HEALTH EDUCATION IN SCHOOLS

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(EDITORS)

Health Education in Schools

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FOREWORD

Health education has for a long time been a 'cinderella' subject in most British schools. Yet the schools are only reflecting the ambivalent attitude towards health education which is displayed by health professionals, society at large and most individuals. However, there are good reasons for thinking that a change in educational and social attitudes is both necessary and possible.

Much was achieved by the first historical wave of public health action – better public water supply, sewerage and housing standards. These, together with certain medical advances such as vaccination, immunization, obstetric procedures and antenatal and postnatal care, caused a dramatic improvement in the nation's health and especially the life expectancy of children, from the 1850s to the 1950s.

We now need a second wave. Much of the illness, disability and suffering in our society is self-inflicted. Excesses or imbalances of smoking, drinking and eating and lack of exercise damage individuals. Less obviously, but just as surely, these and similar practices also hurt and damage others. We assault our children when drunk, each other on the road and our sexual partners with sexually transmitted diseases. Industrial organizations kill and maim their employees with industrial diseases and injuries, their customers with hazardous products and the community with pollution. Our society and social organizations induce stress in an increasing number of people each year, yet families and firms are ill-equipped with the knowledge or attitudes needed to give effective help or to remedy the causes.

Moreover, having helped, directly or indirectly, to inflict illness on ourselves we make matters worse by failing to perceive the illness and by making ineffective use of health services and health products. As infectious

diseases are brought under control, handicapping conditions affect a larger proportion of those who survive and their families must learn how to help to manage the condition. As life expectancy increases, more survive into their eighties and need the help and understanding of their families and neighbours.

It seems obvious that our society has not adjusted to these circumstances and that health education must be a prime way of ensuring that it does. The case for health education is therefore unanswerable. But that does not define what health education needs to be or how it can be provided. Certainly it must be more than just 'giving the facts'. It is clear that direct teaching, whether of schoolchildren or adults, is not sufficient to change attitudes which are culturally deeply ingrained. Moreover, a heavy-handed approach is an assault on individual liberty.

The task of the school must be to ensure that children are given knowledge about human development, good diet, health-promoting habits and ways of organizing families and other social groups which promote cohesion and self-confidence rather than stress and breakdown. This cannot be done by merely adding another 'subject' to an already overloaded curriculum. It depends on all teachers understanding how their subject relates to these aspects of life. And that in turn depends on certain senior teachers in a school being given the responsibility to ensure that the theme of health education gets adequate recognition in the curriculum, and also in the hidden curriculum of attitudes and values which a school transmits incidentally by its organization, teaching methods and relationships.

This book sets out to present a wide view of health education in schools, and I am glad to commend it to teachers. The writers are well known in their respective fields, and the editors are nationally known and respected for their work in pastoral care, health education and curriculum development. From their views teachers will be able to assess their own contribution to health education; that is, to an important aspect of the way in which schools prepare pupils for living in the future.

John Tomlinson
Chairman, Schools Council
Director of Education, Cheshire

INTRODUCTION

In this book we set out to survey the present position of health education in schools in the United Kingdom, and to provide evidence of possible future developments. The book is intended as a basic reader or primer for this wide-ranging and diffuse area of education.

Health education is seldom nowadays seen as a narrow parade of physical matters; it is almost universally understood as an omnibus title for physical and mental attitudes to responsible health for the individual and the community, to well-being within a supportive family life and to lives lived positively and with some contentment. Curriculum terms such as 'personal and social education' correlate closely with this view of health.

We hope that *Health Education in Schools* will, with this wide view in mind, provide support or legitimization for the present endeavours of practitioners in health education working in and with schools, and will offer a framework for consideration by others who are facing the need to systematize work in this area. As John Tomlinson says in his foreword, 'a change in educational and social attitudes is both necessary and possible', and we are quite sure that a planned and co-ordinated approach to health education in schools is bound to develop in future. This book may help in this development, for we feel that the work surveyed here should be seen as part of the basic and in-service training of all teachers, not of specialists only. We also feel that such a survey should be part of the reading of health staff who are associated with schools, and of many medical staff and perhaps parents.

Every educational approach needs to be supported by a philosophy and theory, and this is provided by some of our contributors. We believe, however, that there is a strong practical theme to this book as well, and

many of our contributors are concerned with classroom practice as well as with curricular management and development.

