

Following personal experience of development work in health education in a primary school, I was motivated to investigate those factors which were crucial to its general development within school curricula. This was coupled with a genuine concern for the non-statutory subjects of the National Curriculum. In the climate of the current education 'market', under what conditions could health education, in particular, be expected to survive and flourish within a 'crowded' curriculum? My study therefore focussed on those factors likely both to hinder and help development (1).

Specifically, it was believed important to establish how far 'commitment' would enable an innovation in this area to succeed. 'Commitment' in this sense can be recognised by expressed belief, capability, management support, resource allocation and school climate.

Crowded curriculum

A review of relevant literature established that schools are currently operating under many constraints. These include teacher shortages, the numerous educational 'reforms', and the resultant crowded curriculum (2).

The review also demonstrated that through the efforts of individuals and concerned statutory and voluntary bodies, health education has moved increasingly centre-stage. However, its current position is marginal compared with the traditional academic subjects. Unlike these, it lacks the advantage of a recognised pedagogy. This peripheral position is likely to be maintained through the implementation of the National Curriculum, with its statutory core and foundation subjects.

As one of the 'essential' themes identified by the NCC to give balance and breadth to the whole curriculum, health education has been recognised as important in the overall scheme. However, there have been many positive assertions from the

LOUISE O'CONNOR

Health Education: feeling the squeeze

DES concerning this area, without the necessary action to transfer policy statements into practice (3).

This is despite identified consensus of opinion amongst politicians, educationalists, parents and school governors on the importance of this area of education. However, the review also identified disagreements on the rationale and methodology of health education, particularly when covering controversial and sensitive topics. This in turn leads to confusion concerning the delivery of health education programmes. Educationalists would argue that the radical/educational model of health education must be the one delivered through school curricula (4).

In contrast, the medical model, which appears to have been favoured by central government, is not only ineffective but anti-educational (5). In essence, it is crucial that the affective as well as the cognitive areas of health education are appropriately and effectively addressed.

Good planning

In order to deliver appropriate health education programmes effectively, schools need to make this a priority area for planning and development. Yet it has been argued that there is no incentive or catalyst to begin this process. According to research in the field, the legal obligations of the 1986 Act concerning sex education, for example, or the many recommendations from the DES and others, have

not resulted in widespread action (6).

A case study of the implementation of a health education programme in a middle school provided some interesting material to illuminate this whole debate (1).

The school under discussion had some historical commitment to health education which had manifested itself through a number of initiatives. These included allocation of curriculum time to relevant topics and the appointment of a health education co-ordinator in 1988. This had itself resulted in the formulation of a sex education policy which was set firmly in the context of health education. An increasingly high profile for this area looked set to result in future policy development and practice.

Thus, in the academic year prior to the study (1989), a pilot health education project had been set up by the co-ordinator for the 7th-year pupils. The stated aim of the project was to use a 'historic' approach which built on the children's 'own views and feelings about health issues'. To this end the topics were partly negotiated with the children using brainstorming techniques and free writing exercises. Existing knowledge and perceptions were thus used as a basis for course content, teaching strategies and post-project evaluation (7).

In the event, the programme was deemed a success by participants and observers, including teachers, children, school management and the rele-

vant LEA advisory teacher. All looked set for a future successful programme in 1990 and for related curriculum development in other years. However, this proved to be an inaccurate prediction for a number of reasons. On closer examination, these proved to be inextricably linked to the pressures brought about by the implementation of the National Curriculum.

NC targets

For example, the time needed for planning, co-ordinating, monitoring and evaluation was sadly lacking (Table 1). This was directly linked to the avalanche of new responsibilities created by the National Curriculum. Curriculum development priorities had been determined by the pressing

need to deliver the statutory maths, science, and information/design technology attainment targets. In connection with these priorities, new assessment and reporting procedures were also under trial. Whilst the health education programme under discussion was able to deliver a number of relevant targets, particularly within science, the need to satisfy a number of different criteria was seen as time-consuming and problematic.

