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RESEARCH BRIEFING

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AN INVESTIGATION OF THE PROVISION FOR HEALTH EDUCATION IN SCHOOLS DURING 1998/99

KEY POINTS

- A small but significant proportion of schools appeared not to have a designated health education co-ordinator, and a significant minority of schools did not have a health education policy.

- In most cases teachers were responsible for developing the health education policy, occasionally with involvement by the Board of Governors. Parents and pupils were not frequently involved in contributing to development of the policy.

- Primary schools generally favoured a cross-curricular approach to delivery of the health education theme, and whilst this was also prominent in post-primary schools, many preferred to deliver health education within a single subject or to use a combination of approaches.

- Pupils are introduced to health education topics gradually as they progress through the Key Stages. Pupils are generally taught the 'core' elements of health education during Key Stage 1, and these elements are developed and expanded throughout the remaining Key Stages.

Northern Ireland Statistics & Research agency

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- Health education appeared to be focused most strongly in a few subject areas, whilst other subject areas were not utilised fully in terms of delivering the health education objectives. Greater emphasis could be placed on embedding the health education theme and its objectives more strongly across a greater range of subject areas.

- Given the high proportion of female staff involved in health education, it is possible that it may be perceived as a 'gendered' curriculum area, which could adversely affect the potential for curricular support across the full range of subjects.

- Barriers to the implementation of effective cross-curricular strategies centred on the need to plan, prioritise, support and manage health education, with suitable direction and appropriate training.

INTRODUCTION

1. The primary aim of this study was to provide baseline information on the perceptions, attitudes and practices of 'managers' (health education co-ordinators) and teachers in respect of the management and delivery of health education in primary and post-primary schools.

MAIN FINDINGS

The Perspective of Health Education Co-ordinators

2. It emerged from the study that a small, but substantial, proportion of schools appeared not to have a designated health education co-ordinator. For those schools that had a co-ordinator, time allocated to developing and co-ordinating the health education theme was limited. Co-ordinators pointed to other curriculum demands and priorities, particularly transfer and assessment procedures. In relation to support mechanisms, co-ordinators were generally satisfied with the support offered by colleagues and that provided by the immediate school management.

3. It was evident that a substantial minority of schools did not have a health education policy. This was perhaps indicative of the demanding influence of other priorities. Some teachers, however, did not perceive the absence of a policy as a barrier to delivering effective health education. Policy development was mainly performed by schools alone, although the Education and Library Board (ELB) contributed to policy development on a substantial number of occasions.

4. For the most part, teachers were responsible for developing the health education policy and, occasionally, the Board of Governors were involved. Interestingly, it was reported that parents sometimes, but infrequently, and pupils less so, contributed to policy development. A minority of schools had a working group associated with policy development; while members were mainly teachers, occasionally other professionals formed part of a working group. Some schools had external agencies associated with policy development, but this occurred infrequently.

5. Co-ordinators identified a number of resource materials which were used to develop health education policy, including Department of Education (DE) and Council for the Curriculum, Examinations and Assessment (CCEA) publications. These resource materials supplemented information provided by individuals, agencies and organisations. Some schools drew more heavily on external resources and took a more systematic approach to policy development, but generally, policy documents were based on a limited number of sources.

6. While a variety of resource materials were available for formulating policy, these were overly complex and required a lot of work to extract the important aspects. One suggestion was that resource materials should be more prescriptive, perhaps specifying the health education requirements and delivery mechanisms according to the various Key Stages or even the various age groups within the Key Stages.

7. Policy was disseminated to a range of staff - teachers were the main recipients, but other school members and groups received policy information, including Governors, classroom assistants, secretarial staff, catering staff and pupils' parents. The mechanisms used to convey policy varied, but mainly a document format was used.

8. In relation to staff development, co-ordinators would welcome further training. In particular, co-ordinators pointed to training associated with developing health education in a cross-curricular way, developing management skills to encourage staff to participate, and providing information on developing the content and structure of the health education theme.

9. For those co-ordinators who received training, it was most often offered by their respective ELBs. Co-ordinators who received information and advice in relation to their co-ordinating role proactively pursued further sources of advice and information. This perhaps indicates that information is available on request, but procedures need to be more widely introduced so that more co-ordinators are aware of sources of help.

