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A questionnaire was sent to principals of elementary and secondary schools and regional vocational technical schools in Connecticut to determine the status of health education and family life education in Connecticut public schools. The findings based on data from 221 elementary and 210 secondary questionnaires indicated the following trends in health and family life education in the public schools of Connecticut: (1) Most schools do not offer specific health instruction, (2) Family diets and sex education are available to a very limited number of students, (3) Where health instruction is offered it is incidental, integrated with material in other courses, and covers traditional topics, (4) Educators concurred that family life and sex education have a place in public education, that communities in the state will be receptive, and that existing programs have met with generally favorable reaction, (5) There is an expressed need for in-service training programs, (6) Boys and girls are separated for health and family life education, (7) Available resources are not being fully utilized, and (8) Students are not involved in health and family life education curriculum development. (FP)

(C)

The Status Of Health And Family Life Education In Connecticut Public Schools

Walter G. McIntire, Ph.D.
Project Director
University of Connecticut

A Cooperative Study
by
Connecticut State Department of Health
Connecticut State Department of Education
University of Connecticut

Connecticut State Department of Health
Hartford, Connecticut 06115

THE STATUS OF HEALTH AND FAMILY LIFE EDUCATION IN CONNECTICUT PUBLIC SCHOOLS

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This study had its inception in the concerns of the Connecticut State Departments of Health and Education for the status of health, family life and sex education in the Connecticut public schools. This interest led to a cooperative effort between these departments and the Department of Child Development and Family Relations of the University of Connecticut in the development of this study.

The author especially acknowledges the cooperation and assistance of Estelle Siker, M.D., and Mr. Milton Geyer of the Connecticut State Department of Health and Dr. Ruth V. Byler and Dr. Bernard W. Dolat of the Connecticut State Department of Education. The author wishes to express his great appreciation to those principals who responded to the questionnaires for their cooperation.

W. McI.

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INTRODUCTION

This study had its inception in the concern of the Connecticut State Department of Health and E. .cation as to the status of health education and family life education in Connecticut public schools.

Each department has been receiving increasing numbers of requests from schools for information and assistance in developing and revising health education and family life education programs.

The Report of the Committee on Family Life Education of the Connecticut Advisory School Health Council pointed out that there is a need in Connecticut for evaluation, planning and change in the area of family life education.

This study then was undertaken to establish a base from which the respective sponsoring departments could plan programs to aid or improve health and family life education.

In addition to the analysis presented here, the data derived from this study can be utilized for additional analyses and correlations.

METHOD AND PROCEDURE

Objectives

This study had three general objectives: (1) to describe the status of planned health instruction in Connecticut public schools, (2) to describe the status of family life education in Connecticut public schools and, (3) to provide a base for the evaluation of health and family life education in Connecticut.

Within these limits, rather specific objectives were set. They were:

A. To determine the availability of health and family life education programs to public school students in terms of:
   1. How does availability relate to grade level?
   2. Are specific courses in health and/or family life education offered?
   3. Is material pertinent to these areas offered in related courses?

B. To determine who is providing health and/or family life education in terms of:
   1. Proportion of schools in state
   2. School size
   3. Curriculum content

C. To determine what resources are being utilized in terms of:
   1. Methods
   2. Materials
   3. Personnel

D. To determine the content of health and family life education courses.

The Questionnaires

Two questionnaires were developed for the study. One, designated "Elementary School Questionnaire," consisted of 100 questions relative to health and family life education in grades 1-8. The second, designated "Secondary School Questionnaire," consisted of 130 items and covered grades 7-12. The overlap of grades 7 and 8 was necessitated by the fact that in some schools in the state grades 7 and 8 are departmentalized and are considered to be secondary schools by the Connecticut State Department of Education, while others are self-contained and classified as elementary.

The questionnaire was designed so that responses could be made on IBM cards designed to handle a maximum of five responses to each question.

The Sample

The questionnaire was sent to all principals of secondary schools listed by the Connecticut State Department of Education in the October 1966 Directory of Secondary Schools and Principals and also, to all principals of state regional vocational technical schools as listed in the Educational Directory of Connecticut (1967).

A sample of elementary school principals was drawn for participat n in the study. The sample consisted of all principals from communities having only one elementary school or having one principal for more than one school; one principal from each town having up to six elementary schools; two principals from towns having 7 to 12 elementary schools; 3 principals from towns having 13 to 20 schools; and 4 principals from towns having 21 or more schools. Exceptions to this were made in order that in all towns, all grades could be sampled. Fo: example, in a town with only two elementary schools, where one was k-4 and another 5-8, both school principals were queried.

A total of 252 secondary school principals received the questionnaire. Two hundred sixty-three elementary questionnaires were sent. Also, each superintendent of schools in the state received copies of both questionnaires with a letter explaining the purpose of the study and that principals in his schools were being asked to participate.

Response

In response to the original mailing, 63.88% of the principals responded. An additional 19.81% responded to the follow-up mailing which consisted of the original material plus another letter encouraging their response. Table 1 shows the pattern of response.

TABLE 1

RESPONSE TO MAILED QUESTIONNAIRES

Responses	Elementary		Secondary	
	N	%	N	%
Original mailing	169	64.26	160	63.49
Follow-up	52	19.77	50	19.84
Total	221	84.03	210	83.33
Total Sample	263		252	
Non-Responding	42	15.97	42	16.67

The findings of this study are based on 221 elementary and 210 secondary questionnaires that were returned.

The IBM tally sheets sometimes indicated more responses than called for by the questions. It will also be noted that in some instances there may be overlapping in percentages because more than one answer to a single question was possible.

ELEMENTARY SCHOOL RESULTS

How, Where, and When Taught

Table 2 shows the pattern of planned health instruction at each elementary school grade.