In addition, the health education co-ordinator moved on and was not replaced. Her enthusiastic co-teacher in the 7th year assumed responsibility for the project, but felt somewhat daunted by the need to support two teachers new to the project in areas which could prove problematic

and controversial. (Examples given were sex education and drug education.)

Inadequate INSET

The new teachers themselves openly admitted their need for training and support, but expressed belief in and commitment to the child-centred ethos at its heart. To this end they readily gave up considerable free time to address some of these problems — official non-contact time was not available on a regular basis. Thus some inhibiting factors to delivery were identified, but these appeared partly balanced by experience gained from the foundation work of the previous year, and the expressed commitment and enthusiasm of the teachers themselves.

Table 1 Programme Log.

| Week | Programme Implementation Week by week | Support Activities | Consistency of programme delivered by selected teachers | Testing Monitoring Evaluation |
|------|--|---|--|--|
| 1 | Introduction of programme to children. | Meeting with researcher & 7th year teachers. Explanation/discussion. | All present | Initial tests (children) Teachers semi-structured interviews. |
| 2 | Delivery of Topic I | Meeting of 7th year teachers. Guidance from 7th yr leader. | " | Review of introduction to programme |
| 3 | Delivery of Topic II | — | " | " |
| 4 | Delivery of Topic III | Meeting with Researcher & 7th yr Teachers. INSET given on The World of Drugs Topic. Content & format of Parents meeting arranged. | " | Short review meeting. 7th yr teachers. |
| 5 | Visit to Human Body Exhibition Science Museum | Parents Meeting on Sex Education input of programme. Researcher gives presentation | Exhibition visit with selected parents. Parent Governor & Researcher | Review discussion by all concerned. |
| 6* | Programme cancelled. Teacher shortage | — | Alternative teachers & programme | — |
| 7 | Delivery of Topic IV | — | — | — |
| 8 | Delivery of Topic V | Visit by National Childbirth Trust Presentation. | All present | — |
| 9 | Delivery of Topic VI | *Meeting with researcher cancelled. Teacher pressure. N.C. INSET activities. | " | — |
| 10* | Delivery of Topic VII cancelled Technology week substituted. | — | — | — |
| 11* | Finishing off topic work so far for presentation at school exhibition. Last topics cancelled for lack of time. | — | — | — |
| 12* | Substitute school activities. | Review/evaluation meeting with Researcher. | — | *Final tests - children half incomplete lack of time/ substitute activity. Final interviews with teacher & other key adults. |

Note: An average of 2 days per week was devoted to this programme
*Indicated shortening/cancellation of programme topics and of evaluation activities

Enthusiasm

However, in the event, the contention that teachers are operating within severe restraints was borne out in the case-study school. Much energy and enthusiasm was devoted to implementing the health education programme, but the competing responsibilities, teacher shortage, inadequate INSET and lack of time for planning and evaluating, all contributed to only partial implementation.

The teachers involved demonstrated considerable commitment to planning and delivery of the programme, but in the event this was not enough to ensure either full delivery or further development in this area. This was despite agreement amongst all concerned participants on the importance of health education, and its relevance to the children. One teacher noted that it was particularly relevant for children with learning difficulties.

A balance is needed

In addition, the headteacher maintained that health education was necessary to give 'balance' to the curriculum, while a parent governor stated:

It is very important, very essential to have it... Nowadays it is more important to cover this subject than ever before, it is essential that schools get it right amidst all the other pressures.

However, the school management viewed health education as a subsidiary part of the science curriculum, rather than as a subject area in its own right. (This was justified by the need to concentrate resources on delivery of the statutory areas of the curriculum, for example science, within which health education played a minor role.) As such, no school policy existed or was planned for in the near future. This only reflects the priorities which have been externally imposed through the National Curriculum. As in schools nationally, the necessary incentive did not exist to make health education a central area of the curriculum.

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Could these results have been expected?

