The Future of Health Education

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In this article I propose to consider the future of health education in relation to schools; to explore the continuing need for health education of young people and hence the priorities for schools; and the dilemmas and uncertainties, as well as the opportunities, that affect its provision. What follows relates principally to health education in schools in England; the curriculum in schools in Northern Ireland and Wales is similar to that in England, but the system is quite different in schools in Scotland.

Before looking to the future, it might be worth reviewing what has influenced the provision until now. The need for school health education is no less today than it was at the turn of the century when one in three men recruited to fight in the Boer War were found to be medically unfit[1]. There were stark contrasts then between the health of those who were affluent and those who were poor. Concern about the levels of under-nourishment of large sectors of the population led to the establishment of the school health service and the school meals service. Teaching about hygiene and home economics became part of the curriculum of schools and teacher training. There was concern too, about the effects on family life of the continuing effects of industrialization, and of the use and abuse of alcohol and substances such as opium.

Many of the social inequalities that existed then still exist today. The health services still have to cope with the diseases caused by poverty and affluence and those caused by the use and abuse of tobacco, alcohol and other substances (including both prescribed medicines and illicit drugs). Furthermore, the moral dimension surrounding sex education and family life is every bit as strong. The targets in the government's White Paper, *The Health of the Nation*, reflect these priorities[2].

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There is still a need to teach young people about the elements of good nutrition – whether it is about how to provide a balanced diet with adequate fruit and vegetables on a limited income, or about the diseases caused by excesses of certain types of food. Then there are those factors that relate to other aspects of lifestyle and behaviour. These include the response to opportunities to take physical activity and thereby improve physical fitness; the behaviours related to escapism and the "feel-good factor" – use of tobacco, alcohol, illicit drugs and other substances that affect mood and ability to cope with the pressures of daily living; and, finally, the moral dilemmas concerned with sexual attitudes and behaviour.

Much to Be Proud of

Schools have responded over the years to different degrees and in different ways to provide health education as part of the curriculum for some or all of their pupils at different times. A recent article by Derek Lewis, OBE, a former HMI, provides a useful review of health education in schools during the past 50 years and sets out what has been achieved in that time[3].

By comparison with several other European countries, the education system here has much to be proud of, in terms of what has been provided and achieved in health education. Several of our overseas neighbours look to the United Kingdom for models of good practice.

But how well are schools placed to respond to the health needs of young people in the future? Who is available to support schools in providing broad and balanced programmes of health education? In several respects, the future is uncertain.

This article is based on a talk given to the conference on health education organized by the London section of the National Liaison Group for health and drugs education co-ordinators at Robinson College, Cambridge on 21 March 1994.

The reorganization of regional health authorities is giving rise to uncertainty about the future of health promotion officers, many of whom have provided invaluable support and guidance to schools in the development and resourcing of their curricular programmes. Will health promotion officers in the new system still have a remit which enables them to continue to work with schools?

The reorganization of the health service has been extended now to include the Health Education Authority (HEA). For many of us, it seems only yesterday that the HEA arose like a phoenix from the ashes of the former Health Education Council (HEC). The Young People's Unit of the HEC and then the HEA has been the leading organization in England for the identification and promotion of initiatives in this field. It has provided financial support for research and curricular development in school health education and in teacher education. Its activities have led to the production of a wide range of teaching materials which are used extensively by schools. What will its future be in a reorganized authority, where there will probably be different priorities, roles and responsibilities?

The 1988 and 1992 Education Acts have led to major changes in the school curriculum, to changes in the financial management of schools and in the roles and responsibilities of local education authorities (LEAs). In particular, there has been a serious decline in the number of local education authority inspectors and advisers, including those with a remit for health education.

Loss of Funding

The changes in financial arrangements have encouraged schools to identify their needs for in-service education more carefully and allow them to purchase it from a wider range of organizations than was possible under the former arrangements. But this has not always worked to the benefit of health education – sometimes other aspects of the curriculum have taken priority. However, the Grant for Education Support and Training for Preventive Health Education (GEST) from the Department for Education between 1986 and 1993 for the posts of LEA health education co-ordinators, and that for INSET, provided a tremendous stimulus for health education. It helped to raise the levels of activity in schools and increased the expertise of many teachers. It is disappointing, therefore, to find that the loss of the GEST funding, at the same time as other changes in LEA advisory services, has resulted in the dispersion of many health education co-ordinators and the consequent loss of their expertise and support to schools. What capacity and role will LEAs have in the future to initiate and co-ordinate curriculum development and INSET at the local level?

