of Health

Camille Lashlee, Prevention Services Manager, Centerstone

Yvette Mack, Program Director, Tennessee Abstinence Education Program, Tennessee Department of Health

Kimberly Mahaffy, Director of Latina/o Studies and Assistant Professor of Sociology, Millersville University

Margaret Major, Director, Women's Health/Genetics Section, Tennessee Department of Health

Dr. Gary Nixon, Executive Director, Tennessee State Board of Education

Linda O'Neal, Executive Director, Tennessee Commission on Children and Youth

Bobbie Patray, President, Tennessee Eagle Forum

Nancy Salyer, Director, Worth Waiting For, Catholic Charities of Tennessee

Jeanece Seals, Director, HIV/AIDS/STD Section, Tennessee Department of Health

Dr. David Sevier, Policy Advisor, State of Tennessee Board of Education

Sarah Sharp, HIV Prevention Consultant, Coordinated School Health, Tennessee Department of Education

Stephen Smith, Director of Government Relations/Communications/Labor Relations, Tennessee School Boards Association

Jerry Swaim, Director, Comprehensive Health Education, Tennessee Department of Education

Donna Thomas, Department Director, Caring Choices, Catholic Charities of Tennessee

Nelsie Wooden, Education Services Director, Regional Education And Community Health Services (REACHS)

B.J. Worthington, Chief Academic Officer, Clarksville-Montgomery County School System

APPENDIX 8: Response Letter From the Tennessee Department of Education

PHIL BREDESEN
GOVERNOR

STATE OF TENNESSEE
DEPARTMENT OF EDUCATION
6TH FLOOR, ANDREW JOHNSON TOWER
710 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243-0375

LANA C. SEIVERS, Ed.D.
COMMISSIONER

March 16, 2007

Ms. Ethel R. Detch
Director
Offices of Research and Education Accountability
Suite 1700
505 Deaderick Street
Nashville, Tennessee 37243-0268

Dear Ms. Detch:

Thank you for the opportunity to review the Office of Education Accountability report on "Family Life Education in Tennessee". The Department concurs with your state level administrative recommendations cited in the report. We are committed to increasing our level of compliance with T.C.A. 49-1-205, which directs the Department to develop a program of technical support and assistance for LEAs that provide family life education and that request assistance.

We believe we are meeting many of our responsibilities in this area. As you noted in the report, the Department does provide an instructional framework through the lifetime wellness and healthful living curriculum standards. Training provided through the HIV/AIDS Prevention Teacher Training Center provides LEAs with a professional development opportunity in this aspect of Family Life Education. However, we need to better coordinate and focus our activities to fully meet all of the requirements of 49-1-205. We will assess organizational structure and personnel to find the best fit for this responsibility.

Thank you again for the opportunity to review and respond to the report.

Sincerely,

Lana C. Seivers

Lana C. Seivers

APPENDIX 9: Response Letter From the Tennessee State Board of Education

DR. GARY L. NIXON
EXECUTIVE DIRECTOR

PHIL BREDESEN
GOVERNOR

TENNESSEE
STATE BOARD OF EDUCATION
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March 13, 2007

Ms. Ethel R. Detch
Offices of Research and Education Accountability
Suite 1700, James K. Polk Building
505 Deaderick Street
Nashville, TN 37243-0268

Dear Ms. Detch:

Please find below the State Board staff response to the draft report, *Family Life Education in Tennessee.*

In accordance with Tennessee law, family life instruction is a subset of coordinated school health programs, not a standalone program. Family life education required by TCA § 49-6-1302 was implemented in the same way that all curricular requirements are implemented. Statutory changes have made TCA § 49-6-1302 an ineffective framework for analyzing family life education in Tennessee.

TCA § 49-6-302(a)(8) authorizes the State Board of Education to "set policies governing all curricula and courses of study in the public schools." State Board Rule 0520-1-3-.05(1)(a) requires the Board to "adopt curriculum standards for each subject area, grades K-12. The standards shall specify learning expectations and include performance indicators. The approved standards shall be the basis for planning instructional programs in each local school system." That rule also notes, in subsection (c), that "[i]nstruction in grades K-12 in issues of current concern such as character education, environmental education, economic education, career education, family life education, substance use and abuse, AIDS education, sexual abuse prevention, cardiopulmonary resuscitation, and safety shall be incorporated in appropriate subject areas and grade levels."

The State Board sets "policies governing all curricula" by appointing task forces, composed largely of practitioners and experts from the Department of Education. These task forces prepare curriculum standards which are approved by the Board, and serve as the guidelines for instruction in local education agencies (LEAs). LEAs and the Department staff evaluate the effectiveness of the wellness curriculum that

incorporates family life education just as they evaluate the effectiveness of the chemistry or algebra curricula.

In 1990, in accordance with TCA § 49-6-302(a)(8) and SBE rule 0520-1-3-.05(1), the State Board complied with TCA § 49-6-1302 by incorporating family life instruction (including all of the elements required by § 49-6-1302) into the health and wellness curriculum standards. Since 1990, those curriculum standards have been updated several times. The family life curriculum strands are now a part of the lifetime wellness curriculum, which is available online: http://state.tn.us/education/ci/standards/pe/wellness_912.shtml.

In 2000, the legislature passed TCA § 49-1-1002, the Coordinated School Health Improvement Act. This statute moved the family life curriculum from § 49-6-1302 to a place under the umbrella of coordinated school health programs. TCA § 49-1-1002 requires the commissioner of education, together with the department of health, to provide model guidelines for LEAs to use to address health needs of their students. This model must include "health education, . . . , physical education, healthy school environment, school counseling, school psychological and social services." In addition, § 49-1-1002 makes the family life curriculum a specific component of the coordinated school health program: "In developing such guidelines and standards, the following components must be included, . . . : (1) The provisions of § 49-6-1005(a) and the family life curriculum contained in title § 49, chapter 6, part 13, shall continue to be observed."

In response to this statute, the State Board adopted Board Policy 4.204, Guidelines for School Health Programs (available online at http://state.tn.us/sbe/Policies/4.204%20Guidelines%20for%20School%20Health%20Programs.pdf). As part of an overall coordinated school health initiative, these guidelines include "procedures and policies necessary for local implementation, administration, evaluation and supervision of family life instruction" (TCA§ 49-6-1302(a)(2)).

The Department of Education provides "guidance for putting the standards into practice in the classroom" just as it does for any curriculum standards – through technical assistance programs, curriculum specialists and, in this case, the Office of Coordinated School Health (in accordance with TCA § 49-1-205). Connie Givens is the current Director of Coordinated School Health. In 2006, the legislature passed Public Chapter 1001 (http://tennessee.gov/sos/acts/104/pub/pc1001.pdf), which created, within the Department of Education, the office of school health coordinator. That Act also authorized LEAs to implement coordinated school health programs in accordance with the commissioner's guidelines.

In summary, the State Board staff recommends:

1. That TCA 49-6-1302 be repealed, or amended and rolled into 49-1-1001 *et seq.*, as part of coordinated school health programs (consolidating these efforts will also help schools comply with federal regulations regarding school health programs).

2. That improvements to family life instruction be coordinated through the Department of Education's Office of Coordinated School Health and the Advisory Councils on School Health in each LEA, as outlined in Board Policy 4.204.

Please let me know if you have questions.

Sincerely,

Gary L. Nixon, Ed.D.
Executive Director

GLN/pc

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♦indicates staff who assisted with this project

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