It appears that planned health instruction may be a misnomer for what happens as health instruction, particularly in the primary grades. Depending on grade level, between 41 and 81 percent of the principals report that health instruction is either correlated or integrated into other subjects, not as specific units but as incidental instruction. As the student moves up through the grades, he has a greater opportunity for meeting planned health instruction either as units in other courses or as a separate subject; however, in grades 4, 5, and 6 only about fifty percent of the schools offer this kind of health instruction.

TABLE 2

Which pattern of health instruction best describes that used in each grade in your school?		Percent					
		a	b	c	d	e	Total
In grade K?	a. a separate subject scheduled each week	9	44	7	37	3	177
" " 1?	b. correlated or integrated in other subjects	18	44	13	25	0	194
" " 2?	but not as specific units	22	42	17	18	1	193
" " 3?	c. planned health units taught in other	25	38	21	17	1	200
" " 4?	subjects	27	32	25	15	1	298
" " 5?	d. incidental instruction when deemed	29	31	27	13	1	193
" " 6?	appropriate by the teacher	25	30	31	12	3	176
" " 7?	e. other	16	26	33	17	8	92
" " 8?		20	26	28	19	8	80

Table 3 shows that where health education is integrated into courses, it is integrated into either a combination of courses or into the sciences. As grade levels increase, health education is increasingly integrated into the sciences and decreasingly described as being presented in a "combination of courses."

TABLE 3

Please indicate where health instruction is integrated into courses.		Percent					
		a	b	c	d	e	Total
In grade K?	a. physical education	6	0	16	8	70	108
" " 1?	b. homemaking	5	0	30	11	54	127
" " 2?	c. sciences	5	0	36	9	50	124
" " 3?	d. social studies	3	0	43	5	48	128
" " 4?	e. combination of above	5	0	49	2	44	128
" " 5?		6	0	53	2	38	125
" " 6?		5	0	58	2	35	129
" " 7?		12	0	53	3	35	68
" " 8?		12	0	50	3	35	66

Table 4 shows that most health education in elementary schools is occurring in mixed sex classes, but that as grade levels increase, boys and girls are increasingly separated either completely or for certain units of study.

TABLE 4

Are boys and girls scheduled in the same class or separate classes for health instruction?		Percent a	b	c	d	e	Total
In grades K-4?	a. combined classes	95	2	3			203
In grade 5?	b. separate classes	74	8	18		1	193
" " 6?	c. combined classes except for some	69	5	25		1	186
" " 7?	units of study	59	17	23		1	90
" " 8?		58	16	25		1	85

Table 5 shows that where boys and girls are separated, it is primarily as a result of the nature of the subject matter covered.

TABLE 5

If boys and girls are separated at any grade please indicate the reason.	Percent a	b	c	d	e	Total
a. administrative (space, scheduling, etc.)	11	67	19	4		81
b. nature of the subject matter						
c. both a and b						
d. other						

Table 6 shows that for elementary schools offering health education as a separate subject, most are offering health education one hour or less per week and Table 7 shows the estimated number of hours spent in health education, irrespective of how it is integrated into the curriculum.

TABLE 6

Please indicate how many hours per week are devoted to health instruction		Percent a	b	c	d	e	Total
In grade K?	a. 1 or less	43	5	0	0	53	84
" " 1?	b. 2	45	7	1	0	47	100
" " 2?	c. 3	43	12	1	0	45	103
" " 3?	d. 4 or more	46	10	1	0	43	105
" " 4?	e. not a separate subject	49	11	2	1	37	107
" " 5?		48	13	2	1	37	112
" " 6?		46	14	2	1	37	106
" " 7?		38	9	2	0	52	56
" " 8?		35	9	2	0	54	54

TABLE 7

What is the estimated number of hours per year spent in health education?		Percent a	b	c	d	e	Total
In grade K?	a. less than 40	68	23	5	2	2	168
In grades 1-3?	b. 41-75	53	38	6	2	2	194
In grade 4?	c. 76-110	47	35	14	2	2	196
" " 5?	d. 111-150	43	35	18	3	2	192
" " 6?	e. more than 150	43	34	20	2	2	185
" " 7?		49	27	18	1	4	92
" " 8?		51	24	19	1	4	90

What is Taught

Table 8 deserves special study. It is interesting to note the major topic emphases — and lack of emphases — in the data from the schools which indicated they do have a planned curriculum. For example, major consideration seems to be given to the more traditional values in such units as basic foods, care of teeth, cleanliness and grooming, exercise and relaxation, and safety and accident prevention. On the other hand, family life and sex education units are not generally being taught. Such topics as boy-girl relationships, family interaction, human reproduction, personal adjustment, and venereal disease receive limited or no consideration. The only other area given so little consideration is international health problems.

TABLE 8

Please indicate for each of the following where it first receives major emphasis in your program of planned health instruction.

a. K or 1
b. 2 or 3
c. 4 or 5
d. 6, 7, or 8
e. is not considered

	Percent					
	a	b	c	d	e	Total
Alcohol	0	3	28	54	16	200
Animal reproduction	16	22	22	31	10	198
Attitudes toward self	37	12	31	17	3	203
Basic foods	31	35	24	9	1	208
Body systems	2	11	51	34	3	203
Boy-girl relationships	3	2	13	47	36	196
Care of teeth	57	26	12	4	1	207
Choice and care of clothing	21	23	25	22	9	203
Cleanliness and grooming	51	17	17	14	1	206
Communicable diseases	16	16	35	25	8	202
Community health problems	3	17	30	38	13	200
Dignity and worth of the individual	30	9	23	29	9	202
Drugs and narcotics	1	2	27	56	14	201
Exercise and relaxation	41	13	31	13	15	201
Family interaction patterns	20	11	11	26	32	193
First aid (concepts and procedures)	3	11	39	35	13	200
Home and family in the society	26	17	12	28	16	197
Human reproduction	1	1	3	31	65	195
International health problems	1	2	10	48	41	197
Mental health and personal adjustment	6	5	12	47	30	198
Non-communicable diseases	3	8	32	34	23	195
Personality development	8	7	28	37	20	199
Physical changes during growth	3	6	38	40	13	198
Posture and body mechanics	18	27	36	15	4	203
Rest and sleep	53	23	20	3	1	205
Safety and accident prevention	53	23	16	7	1	203
Smoking	0	2	35	54	7	201
Venereal diseases	1	1	1	9	90	187
Vision and hearing	31	27	26	14	2	201