The 'management of change' literature has identified those favourable conditions to successful innovation implementation. These include belief in the change, commitment to it, capability to deliver it, and the necessary continuing management support (8). Other literature on 'effective' schools has identified the need for coherent whole-school policies to deliver educational programmes effectively (9). Considering the pressures on the case-study school, it was not surprising that some of these areas were found wanting in the innovation under discussion (see Table 1). Thus, despite some initial promising signs, development of health education in any significant way appeared unlikely.

The way to success

The lesson that can be learnt from the case study has implications for schools and health education nationally. Health education programmes can succeed only if they are taught by committed teachers with the confidence and capability that comes from carefully-planned and evaluated programmes. Such programmes must be based on coherent policies formulated from an agreed consensus of good practice between teachers, parents and school governors. All of this requires management support, both moral and practical. Re-

sources, in terms of appropriate INSET, non-contact time for planning and monitoring, and supporting teaching materials are crucial.

Support

My belief is that for schools determining curriculum priorities, some kind of external incentive or catalyst is a necessary prerequisite of such action. It is unrealistic to expect committed but unsupported individuals to carry through curriculum innovation in health education. Central government, through the DES and NCC, must take the lead to ensure future development. Unfortunately a current opportunity has been missed to ensure that schools make health education a part of their development plans (10). The moves by Mr MacGregor and Mr Clark to alleviate some of the pressures on schools may only serve further to marginalise health education by creating 'two-tier' subjects. Resources and status will continue to go to the statutory, high-status subjects.

In summary, the education service is currently undergoing 'death by a thousand initiatives'. There is little incentive to innovate beyond the bounds of the statutory (national) curriculum. Where does this leave health education? Several factors inhibiting its development have been identified, and it has been argued that the related problems are only surmountable if the DES shows real

willingness to address them. Thus, a national statutory policy may provide the necessary incentive or catalyst to effect change. Such a policy could well be based on the principles and practice outlined in *Curriculum Guidance 5* (11). However, without effective monitoring through LEAs and HMI, even a statutory policy is unlikely to have the desired effect. Furthermore, any such policy would also need to consider implementation within the current context of curriculum overload and teacher stress (12). To do otherwise might actually be counter-productive to the development of health education in schools.

Training

Training for those delivering programmes must also be provided, both at the initial teacher education stage and for experienced teachers. School governors also should receive appropriate training in these areas, in order to deliver satisfactorily their responsibilities under the 1986 Act. The NCC has issued some pointers through the non-statutory curriculum 'guidance' on health education (11). Future research should attempt to establish whether this is a sufficient spur to development. Past experience would suggest this is unlikely.

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Co-ordination

The association of health education with National Curriculum science need not necessarily be a disadvantage. This could even act as a spur to development, providing the affective side is not neglected. This may require a whole new perspective on science teaching, with the consequent widening of the science teacher's role. However, it is important that health education should be addressed through whole-school policies agreed by a consensus of teachers, parents and school governors. It lends itself particularly well to cross-curricular treatment, but co-ordination is essential for successful delivery (11).

Sadly, this area of education is under-researched. This in itself hinders the development of health education. Practitioners need examples of good practice to emulate and adapt according to local needs. Investment in relevant research is likely to pay dividends (13).

In conclusion, development in this area comes at a price. Statutory policies with their resource implications are necessary catalysts for change. However, to expect such a crucial area of education to be sustained by local commitment is both unrealistic and unfair. Piecemeal strategies cannot succeed in the long term. Our children both need and deserve health education. Central government should ensure that schools and teachers have the ability to provide it.

Neglect in this area leaves schools open to the charge that they are failing to fulfil central obligations of ERA 1988. Namely, to provide a 'broad' and 'balanced' curriculum, to 'promote the spiritual, moral, cultural, mental and physical development of pupils' and 'prepare pupils for the opportunities, responsibilities and experiences of adult life'. Without concerted and positive action, health education

will be unable to make a full contribution to school curricula, and thus to pupils' lives.

Contact Louise O'Connor, Newlead Cottage, Burney Road, Westhumble, Dorking, Surrey RH5 6AX.

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