In Part I readers will find statements on the theory behind health education. Part II deals with approaches in primary and secondary education, with some emphasis on the Schools Council Health Education Projects. In Part III the contributions of particular academic subjects and of school pastoral organization are reviewed. Although the theme throughout the book is to commend a co-ordinated approach to health education by schools rather than a subject specialism, we need to use the traditional and continuing subject areas in order to transmit the health message.

In Part IV we concentrate on practical approaches to health education within the classroom, and point to the need for informal education skills in the modern view of health education. Part V illustrates the contributions of other services, the necessity for in-service education and the constant need to evaluate our work in this field.

The Appendices to the book should serve as a source of reference of organizations, courses, materials, government reports and books which can support the work of teachers.

This book cannot and should not be prescriptive; it is intended as a source book to provide ideas for those who plan for health education and those who teach it. All schools should have a plan for how they influence children in their health careers, in company with caring parents, but that plan has to be based on that particular school and the personalities within it. We have therefore avoided too much emphasis on particular schemes, in the hope that curriculum planners will seek what their school needs, perhaps from several sources. The formulation of health schemes should only be attempted when set within the specific context of a particular school with its own idiosyncracies and ethos.

We would like to pay tribute to the considerable help given in the preparation of this book by Dee John, Shirley Boyer and Nadine Culshaw. We value also the help of Dr Margaret Jones of the Health Education Council, Mrs Slavin of the Schools Council Health Education Project and colleagues from the Teachers' Advisory Council on Alcohol and Drug Education.

CONTENTS

Abbreviations

The following abbreviations of periodical titles are used in the references to this book:

Am. Soc. Rev.	*American Sociological Review*
Br. Dent. J.	*British Dental Journal*
Br. J. Prev. Soc. Med.	*British Journal of Preventive and Social Medicine*
Camb. J. Ed.	*Cambridge Journal of Education*
Child Dev.	*Child Development*
Curric. Rev. Bul.	*Curriculum Review Bulletin*
Educ. Canada	*Education Canada*
Educ Leader	*Educational Leadership*
Educ. Res.	*Educational Research*
Gift. Child Q.	*Gifted Child Quarterly*
Hlth Educ. Monogr.	*Health Education Monograph*
Hlth Soc. Servs. J.	*Health and Social Services Journal*
Int. J. Hlth Educ.	*International Journal of Health Education*
J. Consult. Psychol.	*Journal of Consulting Psychology*
J. Counsel. Psychol.	*Journal of Counseling Psychology*
J. Curric. Studies	*Journal of Curriculum Studies*
J. Drug. Educ.	*Journal of Drug Education*
J. Educ. Res.	*Journal of Educational Research*
J. Inst. Hlth Educ.	*Journal of the Institute of Health Education*
J. Pers. Soc. Psy.	*Journal of Personality and Social Psychology*
J. Personality	*Journal of Personality*
J. Read.	*Journal of Reading*
J. Saf. Res.	*Journal of Safety Research*
J. Sch. Hlth	*Journal of School Health*
Personn. Guidance J.	*Personnel and Guidance Journal*
Psychol. Rep.	*Psychological Reports*
R. Soc. Hlth J.	*Royal Society of Health Journal*
Sask. J. Educ. Res.	*Saskatchewan Journal of Educational Research*

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PART 1

THE BASES OF HEALTH EDUCATION

INTRODUCTION

One of the major constraining influences upon the success of health education is the failure to develop and use a methodology appropriate to its needs. Those involved in health education have long recognized the need to go beyond the mere passing on of facts and information, if the aim of helping young people to make choices and decisions relevant to their lives is to be achieved. Keith Tones is well known and respected for his work in this area, and in Chapter 1 he explores the philosophy, relevance and practice of the affective domain generally in health education, drawing widely from research in the field. After reading psychology at Cambridge, Keith Tones taught in a secondary modern school and subsequently lectured in colleges of education until his appointment as principal lecturer in health education at Leeds Polytechnic. He is an honorary lecturer in community medicine at Leeds University and has researched various aspects of health education. He is currently involved in running courses at Leeds Polytechnic for health education specialists, both in schools and in the National Health Service.