The Perspective of Teachers

10. In relation to the general provision of staff development, some teachers alluded to financial restrictions associated with staff development courses for health education. Schools generally did not have a budget allocated specifically to health education. In addition, because of other curriculum demands and priorities, teachers believed that financial resources were needed in the curriculum areas. In many instances, however, teachers did indicate that principals would generally be willing to accommodate staff development requests.

11. Teachers from primary schools reported that the cross-curricular approach was mainly used to deliver the health education theme. For post-primary schools, the cross-curricular approach was prominent, but a substantial proportion delivered health education within a single subject, while others used a combination of approaches. For most schools, health education was not restricted to class time but was considered in other arenas such as assembly, break-time, lunch time and extra-curricular activities.

12. Teachers generally acknowledged the benefit of delivering health education as a cross-curricular theme. Some concern was expressed, however, about the effectiveness of using the cross-curricular approach alone, particularly in post-primary schools. Teachers' concerns related to aspects such as depth of coverage and duplication of topics with the cross-curricular approach. Furthermore, teachers had some concerns about lack of expertise in some areas (sex and drug education) and suggested that some topics should be delivered by an individual with a relevant knowledge base.

13. A variety of teaching and learning methods were used to deliver the health education theme. The types of teaching and learning methods varied across the Key Stages. The methods which featured most prominently across the Key Stages were class discussion, small group activity, visiting speakers and film/video. Schools generally, and primary schools in particular, appeared to make extensive use of visiting speakers.

14. A range of teaching resources was used in the delivery of the health education theme. Resources such as videos, worksheets and visiting speakers were in common use across many schools. Teachers' resource packs were identified as an area for improvement. Many teaching resource packs attempt to be all-inclusive, covering numerous aspects of health education, with the result that the information is difficult for teachers to re-structure into a format suitable for delivery to pupils. Ideally, teachers would welcome resource packs in the form of pre-structured lessons, which could be easily adapted for classroom use. The need for a more prescriptive approach was articulated by many teachers.

15. Teachers suggested establishing 'cluster groups' across schools, enabling schools to combine financial assets to purchase resource materials for shared use. Some teachers considered Information Technology (IT) as a potentially useful resource for delivering the health education theme and as a resource base for materials. IT resources suggested by teachers ranged from computer programs with which pupils could interact to a server unit from which teachers and pupils could access and download health education information. Teachers commented on the potential usefulness of a peripatetic teacher who was an expert in health education. The main concern, underlying this latter suggestion, related to the inexperience of some teachers in delivering sex education.

16. It appears that pupils are gradually introduced to a greater diversity of health education topics as they progress across the Key Stages. Initially, in Key Stage 1, pupils are generally taught what might be considered as the core elements of health education and, for the most part, these are continuously taught and focused on throughout the remaining Key Stages. A further issue relates to the introduction of sex education. It is apparent that sex related topics are not introduced widely

before pupils reach the age of fifteen. Perhaps, given the earlier onset of maturity, particularly for females, consideration should be given to introducing sex education a little earlier. Given the differentiation in onset of maturity between the sexes and across individuals, it can be difficult to decide when to introduce sex education or particular topics relating to sex education.

17. It should be noted that health education was not always delivered through the cross-curricular approach. A large proportion of post-primary schools tended to make use of a single period format intended for teaching aspects of health education (eg sex and drugs) considered unsuited to delivery in a cross-curricular manner. Teachers felt that the content of sex education in particular warranted a separate class. This was the case for two reasons: firstly, many teachers thought it appropriate to seek parental consent prior to teaching sex education - approval could only be sought within a predefined context and this could not be assured within a cross-curricular set up. Secondly, teachers felt that the subject matter called for a certain expertise and prudence in the area, together with establishing an atmosphere of confidentiality and openness with their pupils, and this could be achieved best in a single class format.

18. Whilst health education is taught across the curriculum, the results of the study suggest that health education is focused most strongly in a number of subject areas. These subject areas are Religious Education, Physical Education, Science and Technology, Personal and Social Education, and English. The results also suggest that a number of subjects are not utilised fully in terms of delivering the health education objectives.