Table 9 shows that 56% of Connecticut elementary schools offer menstrual education programs, and that where offered, they are offered usually in grades 4-6. Essentially no schools are offering this information to male students. Nurses provide the programs where offered. Interestingly, only 53% of the school administrators responding feel that their menstrual education is adequate.

TABLE 9

		Percent					
		a	b	c	d	e	Total
Many Connecticut Schools are asking for help planning for Family Life/Sex Education Programs. The following questions relate to this health area.							
Do you offer a program of menstrual education?	a. yes b. no	56	41	0	2	1	211
At which grade is this offered?	a. 4 or 5 b. 6 c. 7 or 8 d. all of the above e. not offered	28	23	6	9	35	188
This course is offered to	a. girls only b. boys and girls together c. boys and girls separately d. is not offered	62	0	2	31	5	192
This course is offered	a. as a special presentation by a nurse b. as a special presentation by a teacher c. as part of a specific course offering d. is not offered	62	0	2	31	5	192
Do you consider the program of menstrual education offered by your school to be adequate?	a. yes b. no	53	45	1	1	0	187

Who Teaches — Preparation — Curriculum Development — Resources Used

Table 10 shows that during the 1966-67 year, 80% of the elementary schools did not offer any in-service training or curriculum development projects for their teachers in the area of health education.

TABLE 10

	Percent					
	a	b	c	d	e	Total
During the current school year, did teachers in your school participate in teachers' meetings, workshops, or curriculum development in the area of Health Education?						
a. yes b. no	20	80	0	0	0	217

Table 11 indicates that only one-half of the reporting schools had a local curriculum guide in health education, and about one-half use a health education text series. Fifty-eight percent left course content essentially up to the individual teacher. It also indicates that only 15% of the schools used student evaluation of their programs. Less than 8% of the elementary schools are using standardized tests to evaluate the results of their programs of health instruction.

TABLE 11

In your program of health instruction, do you—		Percent a	b	c	d	e	Total
Use a local curriculum guide?	a. yes b. no	50	50	0	0	0	206
Use a Health Education Text Series?		48	52	0	0	0	197
Leave the content to the individual teacher?		58	42	0	0	0	198
Utilize pupil evaluations of the program?		15	85	0	0	0	188
Use standardized testing programs?		7	93	0	0	0	189

While Table 12 shows that about 20% of the schools are not making major use of films, this may indicate a lack of availability of films or a lack of knowledge about what films are available.

TABLE 12

To what extent do you use films in health instruction?		Percent a	b	c	d	e	Total
In K through 3?	a. very often	15	61	23	3	0	200
In grades 4-6?	b. occasionally	15	68	17	0	0	200
In grades 7-8?	c. rarely	20	57	21	2	0	90
	d. never						

About one-half of the elementary schools sampled rarely or never used resource persons in health education according to Table 13. This again may reflect availability or knowledge of availability.

TABLE 13

To what extent do you use resource persons in health instruction?		Percent a	b	c	d	e	Total
In K-3?	a. very often	6	40	43	10	0	196
In 4-6?	b. occasionally	4	54	37	6	0	205
In 7-8?	c. rarely	3	51	36	10	0	92
	d. never						

Table 14 indicates that classroom teachers have primary responsibility for health instruction. As grade level increases, physical education teachers play a slightly more important role.

TABLE 14

Who has the primary responsibility for health instruction in your school?		Percent a	b	c	d	e	Total
In grades K-3?	a. the classroom teacher	86	12	2	0	1	198
In grade 4?	b. classroom teacher with help of a	80	16	1	3	1	196
" " 5?	specialist or coordinator	76	18	2	4	0	193
" " 6?	c. health education coordinator,	72	18	3	7	0	187
" " 7?	supervisor, or specialist	65	17	2	15	0	86
" " 8?	d. physical education teacher	61	19	4	16	0	80

Attitude and Opinion Survey

Table 15 shows the response of elementary school principals to five statements about family life and sex education in terms of their agreeing or disagreeing with the statements.

To the first statement, "The schools should offer planned programs of instruction in the area of family life and sex education," 77% of the responding educators agreed either strongly (56%) or slightly (21%) with the statement. Only 8% disagreed with the statement and 15% were neutral or uncertain.

In response to the second statement, "Programs of family life and sex education should be offered to co-educational classes rather than to sexually homogeneous classes," 44% agreed that classes should be co-educational, 27% were neutral or uncertain, and 29% disagreed.

Forty-eight percent responded favorably to the statement that "Family life and sex education in the public schools should consist of frank presentation of fact, without moralizing." Nineteen percent were uncertain or neutral, and 33% disagreed.

These educators disagreed in general with the statement that, "Only teachers with successful marriages of some duration should teach in the family life and sex education area." Fifty-eight percent disagreed (43.3% strongly), 20% agreed, and 22% were neutral or uncertain.