Health education, like any educational activity of worth, needs to be underpinned by a sound rationale or deeper philosophy if it is to be taken seriously by practitioners. The essence of philosophic debate lies in asking the right kinds of questions no matter how basic or challenging they might be. This formidable task is undertaken in Chapter 2 by Gill Williams and David Aspin. They ask challenging questions and attempt to provide a contextual framework for teachers to supply their own answers. Gill Williams has wide experience in matters of health education and teacher training, having taught physical education and health education in secondary schools, further education colleges, and colleges of education. After work in Manchester Polytechnic with varied professional training groups,

and after taking a master's degree in educational sciences, she became course director of the MSc in health education at Chelsea College, University of London.

David Aspin is professor of education (philosophy) at Kings College, University of London, having previously taught in the universities of Durham, Nottingham and Manchester.

In Chapter 3 Nicholas Dorn, assistant director for the Institute for the Study of Drug Dependence, looks critically at approaches and attitudes in health education, with drug education as a specific example, and he offers a radical viewpoint. He argues that the aims and scope of such education reflect general trends in society and are part of a much broader range of concerns. He uses three examples to support his argument: a Canadian affective education project, an in-service teacher training manual and a discussion of more radical health education. His opinions are challenging and take us well beyond the limits of more conventional viewpoints of what health education implies.

CHAPTER 1

AFFECTIVE EDUCATION AND HEALTH

Keith Tones

> . . . educators must remember that their goal is to produce well adjusted, rational people who can relate and feel, not just non-linear calculating computers . . . (Osman, 1973)

The school curriculum is an amalgam of planned experiences and activities (including content and method of teaching) which describes the ways in which the school attempts to socialize pupils. Curriculum development is the enterprise promoted by educational innovators aiming to change the existing process of socialization. Innovation is necessary because an educational system rarely keeps pace with true social needs; it is rarely completely *relevant*. It frequently ossifies, and unfortunately curators of the curriculum typically resist the onslaught of the innovator. In the words of Benjamin's (1971) witty and allegorical critique of the American education system, the curriculum is often 'saber-toothed'.

The question of relevance assumes a particular significance when the innovator seeks to add to an already crowded curriculum and may require certain existing parts to be removed. The task is difficult at the best of times but even more problematical when the innovation demands not merely new subject matter but a different emphasis or a different approach. Health education is currently searching for recognizable status within a core curriculum in the schools. Its marginal status is recognized by the Scottish Education Department's Curriculum Paper 14 (1974):

> Health education occupies an indeterminate and ambivalent position: it has not yet been accepted as an essential part of the fabric of education. It tends to fall into the no-man's land between the school and the home, or within the school to be everyone's concern but no-one's responsibility. . . . It is often equated with

sex education in the schools' as in the public mind and this itself gives rise to difficulty and confusion.

The problems faced by health education in pressing its territorial claims doubtless have something to do with its ill-defined boundaries and pretensions to be about everything physical, mental and social – a fact which led Goldstein (1975) to comment, '. . . if the study of health is the study of everything, it is the serious study of nothing'. However, the reference in Curriculum Paper 14 to sex education and the schools' anxiety about trespassing on the preserves of the family and the home provides us with a useful insight into the difficulties faced by health education. Schools have tended to be concerned largely with cognitive matters; their function is seen to be that of supplying information and promoting understanding. Health education requires a shift in emphasis from the cognitive to the affective. Although health education has a very important cognitive base, it becomes problematical only when it deals with values and attitudes; it proves difficult when it probes social problems, attempts to increase teacher sensitivities, develops personal and social skills and even attempts to change pupils' behaviours. Part of this problem derives from the fact that teachers are usually ill-prepared to deal with affective issues and are rarely equipped with the teaching methods necessary to handle them. This in turn is doubtless due in part to a belief that such values and behaviours are indeed the province of parents, and in part to a belief that education should focus predominantly on the provision of knowledge and related cognitive skills. The pursuit of rationality should be the school's main contribution to transmitting that which is most worthwhile in society. As Hirst (1969) says: 'If once the central objectives of rationality are submerged, or are given up so that . . . other pursuits take over, then I suggest the school has betrayed its educational trust no matter how successful it may be in these other respects, and no matter how laudable these other ends may be in themselves.'

It is worth drawing attention to the fact that such an approach is at odds with the preventive aims of health education in the National Health Service (Tones, 1976), which tends to consider that the school has a tougher part to play in the fight to promote preventive medicine. Various government reports would seem to adopt this viewpoint (see Appendix IV).

My own belief is that the school cannot reasonably avoid committing itself to affective health education, and this stems partly from the view that