Health education: from policy to practice

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The information was derived from personal interviews with the head teacher and health education co-ordinator, if there was one. The head's responses were necessary to gain an overview of policy and strategy, and the co-ordinators’ responses were necessary to check whether the policy was being implemented in accordance with the guidelines and whether they had similar aims to the head.

No school had written health education policy, and only one had a written sex education policy.

The schools were all mixed. One was Roman Catholic, one was in a deprived area with 60% black pupils; two of the six had no health education co-ordinator.

The main points to emerge from the head teachers’ responses were that they thought health education was necessary and welcomed the guidelines, which were sensible, practical, and not prescriptive. However, there were differences in the interpretation of the content, particularly in sex education, which was strongly influenced by culture and religion.

Some heads gave health education greater commitment than others, and this was evident in the appointment (or not) and status of co-ordinators. This was strongly influenced by pressures from the National Curriculum and examinations.

The issue of smoking had been strongly influenced by the recent implementation of the Local Authority smoking policy, and there was concern about alcohol. However, no school had any written health education policy, and only one had a written sex education policy.

Health education also went in through tutorial time and the hidden curriculum, although it was perceived by some that the hidden curriculum did not always complement the taught curriculum, and in some cases was in direct conflict — for example with respect to the sale of food, and the physical environment.

Critical

The most important critical factor in the development of policy and strategy was the head teacher, followed by senior management, other interested staff, and the pupils themselves. Uptake of training was variable, directly depending on whether there was a co-ordinator in post.

Co-ordinators in post and their status varied along with what allowances, if any, they were paid. The more senior staff did have additional time (although they had additional responsibilities), but those below senior teacher level did not.

Parents were only informed of the policy through prospectuses, and no copies of the document itself were made available to them. At one school there were communication difficulties due to translation problems.

Further comments made related to the importance of the ethos of the school. The curriculum range of strategies emerged for promoting health education in the taught and hidden curricula. These were clearly more organised in some ways than others.

The main points to emerge from the co-ordinators’ responses were:

- The topic most commonly taught was lifestyles. The least common were Public Health Science and Ecology and the food chain.
- The amount of health education was taught in years 8, 12 and 13.
- Most health education was taught through PSHE-type subjects, followed by Science and Biology.
- Little use was made of the traditional health education subject areas of English, Geography, Social Science, CDT, History, Current Affairs and Drama.

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Too late

All schools dealt with sex education, but the content varied to take account of strong cultural and religious influences. There was a feeling with some co-ordinators that some topics were taught too late.

There was a fear that health education was watered down due to concentration on the mechanics and content of the National Curriculum.

The level of implementation was influenced by whether there was a
The emergence of AIDS poses a significant challenge to sex education in schools. Addressing this topic requires discussion of areas of human behaviour and experience which are sensitive and problematic.

Before teaching on AIDS is undertaken, decisions must be made about a wide variety of issues. What objectives will be pursued? What resources and materials will be used? What terminology is most appropriate to discuss sexual activities? At what age should teaching begin? What are the best methods to use? And so on.

Resources

The seriousness of AIDS as a medical and social problem has led the government to fund substantial public information campaigns about AIDS and the production of two major teaching resources for use in schools. These have been produced to help teachers provide education on HIV and AIDS and have been made available free of charge to secondary schools.

The first of these is the DES video package 'Your Choice for Life', which consists of a five-part video about AIDS and a booklet which gives advice on how the video should be used and the proper framework within which information on AIDS should be presented.

The second resource is the HEA pack 'Teaching about HIV and AIDS'. This consists of three units, each of which contains plans and notes for five lessons on HIV/AIDS. The resource is structured on a spiral curriculum model, with Unit 1 intended for use with 12–14 year olds, Unit 2 with 14–16 year olds, and the third unit with young people of 16 and over.

The survey

As yet, little research has been undertaken to explore the issues and problems associated with teaching about AIDS in schools and to document the extent and context of teaching already undertaken. The aim of the present research was to survey current provision of teaching on this topic in schools in the south-east of England.

All state and independent secondary schools within the SE Thames Regional Health Authority Area were contacted during the summer term of 1989, and teachers in the schools with experience of teaching about HIV and AIDS were asked to complete a detailed questionnaire. The SETRHA area covers the whole of Kent, East Sussex, Bromley, Bexley, and a number of inner London boroughs.

Questionnaires were returned by 388 teachers working in 180 schools. The overall response rate from schools was just over 50%. This varied considerably, however, from one authority to another; over 70% of schools in Bromley responded, as compared with less than a third of schools within inner London.

Policy and co-ordination

Just over a fifth of schools did not have a sex education policy, and just over a third of schools did not have a teacher responsible for co-ordinating HIV/AIDS education. The lack of a sex education policy in so many schools is a serious matter from two points of view.

Firstly the 1986 (No 2) Education Act (effective from 1 September 1987) required schools to have such a policy in place by September 1988, at least eight months prior to the present survey.

Secondly, any education on HIV/AIDS provided in schools lacking a sex education policy would be taking place without the sanction and guidance of the governing body.

It is also unfortunate that over a third of the schools in the survey did not have a member of staff with specific responsibility for the co-ordination of HIV/AIDS education. This fact probably also signals the absence of broader co-ordination in the PSE/health education field within the school.

In-service training

Just over a third of teachers (38.0%) had received some form of specialist in-service training on issues related to HIV/AIDS — in other words, almost none.

The questionnaire asked for information on the following points:

1. The school's sex education policy and co-ordination of AIDS education
2. Experience of INSET on AIDS education
3. Curriculum content of teaching
4. External support employed in teaching about AIDS
5. Resources employed in teaching
6. Objectives pursued in teaching about AIDS
7. Teaching methodology employed
8. Evaluation undertaken
9. Any further information desired on AIDS-related issues