There was general agreement that "Family life and sex education should be integrated throughout the length and breadth of a student's education, rather than offered as a one-shot course somewhere near the end." Eighty-seven percent of the principals agreed, 9% were uncertain or neutral and less than 4% disagreed.

In response to the question, "How would you describe the readiness of your community to the introduction of family life and sex education in the public schools?", 17% of the responding principals described their community as "definitely interested," while 50% described their community as "interested, some opposition." Thirteen percent reported their communities as "opposed," and 20% responded "not an issue in the community."

Table 15 also indicates that of the 34 responding principals who had a program of family life and sex education, about one-third introduced the program with the same procedure and public involvement that any change in the curriculum gets; one-third introduced the program primarily as a result of encouragement and support from civic organizations, parents' groups, churches, etc., and one-third introduced the program with the school taking a leadership role in involving the whole community in introducing it, through churches, parent groups, etc.

Interestingly, no principals reported generally negative response to family life and sex education programs. Fifty-three percent reported strong positive or generally positive reception to their programs, 31% reported no reaction, and 16% reported neither positive nor negative reactions or about equal amounts of each.

TABLE 15

	Percent					
As part of this study we are asking educators to respond to the following items regarding Family Life and Sex Education. For each of the following statements indicate whether you— a. agree strongly b. agree slightly c. are uncertain or neutral d. disagree slightly e. disagree strongly	a	b	c	d	e	Total
The schools should offer planned programs of instruction in the area of Family Life and Sex Education	56	21	14	3	5	214
Programs of Family Life and Sex Education should be offered to co-educational classes rather than to sexually homogeneous classes	24	20	27	10	20	211
Family Life and Sex Education in the public schools should consist of frank presentation of fact, without moralizing.	37	10	19	14	19	211
Only teachers with successful marriages of some duration should teach in the Family Life and Sex Education area.	12	7	22	15	43	210
Family Life and Sex Education should be integrated throughout the length and breadth of a student's education rather than offered as a one-shot course somewhere near the end.	75	12	9	1	3	210
How would you describe the readiness of your community for the introduction of Family Life and Sex Education in the public schools? a. definitely interested b. interested, some opposition c. opposed, some interest d. opposed e. not an issue in the community	17	50	10	3	21	214
If you now have a program of planned instruction in Family Life and Sex Education, was this program introduced— a. with the same procedure and public involvement that any change in the curriculum gets? b. primarily as a result of encouragement and support from civic organizations, parents' groups, churches, etc. c. with the school taking a leadership role in involving the whole community in introducing it, through churches, parent groups, etc.	32	29	35	0	0	34
What is your evaluation of community and student reception of your program? a. strong positive b. generally positive, some reservations c. neither positive or negative, or about equal amounts of such d. generally negative e. no apparent reaction	11	41	16	10	31	51

Influence of School Size

The questionnaire data were analyzed according to the number of elementary schools in the community. Category 1 consisted of school systems with one to six schools; category 2 consisted of school systems with seven to twelve schools; category 3 consisted of school systems with thirteen to twenty schools; and category 4 schools consisted of school systems with twenty-one or more elementary schools.

On Curriculum and Resources – School systems of sample size 2 and 3 tended more often to have a separate subject scheduled each week for health instruction while school systems of sample size 1 and 4 tended to correlate or integrate health education into other subjects.

In grade 3, school systems of sample size 4 integrated health instruction into a combination of subject areas. In the smaller school systems it was integrated primarily into the sciences.

All communities give the classroom teacher primary responsibility for health instruction in kindergarten through third grade.

In grade 6, however, the physical education teacher begins to be utilized more frequently in the larger school systems.

Larger communities use a local curriculum guide more often than smaller communities but there is no appreciable difference in the use of a health education text series by size of school.

On Attitudes and Opinions – The readiness of a community for the introduction of family life and sex education does not depend on the size of the school system. Methods of introduction into a community seemed to be affected by size, however. In the larger communities, either the school introduced it with the usual procedure, or it was initiated within the community. In the smaller communities, the schools took the leadership role but the whole community was involved through churches parent groups, etc. In receiving the program, administrators report that the smaller communities generally showed more positive reactions.

The principals' responses as to whether planned programs of instruction in the area of family life and sex education should be offered did not depend on community size. The principals from larger school systems were not as strong in their agreement with co-educational classes as were the principals from smaller school systems. Number of schools in the community did not relate to responses as to whether "there should be just frank presentation of facts without moralizing to any great extent" or whether "only teachers with successful a marriage of some duration should teach in the family life and sex education area." Elementary principals in all size school systems, strongly agreed that family life and sex education should be integrated throughout a student's educational process.

SECONDARY SCHOOL RESULTS

How, Where and What Taught

Health Instruction — Table 16 indicates that at least 70% of the high schools in Connecticut did not offer a course in health education in 1966-67. For students, the opportunity for having such a course decreases progressively from grade 7 to 12.

TABLE 16

Do you offer a course in Health Education?		Percent a	b	c	d	e	Total
In grade 7?	a. yes	29	70	0	0	1	168
" " 8?	b. no	25	74	0	0	1	166
" " 9?		29	70	0	0	1	167
" " 10?		18	78	1	0	1	139
" " 11?		12	87	0	1	1	139
" " 12?		13	84	1	1	1	134

Table 17 describes the status of planned health instruction in the secondary schools. No planned health instruction is available in at least 23% of the schools. Health instruction is required of all 7th graders in 32 percent of the schools. This required instruction decreases with each successive grade level until at grade 12 only 12% of secondary schools require a health education course of all seniors. Some health instruction is included in other elective courses in less than 50% of the schools.