The introduction of the National Curriculum in schools with the statutory orders for each subject setting out programmes of study and attainment targets, has resulted in a more secure place for some aspects of health education. The inclusion of many important health topics in science and in physical education has also helped to raise teachers' awareness of the issues. The 1988 Education Act identified health education as one of the major cross-curricular themes and the former National Curriculum Council issued very helpful guidance for schools on health education (*Curriculum Guidance 5*)[4].

Curriculum Overload

This document set out the nine principal headings for health education and provided strategies for its inclusion in the National Curriculum. While the National Curriculum has led to more consistent approaches to teaching and learning in most subjects, it has been bedevilled by curriculum overload with densely crowded programmes of study. The recent review by the School Curriculum and Assessment Authority proposes significant changes to the curriculum with a slimming down of the prescribed programmes of study for most subjects and a reduction in the number of subjects which must be studied by all pupils throughout their school careers[5].

The proposed changes could affect health education in two ways. Schools will have more time to cover work other than that laid down in the National Curriculum, at their discretion. This might enable them to plan more and better courses in personal social and health education. But if others are to dictate their priorities for the use of this time, then they will be no better off.

The report includes the recommendation that "The first priority for discretionary time must be to support work in the basics of literacy, oracy and numeracy", but it also points out that "...time must also be found at Key Stage 3 (and Key Stage 4) for sex education as required by law...".

Vocational Courses

Schools are coming under pressure again to increase the range of vocational subjects that are included in the latter stages of secondary education (Key Stage 4). While vocational work could well bring greater relevance to the curricula of the pupils who choose them, the current General National Vocational Qualification course in health and social care is no substitute for a

broad and balanced personal, social and health education programme for all pupils.

The former is more concerned with assisting pupils who choose it to take up a career in one of the caring services on leaving school. The latter should enable *all* pupils to consider a wide range of health issues and develop skills and attitudes likely to promote the pursuance of a healthy lifestyle, with an emphasis on taking responsibility for themselves and for others, based on up-to-date knowledge of the facts and the risks they face if they adopt less-than-healthy behaviours.

Sex Education

Three other recent Education Acts have had significant effects on school health education. The 1986 Act requires the governing bodies of all maintained schools to set out their policy for sex education in the curriculum and to make sure that this policy is communicated to parents. The inclusion of aspects of sex education, including teaching about HIV and AIDS in the National Curriculum orders for science was an important step forward in ensuring that all pupils could be taught not only about the biological aspects of human reproduction, but also about aspects of sexual behaviour and sexual responsibility. The moral dimension to this teaching was also addressed in the 1986 Act. In effect, this has been followed through in the 1992 Education Act, which changed the arrangements for school inspections, since these now have to include inspection of and reporting on schools' provisions for pupils' spiritual, moral, social and cultural development. This should naturally include the work done as part of sex (and health) education.

Certain groups have long campaigned for the removal of all teaching about sex education from the curriculum and the transfer of responsibility for it to parents. This pressure has increased since teaching about sex education and HIV/AIDS was included in the science orders. From September 1994, the 1993 Education Act will remove those aspects of sex and HIV/AIDS education included in the statutory orders for science, while at the same time requiring all secondary schools to provide a separate programme of sex education. It leaves primary schools with the option of providing sex education if they wish to do so. The new Act also formally enables parents to withdraw their children from any programme for sex education that the school provides.

The Parents' Role

Parents are responsible for ensuring that their children are soundly and wisely taught about health and sexual matters. Unfortunately, not all parents feel able to do this effectively and these topics are too important to be left to chance. Schools provide the only common thread for all children and it is vital therefore not to reduce schools' ability to support and extend work in health education that should be started in the home.

The teaching of sex education is not served well if the media and the opposition, hungry for ammunition to serve their cause, are able to highlight deficiencies and occasions when a topic has not been handled as tactfully as it should have been. The teaching of sensitive issues in schools is never easy and it requires considerable skill and confidence on the part of teachers if it is to be done effectively.