19. Notably, History, Mathematics, Art and Design never appear in relation to the top three subjects for delivering any of the health education objectives and Music and Geography also appear infrequently. Obviously, the subject areas which appear often are more suitable for conveying the health education objectives. It could be suggested, however, that perhaps greater emphasis should be placed on attempting to embed the health education theme and its objectives more strongly across a greater range of subject areas.

20. Generally, teachers believed that their schools performed effectively in respect of a number of domains of health education (eg relationships between staff and pupils, appearance and environment). Teachers' perceptions, across schools, generally indicated that further consideration needs to be given to: providing sufficient time and training for health educators; monitoring and reviewing health education; and clarifying the contribution of individual subjects to the objectives of health education.

Barriers

21. The respondents were not asked specifically about barriers to mapping health education across subjects but the responses suggest reasons why there may have been difficulties in this area. The health education theme is, in the main, the domain of female staff; some schools may not have co-ordinators; existing co-ordinators were, generally, not allocated time on a weekly basis for their role and around half stated that they had received no training in relation to their role. Co-ordinators received training from a variety of organisations with 50% citing the ELBs as the provider. In addition, a significant body of schools did not have a health education policy (the cross-curricular approach was adopted by 83% of primary schools but only 60% of post-primary schools).

22. These findings raise the possibility that, given the high proportion of female staff involved in health education, it may be perceived as a gendered curriculum area, in which case the potential for curricular support across the range of subjects could be adversely affected. Where there is no co-ordinator or no policy or no training, there will clearly be difficulties in implementing cross-curricular programmes. Furthermore, the different modes of training from ELBs and other providers may all have different strengths but may not facilitate a co-ordinated approach to integration across subjects, particularly where external trainers may not have expertise in cross-curricular approaches. Co-ordinators stated that they would welcome more staff development focused on cross-curricular strategies and were also concerned that Health Education was not accorded a high priority within schools.

23. The barriers to the implementation of effective cross-curricular strategies are, then, centred on the need to plan, prioritise, support and manage health education, focusing on identification of the requirements of co-ordinators for direction and appropriate training.

CONCLUSION

24. The effectiveness of current practice was assessed in the study, in part, through evaluating teachers' perceptions in relation to the health promoting status of their schools. Teachers estimated the extent to which their school had progressed from a traditional health education perspective to health promoting school status. Generally, both primary and post-primary schools performed well in relation to health promoting status.

25. One area, however, for further development would be to strengthen parental support and involvement, particularly in post-primary schools. Finally, while the vast majority believed they could implement the health education theme effectively,

teachers identified a number of barriers and suggested a number of possible improvements for health education delivery in schools and these are detailed in the report.

RECOMMENDATIONS

26. A brief summary of the recommendations is as follows:

- ❖ Schools should have a health education policy;
- ❖ All schools should have a designated health education co-ordinator;
- ❖ Staff development programmes should be planned in a systematic manner across Education and Library Board areas;
- ❖ Active teaching and learning methods which involve pupils should be encouraged;
- ❖ Curriculum development should be encouraged in several areas; and
- ❖ Current resource provision should be critically examined in relation to the breadth of distribution and relevance.

METHODOLOGY

27. The study employed both quantitative and qualitative methods to explore the management and delivery of health education in schools. The specific approaches used were:

- ❖ Postal survey of teachers in a random sample of 276 primary and 119 post-primary schools. Each school in the sample received three questionnaires, giving a total of 1,185 questionnaires. The overall response rate was 45%;
- ❖ Interviews with a sub-group of 48 teachers from the postal survey sample; and
- ❖ Discussion groups with a sub-set of those teachers interviewed.

THE PROJECT

28. The project was carried out for the Department of Education by the Further and Higher Education Research Unit, School of Education, University of Ulster. The research cost £44,500.

REPORT

29. The full report entitled "An investigation of the provision for health education in schools during 1998/99" is available from the Department of Education, price £5[1].

This paper is a summary of the research report and as such any views expressed are those of the authors and not necessarily those of the Department of Education.

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1. Each educational establishment and library is entitled to one free copy.

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