TABLE 17

Which best describes the status of planned health instruction in your school?		Percent a	b	c	d	e	Total
In grade 7?	a. required of all students	32	3	0	38	27	161
" " 8?	b. required of some students	24	6	0	50	30	161
" " 9?	c. an elective course is offered	25	7	2	38	27	161
" " 10?	d. some "health instruction" is available in	18	7	2	49	23	133
" " 11?	other electives	12	8	2	45	34	130
" " 12?	e. none is offered	12	6	3	44	34	129

Table 18 indicates that when health instruction is integrated into other courses, it is presented as a planned unit of study in 40 to 50% of the secondary schools depending on grade level, and as incidental instruction when deemed appropriate by the teachers in about a third of the schools. From 12 to 21 percent of the schools have a planned program of study with specific units planned in various courses, again varying slightly by grade level.

TABLE 18

If health instruction is integrated into other courses, what best describes how this is done?		Percent a	b	c	d	e	Total
In grade 7?	a. incidental instruction when deemed	33	47	15	4	2	124
" " 8?	appropriate by teachers	33	49	12	4	2	117
" " 9?	b. planned units included in other courses	36	40	18	6	1	120
" " 10-12	c. a planned program of study with specific units planned in various courses	32	42	21	4	1	114
	d. other						

Table 19 shows that the sciences are most frequently used for the incorporation of planned health instruction, with physical education being the next most frequently indicated.

TABLE 19

If planned health instruction is incorporated into other subject areas, where is this most typically done?		Percent a	b	c	d	e	Total
In grades 7-9?	a. sciences	56	6	19	1	19	140
In grades 10-12?	b. home economics	42	12	27	4	17	113
	c. physical education						
	d. social studies						
	e. other						

Table 20 shows that a pattern of separating boys and girls for health education exists to a significant extent through grade 12 and that where boys and girls are separated, the major reason given is the nature of the material covered. However, administrative reasons are indicated as a close second cause.

TABLE 20

Are boys and girls scheduled in the same or separate classes?		Percent a	b	c	d	e	Total
In grade 7?	a. combined classes of boys and girls	32	12	9	35	12	151
" " 8?	b. separate classes	25	14	8	39	13	151
" " 9?	c. combined classes except for some units of study	17	25	10	35	13	152
" " 10?		22	17	11	37	13	125
" " 11?	d. not offered at this grade level	15	13	9	46	17	122
" " 12?		14	16	9	44	17	120
If boys and girls are separated at any grade level for planned health instruction—							
What is the reason?	a. administrative	18	13	20	45	3	153
	b. nature of the material						
	c. both (a) and (b)						
	d. not separated						

Table 21 shows that one period or less per week is the most typical pattern of health education when it is offered as a separate subject in grades 7 through 10. In grades 11 and 12, 2 periods per week for the course is more typical.

TABLE 21

If Health Education is offered as a separate subject, how many periods per week are devoted to it?		Percent a	b	c	d	e	Total
In grade 7?	a. one or less	17	3	0	3	77	147
" " 8?	b. 2	14	3	0	2	81	145
" " 9?	c. 3	15	8	1	2	75	147
" " 10?	d. 4 or more	9	7	0	2	83	118
" " 11?	e. not a separate subject	4	7	1	0	88	118
" " 12?		5	6	2	0	87	115

Table 22 indicates that the length of the health education class period is usually 41 to 50 minutes and the majority of schools use any available classroom for health eduction classes.

TABLE 22

Where are Health Education classes generally held?		Percent a	b	c	d	e	Total
In grade 7?	a. any available classroom	55	7	11	0	27	96
" " 8?	b. special Health Education room	52	7	12	0	29	90
" " 9?	c. gymnasium or auditorium	52	7	20	0	22	97
" " 10?	d. locker room	57	7	15	0	21	75
" " 11?	e. other	51	3	13	0	33	67
" " 12?		54	3	11	0	32	71
What is the length of the Health Education class period?							
In grades 7 & 8?	a. 30 minutes or less	3	8	16	2	71	149
In grade 9?	b. 31-40 minutes	2	3	14	7	74	148
In grades 10-12?	c. 41-50 minutes	2	0	15	8	76	128
	d. 50 or more minutes						
	e. not a separate subject						

Family Life Education — Table 23 shows that courses such as Family Sociology or Preparation for Marriage are available in 20 percent of the schools at the grade 10 level. At grade 11, 32 percent and at grade 12, 54 percent of the schools offer a course of this nature.

TABLE 23

Do you offer in your school a program of instruction in Family Sociology, Preparation for Marriage, or something similar?		Percent a	b	c	d	e	Total
In grade 10?	a. yes	20	80	0	0	0	132
" " 11?	b. no	32	68	0	0	0	125
" " 12?		54	46	0	0	0	124

Table 24 shows that in the schools where Family Sociology is available, it is usually offered as a unit of study in another course. When offered as an elective, as it is in most of the rest of the schools where it is available, it is most often of a full year's duration. At each grade level only about 5% of schools require this course of their students.

TABLE 24

This course is best described—		Percent a	b	c	d	e	Total
In grade 10 as—	a. required of all students	5	29	12	51	2	41
" " 11 as—	b. an elective, and of full year duration	6	39	17	37	2	54
" " 12 as—	c. an elective, and less than a full year in duration	4	39	23	33	1	79
	d. a unit of study in another course						

Units in family life and sex education are offered in 52% of the home economics classes according to Table 25. Forty-one percent of the biology classes offered a unit of this nature. Fewer than 20% of the schools offered units in family life and sex education in sociology or another social science. (An important variable for consideration here would be what proportion of the students in the public schools enroll in the home economic and biology courses?)