The introduction of the new statutory system for school inspections as part of the 1992 Education Act has helped to raise the profile of health education and in the long term could be its saviour. All inspectors inspecting schools as part of the 1992 Act are required to undergo training and to use *The Framework for the Inspection of Schools* laid down by the Office of Her Majesty's Chief Inspector of Schools[6]. The framework is set out in sections and requires inspectors to look at the standards of achievement of pupils, the quality of their learning and the factors which contribute to those standards. Evaluation criteria, set out for each section of the Inspection Schedule of the framework, help the inspectors to arrive at their judgements. They are also guided on the range of evidence they should use in arriving at those judgements.

Inspection of Health Education

The inspection of health education forms part of three major sections in the Inspection Schedule:

(1) In the section dealing with pupils' personal development and behaviour – in particular pupils' spiritual, moral, social and cultural development (Section 5.1).

(2) In the section covering the quality and range of the curriculum, where inspectors must consider the governing body's policy for sex education (Section 7.3(i)).

(3) In the section on pupils' welfare and guidance where the inspectors are required to evaluate the quality and range of health education and the effectiveness of the implementation of the governing body's policy for sex education. In addition, in this section, an evaluation must be made of the effectiveness of the school's procedures for assuring pupils' wellbeing, health and safety (Section 7.7).

Inspection and reporting on health education is implicit in other parts of the framework too, such as in the section dealing with equality of opportunity, the arrangements for links with parents, agencies and the community, and in the different subjects that make up the curriculum.

High Hopes

The inclusion of health education in the inspection is serving to raise expectations – both on the part of the inspectors that the schools will make provision for it and on the part of the schools that they should provide it and therefore expect it to be inspected and evaluated.

It is inevitable that every good point is matched by one that is less satisfactory. The series of reports of HMI inspections of health education in different LEAs, issued since the early 1980s, have enabled the public to learn about the range and quality of provision made by primary, secondary and special schools. These reports have also provided the opportunity for disseminating good practice. But the reduction in the number of inspectors since the 1992 Education Act came into being, coupled with new roles and responsibilities for those remaining within their new department – the Office for Standards in Education (OFSTED) – make it extremely unlikely that Her Majesty's Inspectors will, in the near future at least, be able to undertake surveys of LEAs and inspect and report on school health education.

Drawbacks

In the new system of inspections, the subjects of the National Curriculum are inspected and reported on in their own right, but the inspection of courses and lessons in health education will not form a separate feature in the inspection reports on schools. Unless the inspector is skilled in writing about, for example, pupils' welfare and guidance and is permitted to include well-chosen illustrative examples, it is unlikely that good practice in health education will emerge clearly from these new inspections.

Since all inspectors have to undergo training in the use of the framework – and that includes the lay as well as the professional team inspectors – one might hope that every team will include a member who is well versed in health education. Sadly, that is not assured since the training is short and there is much to cover. The framework itself is lengthy and detailed. Many inspectors are unfamiliar with the nature and use of evaluation criteria and their training course has to concentrate on familiarizing them with the framework, the statutory requirements for education and the code of conduct for inspection. They have to learn how to make lesson observations as a major part of the inspection evidence, using the evaluation criteria in arriving at judgements of standards and quality.

Trainee inspectors are also given opportunities to learn how to report their findings, both orally and in writing. The time that can be given to detailed consideration of any part of any section of the framework is therefore somewhat limited. Most inspectors gain their detailed knowledge by experience in using the framework during inspections.

Inspecting Personal Development

It is difficult to inspect pupils' personal development. It is important that the range of evidence necessary to arrive at sound judgements is not narrowly interpreted. Inspectors with responsibility for reporting on this section of the framework might benefit from more guidance in interpreting the breadth of the evidence on which they might draw. An examination of the evaluation criteria for spiritual, moral, social and cultural development will show how effective courses in health education should contribute to pupils' personal development.