TABLE 25

Do you offer units of Family Life and Sex Education		Percent a	b	c	d	e	Total
In home Economics?	a. yes	52	47	0	1	0	177
In Sociology or some other social science?	b. no	16	83	0	1	0	159
In Biology?		41	59	0	1	0	164
In a program of planned health instruction?		15	84	0	1	0	161
In some other course?		18	82	0	1	0	159

What is Taught

Areas of major emphasis in health instruction are alcohol, attitudes toward self, basic foods, body systems, cleanliness and grooming, dignity and worth of the individual, drugs and narcotics, exercise and relaxation, first aid, posture and body mechanics, rest and sleep, safety and accident prevention, smoking and vision and hearing.

Areas given only minor attention by the majority of the secondary schools are care of the teeth, choice and care of clothing, communicable diseases, community health problems, international health problems, and

TABLE 26

Please indicate for each of the following the degree of emphasis it receives in your program of planned health instruction		Percent a	b	c	d	e	Total
Alcohol	a. major	63	33	3	1	1	188
Animal reproduction	b. minor	30	41	26	1	2	187
Attitudes toward self	c. none	53	40	6	0	1	187
Basic foods		58	34	6	1	1	187
Body systems		70	26	3	1	1	187
Boy-girl relationships		23	60	15	0	2	185
Care of teeth		44	49	5	0	1	186
Choice and care of clothing		32	57	9	0	2	185
Cleanliness and grooming		55	39	5	0	1	186
Communicable diseases		42	53	4	0	1	185
Community health problems		27	60	12	0	1	182
Dignity and worth of the individual		47	41	11	0	1	182
Drugs and narcotics		66	30	2	0	1	188
Exercise and relaxation		51	42	5	0	1	185
Family interaction patterns		20	51	28	0	1	181
First aid (concepts and procedures)		51	44	4	0	1	185
Home and family in the society		25	52	21	0	2	183
Human reproduction		22	47	29	1	2	184
International health problems		9	54	36	0	2	183
Mental health and personal adjustment		32	55	12	0	1	185
Non-communicable diseases		22	63	13	1	2	183
Personality development		36	48	15	0	1	183
Physical changes during growth		46	47	5	0	1	182
Posture and body mechanics		55	40	4	0	1	183
Rest and sleep		51	43	4	0	1	184
Safety and accident prevention		58	39	3	0	1	184
Smoking		72	25	2	0	1	190
Venereal diseases		16	48	34	0	2	181
Vision and hearing		49	46	4	1	1	184

non-communicable diseases. Most of these latter subjects are also areas of emphasis in the elementary school.

Family life and sex education is receiving no emphasis or only minor emphasis in the majority of schools as indicated by Table 26. Areas such as animal reproduction, boy-girl relationships, family interaction patterns, home and family in the society, human reproduction, mental health and personal adjustment, personality development, and venereal disease are not considered at all by many of the schools.

The emphasis in secondary level health instruction seems to be in the direction of individual health and well-being, while interpersonal relations are largely ignored by most schools.

Table 27 shows that only half the schools offer a program of menstrual education and it is usually offered in the 7th grade. Twenty percent of the schools offered it in more than one grade. The majority of schools offer the course only to girls and as a special presentation by a nurse or other specialist.

TABLE 27

Many Connecticut schools are asking for help in planning for Family Life and Sex Education programs		Percent a	b	c	d	e	Total
With regard to menstrual education? Do you offer a program of menstrual education?	a. yes b. no	50	49	0	1	0	193
At what grade is this offered?	a. 7 b. 8 c. 9 or 10 d. 11 or 12 e. more than one of above	42	12	19	7	21	107
This course is offered to—	a. girls only b. boys and girls together d. is not offered	57	18	5	29	1	143
This course is offered—	a. as a special presentation by a nurse or other specialist b. as a special presentation by the teacher c. as part of a special course offering d. as an assembly program	50	23	23	4	1	109

Realizing that secondary students have available to them numerous electives in planning their school programs, administrators were asked to estimate the percentage of their students who were exposed to various concepts considered central to a family life education program.

Table 28 indicates that about 20-25% of the schools have exposed *none* of their students to their future responsibilities and roles as parents, human reproduction, financial aspects of family life, mental health and adjustment, and problems of teenage marriage. Thirty to forty percent of the schools have exposed *none* of their students to: theories of dating and mate selection, divorce as a social problem, working wives as a new

social trend, marriage and family patterns in other cultures, and dynamics of interpersonal relationships. In 40 to 50 percent of the schools none of the students have been exposed to: marriage laws in Connecticut, mixed marriages, the process of marital adjustment, and the value of a pre-marital health examination. Over 50 percent of the schools have exposed *none* of their students to concepts, definitions and theories of love; the concepts of contraception; or the topic of masturbation.

The areas to which all of the students have been exposed in over 25% but less than 50% of the schools, are: human reproduction, personality development, and world population growth. The other topics have been presented to one quarter or less of the students in the majority of schools.

It seems appropriate to conclude that a great many Connecticut students conclude their formal education without having considered major areas of concern in health and family life education.

TABLE 28

Realizing that the median age for marriage in the United States for females is in the 19-20 year range, depending on your source of information, and that the median for males is about 22 years, Family Life Educators have proposed that secondary school students should be exposed to consideration of certain concepts in the course of their academic career to better prepare them for the roles of mate and parent.

By the time a class completes grade twelve in your school, approximately how many of the students will have been exposed to consideration of the following topics in an academic setting?

a. none
b. approximately ¼
c. approximately ½
d. approximately ¾
e. all

	Percent					
	a	b	c	d	e	Total
Their future responsibilities and roles as parents	19	45	11	7	19	129
Theories of dating and mate selection	31	40	15	7	6	132
Divorce as a social problem	33	33	16	7	11	132
Working wives as a new social trend	34	39	12	7	7	132
Human reproduction	20	19	10	16	34	134
Marriage laws in Connecticut	48	29	12	5	7	130
Personality development	15	34	12	11	28	134
Problems of teen-age marriages	26	44	14	7	10	133
Mixed marriages (race, religion, etc.)	42	32	15	5	6	131
Financial aspects of family life	20	44	24	5	8	133
Concepts, definitions, theories, of love	57	28	8	3	4	132
The process of marital adjustment	42	39	11	4	4	132
Concepts of contraception (not methods)	68	17	5	3	8	131
Value of a pre-marital health examination	48	31	9	3	9	133
Marriage and family patterns in other cultures	37	34	16	5	9	130
Masturbation	67	17	8	2	5	132
World population growth	10	26	22	13	28	135
Mental health and personal adjustment	22	32	18	11	18	133
Dynamics of interpersonal relationships	31	30	15	8	16	131

Who Teaches — Preparation — Curriculum Development — Resources Used

There are increasingly more and improved resource materials available to the classroom teacher in health and family life programs. As indicated in Table 29, these materials have not been extensively utilized. Stand-

ardized testing and student evaluations are used the least, with the majority of schools using them rarely or never. Films, health textbooks, and local curriculum guides in health education are used more frequently, with about one-third of the schools utilizing them always or very often. Outside resource persons, school resource persons, and displays are used occasionally.

TABLE 29

In your school, to what extent do you make use of each of the following?		Percent a	b	c	d	e	Total
Local curriculum guide in Health Education?	a. always b. very often	20	11	21	9	38	177
Health textbooks?	c. occasionally	18	19	30	12	21	181
Students evaluations of course?	d. rarely e. never	1	8	26	19	46	172
Outside resource persons (doctors, etc.)?		1	6	58	24	11	181
School system resource persons (nurses, counselors, etc.)?		4	15	57	18	5	185
Standardized testing?		3	8	17	23	49	173
Films?		5	35	53	6	1	189
Displays?		2	16	48	27	7	180

Table 30 shows that the academic background of the health education teacher is most frequently physical education b .t there is often a combination of backgrounds reported.

TABLE 30

Where Health Education is offered as a separate course, what best describes the academic background of the teacher(s) involved?		Percent a	b	c	d	e	Total
In grade 7?	a. physical education	47	27	0	2	24	55
" " 8?	b. sciences	46	32	0	2	20	50
" " 9?	c. home economics	65	9	7	5	14	57
" " 10?	d. health education	45	20	9	7	18	44
" " 11?	e. nurse-teacher	41	15	13	5	26	39
" " 12?		36	15	18	8	23	39

Attitude and Opinion Survey

Four questions were asked relative to family life and sex education and its relation to the public secondary schools. (See Table 31.)

Fifty-eight percent of the principals responded "yes" to the question, "Are you now studying the possibility of a Family Life and Sex Education course in your school?" This response seems to indicate that the educators in the state are becoming increasingly aware of the potential role of public schools in family life education.

Fifty-three percent responded "yes" to the question, "Are you now, or will you soon be, developing or revising a curriculum in Family Life and Sex Education?," indicating that not only are educators becoming con-

cerned, but that they are taking steps to express, through action, their belief in the necessity of public education playing an increasing role in family life and sex education.

The response to the question, "Do you feel a need for such things as regional workshops or in-service training programs in the area of family life and sex education?," indicated that the principals saw a very definite need for workshops, in-service programs, etc. Eighty-two percent responded "yes" to the question.

The principals indicated strongly that they would support and participate in these programs when 84 percent responded "yes" to the question, "Do you feel that you or your staff would participate in such programs if they were available?"

TABLE 31

Relative to Family Life and Sex Education;	Percent a	b	c	d	e	Total
Are you now studying the possibility of a Family Life and Sex Education course for your school?	58	42	0	0	0	185
Are you now, or will you soon be, developing or revising a curriculum in Family Life and Sex Education?	53	47	0	0	0	177
Do you feel a need for such things as regional workshops or in-service training programs in the area of Family Life and Sex Education?	82	17	0	0	0	184
Do you feel that you or your staff would participate in such programs if they were available?	84	16	0	0	0	182

a. yes.
b. no

Table 32 shows that approximately 70% of the principals felt that their communities were ready for the introduction of family life and sex education in their schools. By and large, the schools have taken the lead in introducting family life and sex education programs and such programs have met with generally favorable reception, regardless of how they were introduced.

No clear-cut answer was found to the question, "In general, to whom do students in your school seem to turn for information in the area of family life and sex?," except that they do not seem to turn to principals or deans.

Table 33 shows the response to five statements relative to the principals' attitudes toward family life and sex education and its implementation in the schools.

Eighty-four percent of the responding secondary school principals agree that the schools should offer programs of instruction in family life and sex education, 9% disagree and 7% are uncertain or neutral. While the principals support the idea of this kind of program, this does not imply that they would agree among themselves as to what a program of this type would include.