Many registered inspectors are asking their lay inspectors to take responsibility for the inspection of pupils' welfare and guidance. But while lay inspectors bring a fresh eye and often much useful experience from their careers in the outside world, they do not necessarily have the sort of expertise in picking up and understanding the nuances of what makes for good health education. Inspectors need to look in detail at the organization of the programme and the arrangements for ensuring appropriate co-ordination and coherence; decide on the appropriateness of topics that are taught in different year groups; look at the numbers of teachers who are involved and consider their expertise and training in health education; and, finally, observe the teaching to decide if the styles in evidence are likely to lead to effective and sensitive teaching about health matters.

My work as an HMI over the years involved me in the inspection of health education in very many schools, and taught me about the difficulties of timing the inspection to coincide with teaching about aspects of health education. On many occasions, one had to capitalize on what little was taking place at the time in the school and often rely on other signals that lent support to the judgement that health education had a secure place in the curriculum and that there was sufficient expertise to enable the teaching of sensitive issues to be done effectively.

Health-promoting Schools

Finally, an optimistic note. There is another very important development in school health education which could, and I hope will, provide the model for good practice in all schools in the future. The HEA is acting as national co-ordinating centre for the United Kingdom's participation in the forthcoming European Network of Health-Promoting Schools. This project will link schools from England, Wales, Scotland and Northern Ireland with schools in other western and eastern European countries.

More than 1,300 schools in England expressed an interest in being part of the project when it was first publicized at the end of last year and, so far, more than 500 schools have completed detailed questionnaires about their current level of provision of health education. This alone is yielding much up-to-date and useful information about the status of health education in schools. The selection criteria are rigorous because the project includes a research dimension, and this aspect of the project is being directed by the National Foundation for Educational Research (NFER). It is hoped that the selection process will be completed towards the end of May, in time for a launch conference at the beginning of July.

Initially only a small number of schools will take part in the project, but the intention is to disseminate the outcomes of their work during the life of the project, so that others can begin to learn from their experiences and apply successful strategies. The project schools will be looking at ways of promoting health in a holistic way, and the work will involve not only the pupils and the teachers, but also all the adults who work in and serve the school, together with the parents and members of the local community.

Models of Good Practice

The schools will be encouraged to carry out their own research and to explore different models for becoming health promoting. They will consider not only what is provided by the formal timetabled curriculum but also the wider aspects of the life and work of the pupils and staff: extra-curricular activities, the opportunities for the physical environment to contribute to the sense of health and wellbeing, the quality of interpersonal relationships, the opportunities for increasing personal responsibility, and the development and practice of healthy lifestyles in the school.

Each school in the project will be required to draw up a development plan. They will be encouraged to keep "diaries" and records of their discussions and activities, their successes and their failures, so that the process will be fully documented and provide valuable information and experience for other schools which embark on similar projects later.

The project will need to go much wider than schools if it is to have a major impact on the formulation of successful health promotion strategies and the identification of effective ways of educating people about health. From the outset, the HEA intends to encourage the formation of "healthy alliances" between schools and agencies concerned with health education and health promotion, so that the project can be regarded as a partnership, with a shared philosophy and shared aims of enabling young people to appreciate and follow a healthy lifestyle.

Need for Vigilance

While the future of many aspects of school health education is fraught with uncertainty, schools have many opportunities to develop and extend their work in health education. Everyone needs to be vigilant to ensure that other pressures on schools do not squeeze health education out; and that vested interests do not marginalize or compromise the position of health education in schools or blight the abilities of teachers to teach about health matters sensibly and sensitively. The need for good health education is unlikely ever to disappear, so those in a position to influence it must continue to be active and supportive of the contribution that schools will make in the future.

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References

1. McElwee, W., *The Story of England*, Faber & Faber, London, 1961.
2. Department of Health, *The Health of the Nation*, HMSO, London, 1992.
3. Lewis, D.F., "Oh for Those Halcyon Days!", *Health Education Journal*, Vol. 52 No. 3, 1993, pp. 161-71.
4. *Curriculum Guidance 5: Health Education*, National Curriculum Council, 1990.
5. Dearing, R., *The National Curriculum and Its Assessment*, School Curriculum and Assessment Authority, 1994.
6. Office for Standards in Education, "Framework for the Inspection of Schools", in *The Handbook for the Inspection of Schools*, HMSO, London, 1993.

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