TABLE 32

	Percent					
	a	b	c	d	e	Total
How would you describe the readiness of your community for the introduction of Family Life and Sex Education in the public schools?						
a. definitely interested	30	40	11	4	16	194
b. interested, some opposition						
c. opposed, some interest						
d. opposed						
e. not an issue in the community						
If you now have a program of planned instruction in Family Life and Sex Education, was this program introduced—	54	20	24	0	0	50
a. with the same procedure and public involvement that any change in the curriculum gets?						
b. primarily as a result of encouragement and support from civic organizations, parents' groups, churches, etc.						
c. with the school taking a leadership role in involving the whole community in introducing it, through churches, parent groups, and civic organizations.						
What is your evaluation of community and student reception of your program?	25	48	13	1	13	69
a. strong positive						
b. generally positive, some reservations						
c. neither positive or negative, or about even amounts of each						
d. generally negative						
e. no apparent reaction						
In general, to whom do students in your school seem to turn to for information in the area of Family Life and Sex?	15	15	1	1	69	189
a. counselors						
b. nurses						
c. principal or assistant principal						
d. deans						
e. more than one of the above, or some other person						

TABLE 33

As part of this study we are asking educators to respond to the following items regarding Family Life and Sex Education. For each of the following statements would you please indicate whether you—
a. agree strongly
b. agree slightly
c. are uncertain or neutral
d. disagree slightly
e. disagree strongly

	Percent					
	a	b	c	d	e	Total
The schools should offer planned programs of instruction in the area of Family Life and Sex Education	68	16	7	3	6	193
Programs of Family Life and Sex Education should be offered to co-educational classes rather than to sexually homogeneous classes.	34	23	21	7	15	189
Family Life and Sex Education in the publish schools should consist of frank presentation of fact, without moralizing.	48	14	7	10	20	192
Only teachers with successful marriages of some duration should teach in the Family Life and Sex Education area.	25	15	24	13	33	190
Family Life and Sex Education should be integrated throughout the length and breadth of a student's education rather than offered as a one-shot course somewhere near the end.	77	8	8	4	3	190

To a lesser extent they agreed that this kind of program should be offered to co-educational classes. Fifty-seven percent agreed, 22% disagreed, and 21% were neutral or uncertain.

In response to the statement, "family life and sex education in the public schools should consist of frank presentation of fact, without moralizing," 63% agreed, 30% disagreed, and 7% were neutral or uncertain.

There was less unanimity of response to the statement, "Only teachers with successful marriages of some duration should teach in the family life and sex education area," than to the other attitudinal statements. Forty percent agreed, 36% disagreed, and 24% were neutral or uncertain.

The responding educators offered strong support for the idea that "family life and sex education should be integrated throughout the length and breadth of a student's education rather than offered as a one-shot course somewhere near the end." Eighty-five percent of the principals agreed, 7% disagreed, and 8% were uncertain or neutral.

Influence of School Size

The secondary schools were divided into five groups according to total secondary school enrollment as listed in the Connecticut State Department of Education's *Directory of Secondary School and Principals, October, 1966.* "Group 1" is composed of towns whose secondary schools have a total of up to 500 students enrolled; "Group 2" is composed of towns whose schools have a total enrollment of 501 to 1,000 students; "Group 3" is composed of schools with a total enrollment of 1,001 to 2,000; "Group 4" is composed of schools with a total enrollment of 2,001 to 4,000; and "Group 5" is composed of schools with an enrollment of 4,001 or more.

Analyses of data indicate that no particular pattern is present in the offering of a course in health education by the size of school in grades 9 through 12.

When integrating health instruction into other courses, there are no differences in grade 9; however, in grades 10 through 12 smaller schools tend more often to use planned units in other courses, while the larger schools tend to use incidental instruction and planned programs with specific units in various courses.

In incorporating health instruction into other subject areas in grades 7 through 12, the smaller schools tend to do it in physical education, while the larger schools tend to incorporate it into the sciences.

There are no appreciable differences by size of school in the use of local curriculum guides in health education or in the use of health textbooks.

More often the larger schools offer a program of instruction in family sociology or preparation for marriage in grade 10 than the smaller schools. In grade 12, there are no meaningful patterns in the distribution by size of school of family or marriage courses.

Size of school does not directly relate to whether the course is a required course or an elective at any grade level.

Seventy percent of the "Group 2" schools are now studying the possibility of a family life and sex education course as opposed to about 50% at all other school sizes. Also, more schools of "Group 2" are now, or soon will be, developing or revising a curriculum in family life and sex education. Schools in category 1, the smallest schools, have the smallest percentage with such plans.

CONCLUSIONS

Certain general trends appear to stand out in analysis of the data generated by this study.

1. Most schools in Connecticut do not offer specific health instruction course or give evidence of having a planned program, K-12.
2. Even fewer schools in Connecticut offer planned programs or courses related to family life and sex education.
3. Where health instruction is offered, either as a course, as incidental instruction, or as integrated material in other courses, there is consideration of topics which might be described as "traditional."
4. There are no major differences in planned health instruction or family life education which are related to size of school, as indicated by secondary school enrollment, or number of elementary schools in the community.
5. Educators are generally in agreement that family life and sex education has a place in public education and that it should be essentially an integrated K-12 program.
6. Responding educators in general feel that communities in the state are "ready" for family life education in the schools.
7. Existing family life and sex education programs in Connecticut have met with generally favorable reactions from the communities involved.
8. Development and revision of family life and sex education curricula is taking place in many secondary schools in Connecticut.
9. There is an expressed need for in-service training programs, workshops, etc., in health and family life education, and indications are that administrators would encourage and support the participation of their facilities.
10. Even as students mature and become more aware of themselves as individuals and of their interaction with others, there is a tendency to separate them by sexes because of the nature of the material, for health and family life education. The question to be raised is whether this reason has educational validity.
11. Family life and sex education is at best available to a very limited number of students, and in fact is essentially unavailable to most Connecticut students at this time.
12. At the present time only slightly more than half of the Connecticut public schools offer menstrual education programs.

13. Resources available, such as films, in health and family life education, are not being utilized to the extent possible.

14. There is little apparent effort made to involve students in curriculum development relative to the content of health and family life education.

15. Probably the concluding major impression of the status study is not only that Connecticut's boys and girls are presently receiving very limited health instruction, but perhaps even more crucial, all but very few of our children and youth are leaving our schools without any opportunity to prepare for the family roles and responsibilities which they will assume within a few months to a few years.